

Editorial

And the patient suffers

There is considerable confusion, some would call it cheating, in the marketplace regarding the naming of certain types of restorative materials. The end result: the patient suffers.

When practitioners see the term "glass-ionomer" in a material name certain assumptions are made. One is that an acid-base reaction contributes to the setting process, another is that release of fluoride from the material will occur over time. Fluoride release is a highly desirable property, and, in recent years, certain manufacturers have taken to using the term glass-ionomer for materials that are not, in fact, glass-ionomer materials but rather modified resin-based composite materials. Some of the confusion has arisen as a result of the rapid evolution of restorative materials in the past few years, particularly in glass-ionomer materials and resin-based composite systems. The new concept by Mitra for improving glass-ionomer materials has undoubtedly added to the uncertainty in the minds of practitioners as to where such hybrid materials belong—are they glass-ionomer materials, are they resin-based composite materials, or are they truly a blend that deserves the use of the term glass-ionomer?

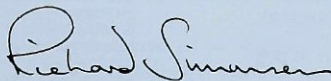
In the Guest Editorial that follows, a solution to the problem surrounding the use of the glass-ionomer terminology is suggested by three colleagues from the United Kingdom—John McClean, John Nicholson, and Alan Wilson. The categories they suggest for clarifying the confusion that has been created by overuse of the glass-ionomer name should form the basis for further discussion, or be adopted outright by the dental community.

The three authors, all experts in their field, are proposing three categories that will separate true glass-ionomer materials from impostor glass-ionomer materials. Their suggestions are well-conceived and deserve attention. What remains to be seen is whether the manufacturers who are presently abusing the terminology in their marketing and advertising practices will fall in line and follow such standards.

What becomes clear from the McLean et al article is that some common products are presently mislabeled. Thus, economic gain for the makers of such materials is occurring at the expense of the practitioner and, most regrettably, at the expense of patients who have been diagnosed as requiring a glass-ionomer material for a certain restoration. A practitioner who believes he or she is placing a glass-ionomer material expects that the benefits of such materials will be passed on to his or her patients. If the material has been falsely labeled a glass-ionomer, not only is the practitioner misled, but the patient is cheated. Such abuses in the marketplace cry out for some standardization.

McClean, Nicholson, and Wilson are to be congratulated for their timely paper, which, as they suggest, should form the basis for a better understanding of the important differences between glass-ionomer materials and resin-based composite materials. Further debate on this topic is encouraged, and adoption of specific standards by standards organizations, editors, and manufacturers should follow expeditiously.

If the few manufacturers who are presently taking advantage of practitioners and patients choose to ignore reasonable suggestions put forth by experts from within the profession, additional governmental regulation is sure to follow. It is to the benefit of all—practitioners, patients, and the dental industry as a whole—if the suggestions of McLean, Nicholson, and Wilson are heeded.



Richard J. Simonsen
Editor-in-Chief