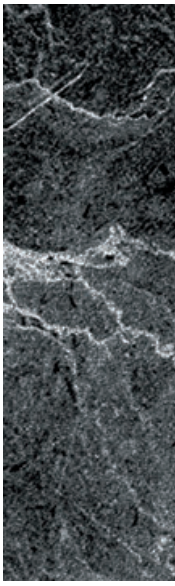

Perspectives

A CALL TO ALL TEACHERS OF ESTHETIC RESTORATIVE DENTISTRY

A competency is a complex behavior or ability essential for the general dentist to begin independent and unsupervised dental practice. Competency includes knowledge, experience, critical thinking, problem-solving, professionalism, ethical values and procedural skills. These components of competency become an integrated whole during the delivery of patient care. (ADEA; Competencies for the New General Dentist, 2008)

"Conservative" is derived from the Latin: *conservare*, to "save" or "preserve." Patients can be influenced in their decision-making when they believe a proposed treatment is "conservative." "This procedure is completely reversible" is also an attractive invitation because "reversible" according to Wiktionary (November 24, 2009) indicates the following meaning: (physics) (of a phase change) capable of returning to the original state. How many of the procedures we currently perform in Esthetic Restorative Dentistry are truly reversible? Any? How many are truly conservative? Lloyd Miller taught me in 1996 that clinical dentistry revolves around health, function, and longevity of the dentition. Esthetics is important, he said, but must remain secondary to our primary mission.

This was my personal credo and what I taught my students until ethics experts Drs. Patthoff and Ozar published, ". . . in esthetic dentistry it is the *patient's* judgment—not the oral health professional's judgment—which is alone sufficient to determine whether the result is appropriate" (Need vs. Desire: Professional Judgment in Esthetics, *AGD Impact*, August 2007). Now the dentist's decision-making has gotten more difficult. Now the need for credible teachers and role models is even more important.

It is a great honor and a great responsibility to be a teacher of dental students at two major Dental Schools. When I speak on *esthetic dentistry*, which I do most often, I can sense my students' eagerness to listen and learn. My gut tells me that I am guiding them into new territory. Gordon Christensen, who speaks to more dentists and dental students than anyone I know, confirms that most of our dental schools do not teach very much about esthetic dentistry. He reports that many schools graduate students who have not performed even one porcelain veneer or all-ceramic crown.

I picked up the November/December 2009 issue of what I believe is the best of the large-sized magazines that go out free to all dentists. This one is "peer reviewed" and lists the board of reviewers. They are the same names I see listed on most peer-reviewed dental journals I read. In my opinion, they are the best of the best. In the article by Dr. X, I see a patient who undergoes "preventive root canal therapy," and "aggressive tooth preparation" to receive 10 maxillary all-ceramic restorations and her "smile makeover." According to the author, the patient did consult with an orthodontist, but "seemed hesitant to undergo orthodontics, and was then referred for a consultation with a periodontist to evaluate for

DOI 10.1111/j.1708-8240.2010.00316.x

gingival and osseous recontouring to create a more even gingival line when smiling." Then he states that "After consulting with these specialists, she decided that she would prefer not to have orthodontics at her age (57), nor undergo a surgical periodontal procedure. At this point she was educated enough to understand the limitations that she was imposing on her smile makeover. The next step was to take comprehensive records (including diagnostic impressions, bite records, a preoperative facebow record, a full-mouth series of x-rays and a complete set of photographs) and to have the laboratory create an esthetic wax-up to more accurately depict what could be achieved without enlisting the services of the specialists."

It bothers me that Dr. X did not make all of these diagnostic records and formulate alternative treatment plans before his patient consulted with the orthodontist and periodontist. Had the orthodontist and/or periodontist known what Dr. X was planning for the patient if she refused their participation, and seen his work up, perhaps they would have taken a different approach in their presentations to her. Even a modified orthodontic approach would easily have saved the patient's intentional endodontics for her upper right canine, and surely would have preserved more tooth surface enamel to bond Dr. X's all-ceramic restorations.

Is it important to save tooth surface enamel? In "The Myth of Instant Orthodontics" (*JADA*, April 2008), Drs. Jacobson and Frank make it clear that:

1. Survival rates of bonded porcelain restorations are best when at least 50% of the prepared surface is enamel and **the entire** intended restorative margin is in enamel
2. Only a 5% dental rotation can likely be corrected by a restorative endeavor without excess removal of enamel
3. Aligning a healthy tooth with a porcelain veneer restoration (PVR) is not a conservative procedure and more conservative treatment options (such as orthodontics, bleaching, direct bonding, and enameloplasty) should be offered to the patient
4. The ethical implications of PVRs for correction of tooth malalignment should not be ignored. Patient autonomy is important, but it does not outweigh all the other principles in the profession's code of ethics

Someone had to teach Dr. X how to do this kind of treatment. Someone else had to accept this article for publication in a magazine that seeks credibility. If this treatment is wrong, who's at fault? Not just Dr. X in my opinion. So what can we do?

1. Those who serve on editorial review boards should stop accepting such cases for publication
2. Those who serve as program chairs need to choose speakers who do not show such cases

Ultimately, the future of dentistry will be guided by our freedom to make integrity-based decisions that rely on the strength of scientific evidence rather than the lure of commerce. (Kois, J. Dental morality or misguided science? Guest Editorial, *General Dentistry*, May 2008)

Sure, there are clinicians who do such cases routinely and feature them in their own private courses and publications. That does not mean the rest of us have to join in. Let our students know we practice what we preach. It will make a difference.

Yes, it is possible that Dr. X really did the best he could for this patient and her demands forced him to treat her as aggressively as he did. And, yes, hating one's smile is now considered pathology and some dentist can be hired to fix it. But, please let us not publish such cases. There are too many young dental graduates who will read them and follow suit and even take

private courses with the authors. And, please, let us incent all dental schools to teach conservative, ethical *esthetic dentistry* to their students before graduation and provide educational programming to assist them. Complaining is not enough. We need to do more. We can do more.

Joseph R. Greenberg, DMD, FAGD

Clinical Professor of Restorative Dentistry and Course Director of Advanced Restorative Dentistry, The Kornberg School of Dentistry at Temple University

Reprint requests: Joseph R. Greenberg, DMD, 600 Newtown Road, Villanova, PA 19085, USA; email: jrgdmd@verizon.net

The opinions expressed in this feature are those of the author and do not necessarily represent those of Wiley-Blackwell.