The Measure of Change

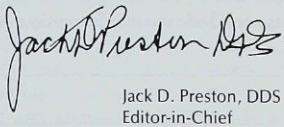
In the 35 years that I have been observing dental practice, it has become apparent that change itself is the only constant. Changes are neither consistently good nor bad, and, in fact, whether a specific change is to have a positive or a negative effect on the profession is not always obvious at the time it is first made. Any substantial deviation from the current norm always evokes enthusiastic support from some individuals and pessimistic opposition from others. For example, when mercaptan rubber impression materials first appeared, one of my mentors refused to use them, contending that since the material contained sulphur, arsenic would also be present—and he wanted nothing to do with an impression material that he felt was toxic. A peer of the same man noted that the reaction time of the material could be controlled, and the material could be silver plated, was more resilient, and appeared to have many of the properties that were sought in an impression material—and he proceeded to learn to use it properly. This was my first exposure to polar attitudes toward change, but many others have followed. The advent of metal ceramics divided restorative dentists, with some enthusiastic supporters and some doom-predicting opponents. Even the air turbine handpiece had its detractors. Almost nothing is universally liked or disliked.

This polarized response can be seen widely today—some feel dental implants solve all tooth replacement problems and others see limited if any use for such "radical treatment." Dental lasers are seen by some as an absolute necessity—a phenomenal instrument for dental surgery. Others see lasers as an "answer to a question that is yet to be raised." Such controversy is good. Eventually, the marketplace (read that as you, the consumer) will determine the efficacy and desirability of a product. There may be international differences as to how concepts are applied and how specific materials are used, but to a large degree, those differences are narrowing.

It is when agencies or societies begin to invoke controls and restrictions that illogical limitations are imposed. It is frightening to see what governments can do to health care standards. I will not expound on that for now, since a number of toes seem to be prominent and are easily trod upon. However, I have frequently recommended (with only a slight tongue-in-cheek posture) that in the United States any legislator who votes for a health care bill must agree to participate in it. Constant vigilance and concentrated effort by the profession are required to impede the efforts of uninformed politicians who have glib answers to health care problems, yet have never been introduced to the concept of quality.

Similarly, I am concerned when societies begin to limit or dictate what a specialist can do within a specialty. Logical, studied guidance is essential, but empirical, dictatorial decrees must be avoided. It would seem that any practice associated with a specialty, when the practice is preceded by adequate training and supported with demonstrable clinical skill, could become an adjunct service of the specialist. (I hope this use of "specialty" and "specialist" will not lead to another semantic schism such as has arisen with "prosthodontics" and "prosthodontists.") Specifically, I refer to whether the prosthodontist should place dental implants. Whereas I prefer not to do so, I do not see that this personal preference should restrict the ability of someone who prefers to offer such services and is adequately trained to do so. The result should validate or negate the concept, and I am comfortable that eventually this question, like so many others that have come before it, will answer itself.

Societies or agencies that choose to intervene in such areas should do so for only one reason. This reason should have nothing to do with economics, self-preservation, self-adulation, "turf wars," or personal prejudice. Our goal should be to stand aside, allow the practice to mature, and stand guard to ensure to the best of our collective abilities that the patient is protected. Changes that are good for the patient should and will survive; those that are not are usually cast aside. There is room for disagreement, but assuring quality of care should override any other factors.



Jack D. Preston, DDS
Editor-in-Chief