# On Inconvenient Truths

Some clinical truths are harder to accept than others. They may challenge dearly held practice convictions and require courage and forceful resolve to absorb their implicit inconveniences into routine practice. The discipline continues to require enlightened and imaginative leadership to deal with this difficult remit while ensuring a benchmark of high professional standards with global implications. To date, all of us have been beneficiaries of the necessary and ongoing shifts in the applied scholarship agendas of service, education, and research, as we continue to seek collective responses to current inconvenient truths.

I joined our discipline's clinical academic community during the twin solitudes era of the 1960s. In those days, prosthodontics was arbitrarily divided into those who "did pink" (removable) and those who were determined to avoid it at all costs (fixed). The split was routinely underscored at numerous meetings where examples of clinical and laboratory virtuosity provided brilliant pictorial presentations. In those days, there was little mention of possible expiration dates for clinical ingenuity, and in retrospect, it appeared that treatment decisions often precluded serious concerns regarding long-term outcome criteria. (The memory of so-called periodontal prostheses still lingers as a bizarre example of oral rehabilitation achievement.) Gradually, traditional materials science and laboratory skills merged with stronger biological concerns and led to subtle if profound shifts in dentist- and patient-mediated perceptions. It remains tempting to regard Brånemark's research in osseointegration as the catalyst for a nearly overnight convergence of prior scholarly initiatives, culminating in the discipline's ensuing giant leap of clinical science. The related chapters of prosthodontic mindsets rapidly coalesced into a single narrative as treatment challenges (more often dilemmas) were confronted with a far better answer to the perennial question: What is the ecologic price implicit in both the predicament of tooth loss as well as its management? The question's implied inconvenient truth was met head on with a new level of scientific clinical rigor. Consequently, clinical teachers of my vintage, together with our midcareer colleagues, have been fortunate indeed to preside over an educational and practice era wherein the risk of treatment anarchy was finally countered with better evidence-based clinical decisions. The individual clinician's claim to being the single hegemon was challenged by wide and new intellectual capital, culminating in hopes for an even more exciting era of ecologically sound dental therapy.

Regrettably, the old traditional dentistry habit of promoting technology without strong scientific underpinnings continues to die hard. The integrity of purpose and scientific rigor that characterized the original osseointegration clinical research has been largely discarded as passé. Partnerships with commercial enterprise now dominate continuing education with an educational thrust based on a veritable catwalk of implant designs and their presumed impact on the timing of occlusal loading protocols, together with technique-driven agendas that underscore the superiority of a near-robotic approach to managing patient needs. New lecture circuit celebrities are recruited to promote osseointegration's newer and expanded promise, which falls significantly outside the technique's initial oral ecologic context. The inconvenient truth is the discipline's dire need for rectitude and a nondoctrinaire frankness about the resultant predicament.

I hasten to acknowledge that medical marvels such as endoscopic surgery and robotically performed orthopedic replacements continue to elicit wonder and gratitude for the scholarly and commercial synergies that created them. We in prosthodontics have been in the "biological spare parts" business for a long time, but without having to face the serious hazards that continue to confront our medical colleagues. And our extraordinary osseointegration treatment advances are very much the result of comparable synergies in the pursuit of a better world of patient care. However, the risk of yet another anarchic phase in treatment decision making has resurfaced. The resultant inconvenient truth is that our disinterested and open-minded quest for truth in clinical progress risks being compromised and may ultimately subvert the public interest. We are confronted with the predicament of becoming inadvertent handmaidens of industry by subscribing to complexity in the name of technological advances, and surrendering to data that promote products without information on long-term outcomes. Above all, we risk overlooking safety, simplicity, and prudence in our clinical judgment.

The recent news regarding the content and quality of "outsourced" materials used in routine laboratory protocols in prosthodontic treatment underscores the ambivalence of our professional predicament. It has sent shock waves through the ranks of our profession and our longstanding partner, the dental laboratory industry. It is an inconvenient truth of alarming proportion, and thus merited an invited commentary on the subject from a highly respected clinical scholar. Dr Gary Goldstein's essay is a lucid and articulate analysis of a serious challenge to our professional judgment and conduct. It is a stark reminder that whatever ethical bed we make, we lie in.

George A. Zarb, Editor-in-Chief

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