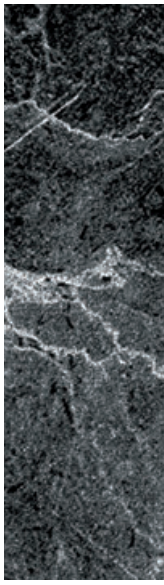

Perspectives

DENTAL ACADEMIA, COMMERCIALISM, AND THE RISE OF THE "INSTITUTES": WHERE HAVE WE GONE WRONG?

The profession of dentistry has changed dramatically since I graduated from dental school in 1967. After 40 years, substantial changes are to be expected and some of the changes are unquestionably positive, some unquestionably negative, and others are somewhat equivocal. Some of the positive changes include the well-documented decline in dental caries among large segments of the population; the discovery of the acid-etched enamel process, and the concomitant evolution of minimally invasive adhesive approaches for restorative dentistry; the advent of predictable osseointegration with titanium-based root-form implants; and the initial attempts to develop an evidence-based approach for clinical practice.

Negative changes include the increase in advertising and direct marketing to the public by professionals and organizations, the unchecked rise of frank commercialism in the profession, the enormous cost of obtaining a dental education and the subsequent accumulated debt that requires servicing after graduation, and the increase in frivolous litigation that has plagued the professions of both medicine and dentistry.

On the other hand, the tremendous emphasis on esthetics that has consumed both society in general and the dental profession specifically has both positive and negative aspects. Practitioners and patients have both been thrilled and gratified with treatments that dramatically improved patients' smiles and their overall esthetic appearance. Often, these improvements can be achieved using minimally invasive approaches.

With proper data collection, diagnoses, treatment planning, and execution of therapy, it is possible to take very difficult clinical situations and transform them into smiles of beauty through complex multidisciplinary therapy that may require many months or even years of treatment. Unfortunately in recent years, "complete make-over" treatment plans have become popular in both local and national media. Most of these treatments represent unacceptable compromises in the long-term quality of care, and it is unlikely that these patients have given proper informed consent indicating that they understand the available therapeutic options and their long-term consequences.

Many of the trade publications present case reports describing what can best be termed atrocities of unnecessary treatment where patients receive 28 units of bonded ceramic restorations in two appointments based on a misguided preconceived notion of an optimal occlusal position that is not supported by scientific literature. Again, one must question whether these patients gave adequate informed consent.

The average general practitioner is in a very difficult position in today's world. They may well be faced with servicing a substantial debt as a result of the costs of obtaining an education and the costs of establishing a practice. Companies are introducing and marketing products at an unprecedented rate and

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most of these products come on the market with virtually no clinical testing. Clinicians want to provide the most contemporary care available for their patients and concomitantly are being urged at all times to practice "evidence-based dentistry." Unfortunately, that evidence base is sorely lacking in most areas of restorative dentistry, and at best requires a synthesis of information from a variety of sources. These practitioners find themselves running a small business (which they are poorly equipped educationally to manage) and managing a staff of semi-hysterical employees (and again their formal education does not prepare them for this). They also try to keep up with the latest and greatest, and they do not know to whom they should listen. They are not only dentists; they are also people, with husbands and wives, children and parents. They are trying to be community leaders, Boy Scout or Girl Guide leaders, coaches, and maybe even pursue some of their own interests and hobbies as well.

These practitioners need unbiased, ethically based sources of information and hands-on instruction to guide them in their patient treatments (incidentally, patient treatments are not "cases" as they are frequently described in articles on "cosmetic dentistry"). It is my opinion that the primary source for such continuing dental education should have been the nation's accredited dental schools. It is also my opinion that many of the nation's leading institutions have not stepped up to the plate in this regard, and as a result the void that has been left has been filled by the rise of numerous nonaccredited institutes of continuing dental education.

It is undoubtedly incorrect to paint all dental schools with the same brush, and equally inappropriate to do the same with all of the postdoctoral institutes. However, many of the institutes seem to have very different missions than do most accredited schools of dentistry. Most ethical dentists would agree that their goal for their patients is to restore their mouths to optimum function, comfort, and esthetics with a minimal amount of intervention. Most would emphatically agree that prevention is superior to treatment, and that conservation of tooth structure is a key factor in the longevity of the tooth/restoration complex. The phrase "The best dentistry is no dentistry" (Dr. John Kois and/or Dr. Winston Chee, CAIC Annual Meeting, Lake Arrowhead, CA, personal communication, 1998) basically sums it up.

