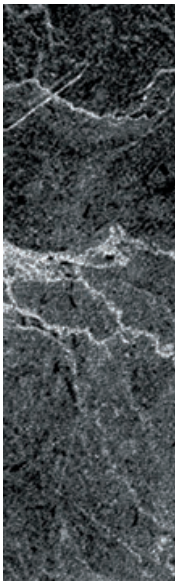

Perspectives

WHO ARE YOU?

Dr. Myron Nevins was asked to give a keynote address at the 5th Annual European Society of Implantology meeting during the Carnival in Venice, Italy. His topic was "Osseointegrating Implants: Past, Present and Future." While discussing the future of implantology, Dr. Nevins stated that he hoped that the future is not characterized by our having to apologize to the public for therapy we have performed.

Dr. Thomas Albrektsson spoke during the "Failure Festival" at the American Academy of Osseointegration (AO) meeting in San Antonio, Texas. Dr. Albrektsson discussed the alarmingly high failure rate of an implant design and treatment approach, which, despite manufacturer claims, has been documented by highly reputable examiners. Dr. Albrektsson asked the question, "Who is responsible for these failures?" In a moment reminiscent of Dylan's "Who Killed Davy Moore," blame is avoided as follows:

"Not I," says the FDA. "We only provided the 510K, based upon the data that was submitted."

"Not I," says the manufacturer. "We got a 510K before we sold the implant."

"Not I," says the patient. "I did what my doctor told me to do."

Dr. Albrektsson's disconcerting conclusion is that the treating clinician will be left holding the blame, when all he did was trust both the FDA and the implant manufacturer to release only proven products for his or her use.

Dr. Albrektsson ends his presentation by asking what gives a company the right to release products without, in his opinion, appropriate testing, and then to contest the results of researchers when their findings are not to the company's liking.

Unfortunately, the answer to Dr. Albrektsson's last point is that this is what companies do all too often, to capture market share and satisfy stockholders. It is naïve of us to believe that corporations of any type hold our best interests as their primary concern. The sine qua non of successful business is generating a profit.

However, such a profit need not be generated at the expense of patient welfare and the profession's reputation. A more effective corporate strategy is one in which the customer base (in this case the dental profession and the subsequent treated patients) benefits greatly from the product produced (through predictable, desirable treatment endpoints), which in turn increases demand for the product (dental implants and components).

Recognition of the need to strike such a balance between corporate earnings and customer welfare and satisfaction is paramount. Implant companies must perform appropriate, critical testing before launching new products. Many companies behave in such a responsible manner.

I am not referring to market testing, or product release driven by a perceived "opening," catchy slogans, clever implant names, or a desire to improve short-term

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profits. Companies must realize that it is in their best interests to ensure clinical success following implant therapy. Failure to do so will prove catastrophic to these companies in the long run. The pool of potential dental clinicians is not bottomless. It is true that implant use, and the number of clinicians performing implant therapy, continues to expand. However, such expansion cannot continue unchecked forever. As competition for this finite pool increases, and as the number of "dental free agents" decreases, the companies who have continually proven their integrity and worth will dominate the field. Repeated failure of new products causes clinicians to look elsewhere for their solutions. At some point, each clinician will say to himself or herself, "I won't get fooled again."

The dentist must accept at least partial responsibility for the current state of implantology. He or she is the final arbiter of care and must act accordingly.

I was asked to speak at the aforementioned AO meeting in San Antonio. My topic was "Why My Graft Failed." After spending quite a bit of time redefining success following guided bone regeneration (GBR) therapy, and reviewing the technical prerequisites for such success, I stated that "the reason GBR therapy (and by extension, implant therapy) fails is us."

1. We do not take the time to master the appropriate techniques. A weekend course taken by a clinician with only the most rudimentary implant knowledge frequently leads to less-than-ideal treatment outcomes.
2. We find excuses for our failures other than ourselves. When soft tissue primary closure is lost following GBR therapy, it is never because we treated the area inappropriately. We must have used the wrong membrane, or the incorrect graft material, or the patient ate the wrong foods postoperatively.
3. We utilize less-than-ideal materials and accept compromised definitions of success because of our diagnostic and technical inadequacies. I often receive inquiries from clinicians who have attended my lectures asking my views on why they have attained less-than-ideal treatment results following GBR therapy. They frequently state that, although they do not utilize the same techniques or materials as those I speak about, their results are "adequate." This is a word that should *never* be in a clinician's vocabulary. There are only two manners in which to treat a patient: the best you can in a given situation, and every other way. Only the most optimal treatment endpoint that you can attain for an individual patient, when faced with a specific clinical challenge, is acceptable.
4. We utilize materials based upon cost, catchy marketing phrases, and company perks. Such considerations have no place in a conscientious clinician's decision-making process. Less expensive materials should be employed on the basis of their documented clinical success, not on the advice of a clinician's financial advisor.
5. We blindly accept manufacturer claims, or review "research" with an uncritical eye. More-than-adequate data exists to point to proven materials and techniques for resolution of patient problems in almost all clinical situations. We must only employ new techniques and materials if they have been shown—through appropriate, nonbiased studies—to deliver tangible patient advantages and success rates at least equal to those of proven therapeutic approaches.

It is disconcerting to visit company booths promising the next big miracle, or to sit in on beautiful presentations of new products with little supporting data. In such instances, the sizzle is

everywhere, but the steak is conspicuously absent.

Our patients do something amazing. They give us their bodies, and they ask us to help them. We must never lose sight of this fact.

Dr. Gerald M. Kramer, the chairman of my periodontal training program, would tell us of graduates who had all the requisite acumen and clinical skills to perform beautiful therapy, but who had lost their way. Once these clinicians began down the wrong path, Dr. Kramer would warn us, they would never come back. We must all decide which road we will take.

Who are you?

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