PROFILE

Ronald E. Goldstein, DDS

Current Occupation
Private practice

Education
Emory University School of Dentistry, Atlanta, GA 1957, DDS

Academic and Other Affiliations
Clinical professor of oral rehabilitation, Medical College of Georgia School of Dentistry, Augusta, GA
Adjunct clinical professor of Prosthodontics, Boston University's Henry M. Goldman School of Dental Medicine, Boston, MA
Adjunct professor of Restorative Dentistry, University of Texas Health Science Center, San Antonio, TX

Professional Memberships
American Academy of Esthetic Dentistry (AAED)
American Dental Association
American and International Associations for Dental Research
European Academy of Aesthetic Dentistry (lifetime honorary)
American Academy of Fixed Prosthodontics

Positions Held
Cofounder and past president, AAED (1975–1976, 1977–1978)
Past president, International Federation of Esthetic Dentistry (1997–2002)
Coeditor-in-chief, *Journal of Esthetic Dentistry* (1993–1998)
Past president, Alpha Omega International Dental Fraternity (1976)
General chairman, Thomas P. Hinman Dental Meeting (1978)

Honors/Awards
1992 Charles L. Pincus Award for Contributions to Esthetic Dentistry from the American Academy of Esthetic Dentistry
1992 Outstanding Contribution to Cosmetic Dentistry Award from the American Academy of Cosmetic Dentistry
1997 Achievement Award, Alpha Omega International Dental Fraternity
1987 Distinguished Practitioner, National Academies of Practice
2001 Distinguished Alumni, Emory University

Publications
Author, *Change Your Smile* (published by Quintessence Publishing Co., now in its third edition, it has been translated into eight languages)
Author, *Esthetics in Dentistry* (published by BC Decker, now in its second edition)
Coauthor of *Bleaching Teeth, Porcelain Laminate Veneers, Porcelain & Composite Inlays & Onlays, Imaging In Esthetic Dentistry*, and *Complete Dental Bleaching* (all published by Quintessence Publishing Co.)
Editorial advisory board, *New Beauty Magazine*
Column editor, *Contemporary Esthetics and Restorative Practice* (2000–2005)
Advisory board, *Dentistry Today* and *Inside Dentistry* (current)

Personal Interests
Photography, wine, great food

Notable Contributions to Dentistry
Developed over 150 different dental instruments (burs, diamonds, etc.)
Created esthetic techniques for direct bonding using composite resins in the 1960s
Authored the first textbook on comprehensive esthetic dentistry (*Esthetics in Dentistry*)
Authored the first comprehensive guide to esthetic dentistry for the lay public (*Change Your Smile*)
Cofounded the first academy devoted to esthetic dentistry (AAED)

Other Items of Interest
In the 1960s created a successful program in mental health and retardation used in 5,000 cities in the United States, and later internationally, through the Junior Chamber of Commerce

Attitudes and Problems Faced by Both Patients and Dentists in Esthetic Dentistry Today: An AAED Membership Survey

RONALD E. GOLDSTEIN, DDS*

In recent years, the subject of botched dentistry has been featured in the public media.[1] Although the Webster's[2] dictionary definition of the word "botch" is to put together unsuitably or unskillfully, in a professional setting "botch" implies either severe esthetic or functional dental failures. In the first edition of my textbook *Esthetics in Dentistry*,[3] published in 1976, under the subject of esthetic failure it states, "Successful dental treatment is the objective of every dentist and it is measured not only by the attending dentist, but also by the patient. What is considered esthetic by the dentist may not be seen so by the patient." Therefore, an esthetic failure may not necessarily be botched as it can be caused by not meeting the patient's own expectations, even though the treatment may have been done correctly. Overall, botched dentistry consists of treatments considered to be below the prevailing standard of care, and many times these types of cases have been completed by dentists who attempted treatments above and beyond their capabilities. Examples of botched esthetic cases are seen in Figures 1 through 3.