Many of the institutes and their disciples seem to have lost sight of this dictum and instead seem to create a treatment plan according to the most expensive option requiring the most possible irreversible treatment. The overtreatment illustrated in many of the case reports published in the trade journals is blatant, and quite frankly offends many hardworking, ethical practitioners.

This situation has arisen because of the confluence of a number of interesting factors. Most dental schools have, as part of their mission, the dissemination of evidence-based information to graduate dentists and auxiliaries. This has traditionally been done through departments of continuing education, and different dental schools have opted to use different approaches to continuing dental education. Some have been very conservative and have chosen to offer a number of programs that are quite traditional in terms of both content and pedagogy. Others, with perhaps an eye on the budget and with a mandate to become a revenue center for the institution, have been more aggressive and have offered a wide variety of programs, often addressing controversial topics and embracing some questionable philosophies of practice. Again, most of these programs have been offered using a traditional lecture approach.

These types of programs have been offered in lecture format primarily because they are the easiest programs to organize, and because with most states adopting mandatory continuing education, there is a market for them. This market is

shared by dental schools, local, state and national dental societies, private entrepreneurs, and dental manufacturers and laboratories. What most schools failed to recognize is that there is a limited but significant market for hands-on courses, specifically in the area of esthetic adhesive restorative dentistry. The schools had both the facilities and the faculty to present these kinds of programs. They would have presented them from an ethical, evidence-based perspective, and they would have been very successful.

While there are obviously some notable exceptions, most accredited dental schools provided few, if any, such programs. This was likely because such programs are difficult to organize and present in an efficient manner, and because schools underestimated the demand for these types of courses.

To their credit, the institutes recognized the void and stepped up and did the difficult organizational and marketing work essential to achieve success in this area. Because the organizers of these institutes are charismatic, hardworking, and ambitious individuals, many of the institutes have been incredibly successful. Some of the institutes offer an excellent, evidence-based continuum of programs presented in a variety of formats including hands-on courses. Here, the programs offered by Frank Spear, John Kois, and the L.D. Pankey Institute come to mind.

The quarrel I have with some of the other institutes is primarily with a core philosophy that seems to be centered around the concept of maximum treatment (and profit) versus doing the minimum possible to bring the patient to an optimum state of oral health. The vulnerable young practitioner, servicing a large debt, wanting to reap the rewards of a successful practice, is easy prey for such an aggressive approach. The vision of a million-dollar-a-year-plus practice achievable in a short time must sound very appealing to such inexperienced practitioners, and obviously many are buying into the concept.

However, the basic concept of conferring bogus degrees on participants in dental continuing education programs when the provider has no legitimate jurisdiction granted in this area by either the American Dental Association or state licensing bodies is ludicrous. I believe that marketing one's practice as being superior is essentially unethical and a 20-second perusal of the yellow pages in any major metropolitan area will unveil many such examples. Advertising one's practice as "mercury-free" or "metal-free" in my opinion infers superiority and there is absolutely no evidence base to support the notion that such practices are superior. Indeed, one can logically make the case that by denying patients the option of metal restorations, such practices are inferior.

In summary, there is no question that dentistry has entered an unprecedented era of commercialism. In the long term, this will benefit neither patients nor the profession. The failure of many dental schools to provide hands-on, multidisciplinary programs of continuing dental education when they already had the faculty and facilities in place has given rise to numerous dental institutes that have filled that void. While many of these institutes (and some dental schools) are providing the necessary types of continuing education programs from an ethical, evidence-based position, some are providing programs based on income production and overtreatment.

Based on many years of experience in private practice and in the dental academia, and through giving hundreds of presentations to dentists all over the world, I am confident that the majority of practitioners are ethical and want to provide the best care possible for their patients, with the driving factor always being what is best for the patient, not what is best for the dentist's pocketbook. It is easy to become depressed at the current situation, but it is not too late.

Dental schools need to step up to the plate and begin to offer the kinds of programs that are needed. New, ethical, evidence-based institutes need to be created to compete with the marketers. I believe the market (practicing dentists) will make good choices if given the appropriate options. For what it is worth, that is my opinion.

Terry E. Donovan, DDS

Terry E. Donovan, DDS, professor and section head of Biomaterials, Department of Operative Dentistry, University of North Carolina School of Dentistry, Chapel Hill, NC 27599-7450; e-mail: Terry_Donovan@dentistry.unc.edu
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