Mediocrity

For those of us who practice the specialty of prosthodontics, it is an unfortunate fact that a large percentage of the practice is directed toward replacing failing restorations. While failure may occur in spite of technical excellence, it is disappointing that failure as a result of poor concept or shoddy execution is so prevalent in patients seeking prosthodontic care. In a previous editorial (Volume 3, No. 1, pp 5), the difference between perfection and excellence was discussed and some distinctions were made. That writing was in no way meant to discourage the *quest for perfection* while recognizing that perfection is only a goal—never a realization. All of us at one time or another have had to remove restorations the we ourselves had previously placed, even though care had been performed with attention to detail and accompanied by adequate patient instruction. Success is never assured. Whereas failure is obvious, success at any given moment is only an optimistic illusion.

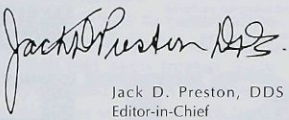
What causes this editor increasing concern is that in spite of the development of improved materials, enhanced technical and biologic understanding, and almost unlimited opportunities for continuing education, restorative failure seems to be almost accepted as inevitable. Such a statement demands some discussion of what constitutes "failure." If the materials used are adequate, and the restoration is crafted with attention to the biologic requirements of the patient, it is nonetheless entirely possible that, during the lifetime of the patient, a restoration may wear to the extent that it requires replacement. This is not, in my estimation, failure as long as the foundation, the teeth, and the periodontium remain healthy.

When a restoration is well designed and executed, the patient is properly instructed in maintenance, and failure occurs as a result of the patient declining to receive needed maintenance therapy or perform essential home care, then, again in my estimation, this is not a failure for which the dentist should take responsibility. Certainly, some patients are more prone to oral disease than others. Factors such as unfavorable gingival and alveolar morphology, dental dysplasias and anomalies, occlusal relationships, general medical conditions, etc are not under patient control, but they may demand greater than average attention to oral home maintenance and professional care. Once the patient has been instructed in the need for intensive home care and has been given adequate information for maintenance and recall, the primary burden is on the patient. However, it has not been uncommon for those whose previous neglect necessitated complex restorative procedures to lapse into their previous habits, with the result being dental or periodontal failure.

Whereas the restoring prosthodontist may logically eschew responsibility for such failures, as prosthodontists with our yearning for perfection, we often are left wondering what technical error might have predisposed such failure. Such is the lot in life of obsessive-compulsive individuals.

The true failures are those that result from inadequate diagnosis, proceeding with a restoration that is beyond one's technical understanding or ability, compromising where no compromise is warranted, failing to provide optimal technical care, or overlooking those fatal flaws that are detected but not corrected. Why is it that so much of the prosthodontist's time is spent restoring such failures? I believe that it is the result of an increasing acceptance of mediocrity on the part of so many individuals who are providing restorative oral care. Whether mediocrity results from an unwillingness to expend the time and effort to produce a better product or ignorance of what constitutes adequacy, I do not know. Possibly, the exigencies of having to treat patients with limited finances or inadequate third-party coverage become excuses for not striving to achieve a better result. All of us are faced with having to work within a patient's abilities, but optimum does not necessarily mean maximum. It is no sin to not provide the most ideal care when such care is not within the patient's abilities. However, one must know what the most ideal care might be and logically and knowingly accommodate to the limitations imposed by the patient without compromising the outcome.

A current advertising slogan applies to restorative care: "Good enough—isn't." Any time one seeks to excuse a less than adequate result with the thought that it is "good enough," it is probable that mediocrity has become a goal. Perhaps in these days of a society oriented to fast-food and disposable plastic merchandise, mediocre dentistry is following the trend. It is my belief that a large part of the problem we experience in all aspects of our lives results from acceptance of mediocrity as a goal—of excusing poor quality or poor performance without seeking a better result and exerting the effort to achieve it. I believe patients would be better served if dental educators, practitioners, and manufacturers all held to the premise that mediocrity should be equated with failure, not success, and that the long-term oral health of the patient should be held in higher regard than the exigencies of the moment. Whether legislated, implied, or merely facilitated by failure to recognize it for what it is, mediocre dental care may be worse than none at all.



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