Further discussion in *Esthetics in Dentistry* states:

Patients sometimes consider their restorative treatment as an esthetic failure when it is actually a compromise. This usually happens when the patient was not fully aware of treatment limitations. When an esthetic compromise is necessary, a thorough explanation of the limitations and the reasons for them is essential. The patient needs to understand the compromise before treatment begins.[3]

Not long ago, a patient came to me, after having searched for more than 15 years, to obtain the esthetic results she envisioned. She had received treatment from five different dentists, which consisted of eight different sets of temporary restorations and five final sets of

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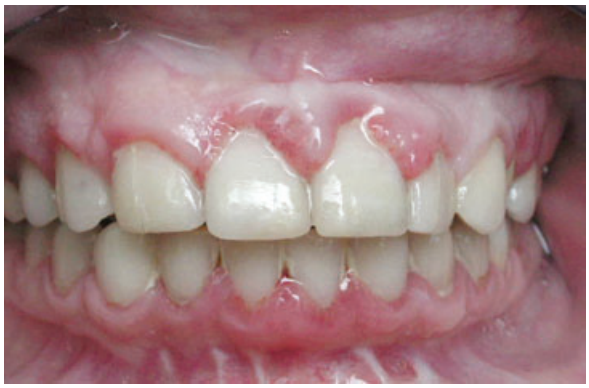

Figure 1. Poor-fitting porcelain laminate veneers caused this patient to have extensive periodontal treatment before the restorations could be redone by another dental office.

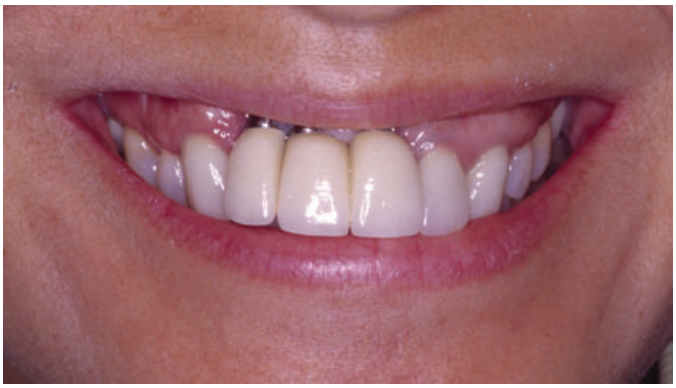

Figure 2. Inadequate diagnosis, treatment planning, and implant surgery led to an unacceptable functional and esthetic result for this patient.

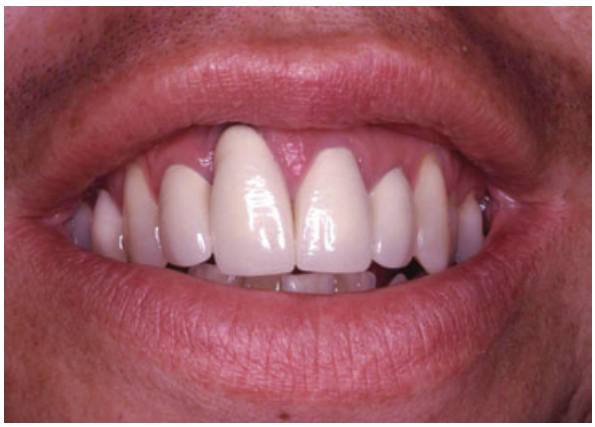

Figure 3. Failure to provide the patient with adequate specialty consultation plus poor diagnosis and prosthetic choices resulted in this patient's dissatisfaction with his final esthetic result.

restorations (which she refused to have seated with final cement). This was a situation where all the dentists did their best to please the patient, and from my viewpoint they all achieved acceptable results; however, to the patient the results were esthetic failures.

Botched dentistry might include full-mouth reconstructions with defective open margins throughout or inadequate occlusions to the extent that simple occlusal adjustments do not correct the situation, potentially causing discomfort and additional health concerns. An extreme botched treatment could be one in which the dentist was so incompetent that the result bordered on malpractice!

Although we never know what circumstances a previous dentist encountered during his or her treatment, the examining dentist is ethically obligated to perform a thorough clinical exam, tooth-by-tooth and arch-by-arch. This also means taking full-mouth radiographs and doing occlusal analysis, especially if the patient has pain chewing or if there is evidence of temporomandibular joint dysfunction. Any defects must be documented in the patient's chart. As I discussed in *Esthetics in Dentistry*:

Comments on the discussions and the patient's choice of treatment should be recorded in the patient's

chart, and the patient should get a letter documenting this choice. This will serve as a reminder to the patient who may forget the limitations and may consider the treatment of the previous dentist poor.[3]

Most conscientious dentists would try to redo treatment until the patient is satisfied or until functional problems are corrected. In circumstances of botched dentistry, the patient has lost confidence in the dentist's ability and usually chooses to go elsewhere for the treatment to be redone.

