

Cosmetic Dentistry Is Still Dentistry

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I have read Dr. Mulcahy's thesis with interest. Despite its title, the paper does not really address the issue of whether cosmetic dentistry is health care or not. Instead, it seems that Dr. Mulcahy has three main concerns about the direction in which dentistry is heading today: (1) that "increased emphasis is being placed on the significance of esthetics," (2) that "general practice may find itself at the brink of a fragmentation process if cosmetic dentistry should acquire... recognition as a specialty" and (3) that there has developed an "aggressive, overzealous business attitude... along with the heightened emphasis... on cosmetic dentistry."

While Dr. Mulcahy's paper is long on generalizations, it is very short on specific examples that can be addressed directly. Nevertheless, I would like to take this opportunity to respond to his concerns.

Dr. Mulcahy himself states that "ideal appearance has always been an integral aspect of restorative dentistry." In other words, historically, one of the criteria of successful restorative dentistry has been the ability to produce ideal appearance in the restored teeth. In the past, however, a limiting factor has been the physical characteristics of the materials available and the techniques they imposed.

The advent of adhesive dentistry has enabled the practitioner to come closer to achieving more ideal appearance while practising a more conservative style of dentistry. One could ask which are the more health-oriented and ethical treatments: (1) A traditional G V Black amalgam with associated extension for prevention and undercuts for retention or a bonded composite requiring removal only of carious tissue? (2) A full-coverage, anterior crown on a tooth with 40% to 50% structural damage or a bonded porcelain veneer? Cosmetic dentistry is conservative dentistry, and conservative dentistry is health care.

I am not trying to be disingenuous when I refer to the above services as cosmetic. They are cosmetic if that is the dentist's philosophy of practice. I am sure, however, that Dr. Mulcahy's concerns lie with the ethics of the cosmetic make-over involving multiple restorations, crowns or veneers.

Unfortunately, Dr. Mulcahy assumes the worst of those who practice cosmetic dentistry: "... the operator provided what he or she considered most appropriate" implies an imposition of inappropriate treatment upon the patient. Yet, only a

few lines later, he states, "Dentists have the overall obligation to provide only the most appropriate treatment that is in the best interest of the patient." This brings about the question, Who decides what is the patient's best interest — the dentist or the patient? To assume that the dentist must impose a treatment plan on the patient is to assume that the patient is "gullible" as Dr. Mulcahy states. I certainly disagree.

Today's average patient is more highly educated and aware of his or her wants and needs than ever before. Many come into my practice having thoroughly researched their options and being very knowledgeable about possible directions that their treatment may take. An ethical practitioner of cosmetic dentistry, like an ethical practitioner of restorative dentistry, listens to and understands the patient's concerns, takes a thorough history and performs a complete examination. When all of this has been completed, he or she provides a treatment plan based on the diagnosis derived from the information gathered. In most cases, he or she discusses alternative treatment modalities with the patient and compares the advantages and disadvantages of each. Then, and only then, having had professional guidance and advice, does the patient take responsibility for the ultimate treatment decision. The days of paternalistic medical or dental practice are past.

As for the "increased emphasis on... the significance of esthetics," one has only to study the media to understand where that emphasis arises. One may decry it, but the fact remains that appearance, even up to "Hollywood standards," is highly motivating to the public. The public are our patients. It should also be noted that no ethical practitioner would undertake extensive cosmetic procedures until all underlying biological disease had been treated first. In fact, looking at it from a more positive point of view, the desire for improved appearance might be the factor that could motivate an individual to seek dental care and, by so doing, have their existing biological dental disease treated. After all, isn't the desire for straight, uncrowded teeth what motivates most patients to seek orthodontic treatment? An added benefit is that it allows the dentist to align the teeth more ideally for sound occlusion and disease prevention at the same time.

Should cosmetic dentistry be recognized as a specialty, and would this bring about a "fragmentation process" if it were to happen? In my opinion, the answer to both questions is no.

I do believe, however, that professional ethics require that anyone practising cosmetic dentistry be knowledgeable and skilled in its methodology and techniques. Unfortunately, few dental schools provide much in the way of education in these areas in their undergraduate programs. Many graduate dentists have taken little post-graduate training in the field, yet they believe that their degree entitles them to claim expertise in cosmetic dentistry. As with any other specialized area of practice (e.g., orthodontics, periodontics or endodontics), there should be some standard to which practitioners must be held before incorporating that service into their practice. It is from the unrestricted practice of cosmetic dentistry that "formulization of dental esthetics" arises. A dentist properly trained in cosmetic dentistry techniques would tailor the results to the individual requirements of the patient.

Even if specialization occurred, would it lead to fragmentation? I think not.

Specialization has occurred in several areas of dental practice. The role of the general practitioner has become that of the gatekeeper and supervisor of the treatment process. He or she undertakes that level of treatment for which they have been trained and are competent. They hand off to the specialist when the level of care required exceeds their ability. Why would it be different if cosmetic dentistry were a recognized specialty?

Finally, regarding the "overzealous business attitude" that Dr. Mulcahy believes has accompanied today's emphasis on cosmetic dentistry, we have, indeed, seen an increased awareness of the business aspects of dentistry. I believe, however, that this has arisen coincidentally and concurrently with the rise of cosmetic dentistry and is unrelated to it. It derives from that "glut of dentists that exists in some parts of the country," as Dr. Mulcahy states, as well as from the omnipresence of dental insurers trying to impose their financial needs on our patients and us through policy restrictions and the establishment of alternative care delivery systems.

The fact is that dentistry is both a respected profession and a business. Professionalism imposes high ethical standards on us while business imposes management requirements. These management techniques are only marginally addressed in undergraduate dental school curricula.

The days are gone when practices could be managed sloppily and still yield a comfortable living, dare I say profit. Today's environment of increased costs (staff, rent, materials, equipment and technology) requires each practitioner to analyze the elements of his or her practice to determine a fee schedule that is suitable to individual practice needs. In doing such an analysis, many find that their fees are woefully unrealistic. The attitude I have seen from most lecturers, whether from south of the border or not, has been that, if proper analysis dictates that you should raise your fees, then you should not be afraid to do so. Is it more ethical to provide a service and lose money than to provide a high-quality service and make a profit? I think not. That is what fee-for-service dentistry is all about.

I, personally, have never heard a call for fee raises based on comparison to the salaries paid to sports stars. What I have

heard is as stated above: Analyze your costs against a realistic expectation of income, factor in such elements as time, skill and specialized knowledge required to perform the service and come up with an appropriate fee. This is, as I understand it, what our provincial dental associations have been telling us for years.

In conclusion, it seems to me that Dr. Mulcahy's concerns centre on ethical issues: the ethics of overtreatment and overcharging. These concerns apply to all aspects of dentistry, not just cosmetic dentistry. The solution is to ensure that ethics remains a strong component of our professional training.

Since time and space are limited I will conclude with the hope that Dr. Mulcahy's thesis and my response to it may be the basis for an ongoing dialogue within our profession on this important topic. ♦

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The views expressed are those of the author and do not necessarily reflect the opinion or official policies of the Canadian Dental Association.

C D A R E S O U R C E C E N T R E

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