Further discussion in *Esthetics in Dentistry* includes:

Dentists assume the laboratory procedures are done correctly. Occasionally failure does occur through no fault of the dentist, who must still assume the responsibility and undertake the repair. Patients are not interested in what the laboratory did or did not do. If dentists want to maintain rapport with the public, they must continue to assume responsibility.[3]

On June 29, 2004, *The Wall Street Journal* published an article written by Amir Efrati titled "New Business for Dentists: Fixing Botched Cosmetic Work,"[1] which featured quotes by some of dentistry's leaders in the profession. In an effort to determine how extensive the problem has become, in May 2006 a four-question survey was distributed via email to all members of the American Academy of Esthetic Dentistry (AAED).

What follows is a summary of the 71 responses received from AAED members, representing a response rate of 54%. The answers are based upon the individual members' own experience in clinical practice.

The first question was "*What do you see as the biggest threat to our profession today?*"

As seen in Table 1, these answers represent the frustration and disappointment Academy members are feeling with the quality of treatment that has become more common today. One respondent identified the change as "the lack of meticulous care of yesterday." Part of this issue is complicated by the profession's inability to create standard guidelines for esthetic procedures. As another respondent commented, "There is no cohesiveness with the legitimate dental schools, so other institutes like [. . .] will proliferate."

Another respondent commented that unregulated self-established esthetic institutes contribute to "unethical 'destruction for production.'" Unfortunately a small percentage of dentists too often do extensive treatment beyond their capabilities, which compromises the quality of the treatments by focusing on profit making, and thereby often aggressively overtreating their patients.

TABLE 1. RESPONSES TO QUESTION ONE: "WHAT DO YOU SEE IS THE BIGGEST THREAT TO OUR PROFESSION TODAY?".

	%
Botched dentistry	24.30
Overtreatment	17.76
Shortage of qualified faculty	14.02
Misrepresentation of dental products and direct marketing to the public	9.35
Third-party interference	9.35
Unregulated esthetic institutes	8.41
Failure to train dentists properly in ethics and professionalism	7.48
Patient ignorance/lack of public understanding	1.87
None	1.87
Cost of dental education	1.87
Becoming a trade, not a profession	1.87
Malicious litigation	0.93
Controlling the dentist/patient ratio	0.93

Results for this question show that the biggest threats to our profession today are botched dentistry and overtreatment, with the combination of them amounting to 42% of the membership survey.

Further contributing to the problem, some educational institutes have "a shortage of qualified faculty," as identified by many respondents. As one member commented, the result will be "poor education of dental students with regards to understanding their limitations, how to appropriately treatment plan, and how and when to utilize an interdisciplinary team."

The second question was "*What is the biggest threat to esthetic dentistry today?*"

As seen in Table 2, these responses demonstrate that commercially oriented esthetic dentistry has become the biggest threat to esthetic dentistry today because of the impact it has on the public's perception. As one member commented, "We are developing a reputation of money-hungry dentists." The current obsessive esthetic concerns by patients only aggravate the damage unethical dentists can generate for the profession. One member summarized the threat well, "Unethical dentists taking advantage of the current demand for 'cosmetic dentistry' and providing unnecessary, poorly performed restorative procedures on unsuspecting patients."

The third question was "*What is the single biggest complaint you receive from patients today?*"

TABLE 2. RESPONSES TO QUESTION TWO: "WHAT IS THE BIGGEST THREAT TO ESTHETIC DENTISTRY TODAY?"

	%
Overtreatment	33.04
Influence of unregulated educational institutes	18.26
Inadequate training	16.52
Botched dentistry	10.43
Unrealistic expectations created by the media	7.83
Inadequate product research	6.96
Shortage of qualified laboratory technicians	3.48
Patient ignorance	0.87
Lawsuits	0.87
Bleaching techniques that cause early destruction of enamel	0.87
The unlikely long-term life and longevity of posterior composite restorations in permanent teeth	0.87

Results for question two again emphasize overtreatment and botched dentistry (43%), with the influence of unregulated educational institutes and inadequate training amounting to 35%.

TABLE 3. RESPONSES TO QUESTION THREE: "WHAT IS THE SINGLE BIGGEST COMPLAINT YOU RECEIVED FROM PATIENTS TODAY?"

	%
High costs	25.88
Previous botched dentistry	24.71
Treatment time/length	16.47
Not applicable	5.88
Inadequate insurance coverage	4.71
Patients unhappy with their smile	3.53
Dentists being late/patients waiting	3.53
Not enjoying going to the dentist	2.35
Complaints about traffic and parking	2.35
My patients do not complain	2.35
Insensitivity to patient's pain	2.35
"The dentist doesn't listen to what I have to say"	1.18
Lack of honest communication from the dentist	1.18
Previously uninformed about treatment options	1.18
"I feel that I'm being sold something rather than getting a professional consultation"	1.18
Color realism in restorations	1.18

Not surprisingly, the single largest complaint received from patients was high cost; however, one-quarter of the respondents listed botched dentistry as the most frequent complaint received from patients.

As seen in Table 3, previous botched dentistry is an issue that should concern all dentists because of the repercussions it has on the image of esthetic dentistry. As one respondent commented, "Poorly executed dentistry leads to a generation of distrust in the profession as

a whole." The lack of effective communication between dentist and patient leads to poor esthetic outcomes. It also makes patients have misgivings about dentists, as exemplified by one member's response about the biggest complaint received from patients today, "They have been deceived by their dentist and were uninformed prior to treatment. I always hear 'If I only knew before.' "

In addition, these patients become challenging to work with for the next dentists. As one member commented on the biggest complaint received, "Why didn't someone tell me I had a problem before now?" This makes the relationship between the dentist and the patient more challenging due to the patient's loss of confidence in the profession. Therefore, "the psychological management of the traumatized 'retreatment' patient," as a respondent commented, becomes an additional obstacle the dentist has to overcome.

TABLE 4. RESPONSES TO QUESTION THREE: "IN YOUR PRACTICE, WHAT IS THE BIGGEST PROBLEM YOU FACE IN ESTHETIC DENTISTRY TODAY?"

	%
Unrealistic patient expectations	22.89
Previous botched dentistry	19.28
Not enough qualified ceramists	12.05
Concept of esthetics unduly influenced by the media	7.23
Not applicable	4.82
High costs	3.61
Inadequate research on dental materials	3.61
Shade matching	3.61
Having sufficient time	2.41
Patient ignorance	2.41
Overtreatment	2.41
Fear of charging the appropriate fees for the procedure	2.41
Communication problems between the generalist and the specialist	1.20
Psychological management of the traumatized "retreatment" patient	1.20
Patient ignorance in conjunction with the dental professionals who perpetuate it	1.20
People with the resources not interested in esthetic improvement	1.20
Adjacent implant esthetics, soft tissue appearance after major grafting	1.20
Dealing with bureaucracy from educational institutions	1.20
What to do for dentintogenesis imperfecta patients from 6 to 20 years of age	1.20
Cultivating patient appreciation for a natural appearance	1.20
Knowing what the patient really wants and exceeding their expectations	1.20
Poor dental health	1.20
Increasing amount of general gingival recession and heavy neck defects on young adults because of acids in drinks, food, and drugs in connection with excessive toothbrushing	1.20

When confronted with the largest problems members face in esthetic dentistry today, unrealistic patient expectations (22.89%) and previous botched dentistry (19.28%) were the most frequently mentioned.

The fourth question was "*In your practice, what is the biggest problem you face in esthetic dentistry today?*"

As seen in Table 4, "The quick fix epidemic," as a member commented, "has become prevalent in the practice. Unrealistic patient expectations are specifically related to the effect the dramatic makeover shows have had on patients." As one respondent stated, "The media has created distorted images of beauty, and today, these esthetic patterns create expectations by the patient that on many occasions, cannot be satisfied by the dentist." In addition, sometimes these expectations are not adequate treatments for the patients. As another member pointed out the expectations become "the search for stereotypical esthetics which contradicts with the philosophy of the research of forms and natural colors, harmony."

Unrealistic patient expectations coupled with incompetent dentists are a recipe for disaster, making the

combination one of the biggest problems members face in esthetic dentistry today. The problem then, as a member remarked, results in "patient ignorance in conjunction with the dental professionals who perpetuate it."

Previous botched dentistry also places a major concern for dentists today because of the proliferation of litigation. Malpractice lawsuits largely affect the profession because as one member commented, "There are too many gray areas open for interpretation that can lead to litigation." These legal implications are not only an issue for incompetent dentists, they can also become a significant concern for the dentists who treat the unsatisfied patients. As one respondent pointed out, the challenge then becomes "how to tell the patient someone else screwed-up without getting into the middle of a lawsuit."

Although this study was only a general assessment of a limited group on the current situation of esthetic dentistry, it is hoped that a more detailed professional study on the subject will be undertaken to help determine if these findings represent other segments of the profession, or if these findings are the results of the types of dentistry practiced by AAED members only.

The results of the survey do emphasize the significance of an increasing problem. *The Wall Street Journal*'s June 29, 2004, article, referred to repairing botched dentistry as "the latest trend in cosmetic dentistry."[1] The survey of AAED members, 2 years later, suggests that this issue continues to concern American consumers and dentists.

On June 16, 2006, ABC News' primetime show *20/20* aired a segment on botched dentistry warning consumers of the seriousness of the issue.[4] The producers interviewed both dentists and patients who had been victims of botched dentistry. The patients attested first-hand to the pain and frustration resulting from botched dentistry. As noted earlier, examples of botched cases are seen in Figures 1 to 3.

The problem for consumers is not simple. When faced with "glowing" ads attesting to the cosmetic capabilities of the advertising dentist, it becomes difficult for prospective patients to determine who is and who is not capable to successfully treat their esthetic and/or functional dental problems. Furthermore, these same consumers have trouble differentiating between qualifications of a dentist who may have taken a 2- or 3-year postgraduate course and one who "graduated" from a 2-day to 2-week esthetic course. As one member said, "The biggest problem I face in esthetic dentistry today is unethical advertising by my peers. Announcement of credentials that are nebulous at best leaves the public understandably confused."

The challenge is then to have effective communication with the patient. As one respondent commented, the focus becomes "knowing what the patient really wants and exceeding their expectations." When working with patients who have been victims of botched dentistry, it is important for the dentist to realize that most esthetic evaluations are subjective. However, the main consideration should be how the patient visualized the results prior to treatment and whether he or she received the results desired. In order to avoid a misunderstanding between the vision of the patient and the vision of the dentist, it is recommended to always have the patient wear the provisional restoration long enough to be convinced that the final treatment will meet his or her expectations.

Unfortunately, organized dentistry has never established testing or guidelines that go beyond basic state board requirements. What "passes" now for guidelines are the society or academy exams and the standards, which dentists can utilize in their advertising. As one member commented, "I see an important responsibility and chance for our academy and esthetic academies

worldwide to set limits to this excess by informing the population what esthetic dentistry can or cannot do." To make matters worse, there are numerous reports of some dentists using computer imaging to alter the results of their treatment! There is no doubt that this subject presents an extreme challenge to the profession.

Esthetic dentistry has never been declared a specialty. Perhaps in the future it could be if the American Dental Association and other professional associations can develop meaningful standards of what would define a specialty in esthetic dentistry. Like other specialties, esthetic dentistry would need a certified 2- to 3-year postgraduate program at an approved dental school.

Overall, it is clear that consumers do need more protection. This means that as ethical dentists we need to step up to the challenge and provide more education for dental consumers and the general public.

REFERENCES

1. Efrati A. New business for dentists: fixing botched cosmetic work. The Wall Street Journal, 29 June 2004, B1.
2. Webster's new dictionary and thesaurus. Concise ed.: New Lanark, Scotland: Geddes & Grosset 1990.
3. Goldstein RE. Esthetics in dentistry. Philadelphia (PA): J.B. Lippincott Company; 1976.
4. Open wide—at your own risk. 20/20. ABC; 2006 June 16.

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