# To treat, or not to treat

*Without a firm idea of himself and the purpose of his life, man cannot live and would sooner destroy himself than remain on earth, even if he was surrounded with bread.*–Fyodor Dostoyevsky (1821–1881)

There are two extreme accusations in dentistry that should be laid to rest: "overtreatment" and "supervised neglect."

The difficulty in avoiding these extremes is simply that much of what we do for our patients falls under the art of our profession, not the science. Like medicine, we base much of our treatment selection on fundamental scientific knowledge, modified heavily by experience, empirical data, anecdote, educated guess, and, increasingly frequently in the case of overtreatment, on daily "production" goals.

Whether we are guilty of undertreatment through ignorance or laziness, or of overtreatment through ignorance or greed, both extremes should be eliminated from our lives. Astute readers of QI realize that the theme running through my editorials these past few years is comprehensive, patient-centered, sequential care, delivered in the minimum amount of treatment necessary for predictably successful outcomes. That is what "evidence-based" knowledge is all about–increased likelihood of successful outcomes. "Best practices" is the other contemporary term that reflects the profession's attempt to choose treatment options that are most likely to be successful. By whatever name, top practitioners realize that successful long-term outcomes support a profession while unsuccessful outcomes can destroy public trust.

The Mjör and Toffenetti article on secondary or recurrent caries (page 165) relates to this point, as did our Current Concepts about "when is caries caries," published in September 1998. The articles are instructive for the attending dentist and staff, and should become part of our core knowledge base.

The problem is obvious. The literature reports that about half of all replacement restorations are scheduled due to recurrent caries, while controlled epidemiologic studies report a recurrent caries rate of around 5%. Even given the obvious differences in study protocols, as pointed out in Mjör and Toffenetti's article, the strong suggestion remains that most of us err on the side of aggressive precaution when we suspect recurrent caries.

As the profession evolves, our knowledge and understanding evolves, too. Mjör and Toffenetti's article adds substantially to that knowledge and understanding as it reviews the literature and offers consensus types of conclusions about secondary caries and its management.

It is my long-held belief that best care demands the least intervention necessary to preserve form, function, health, and appearance. It is generally not acceptable to perform a procedure simply because there might be a problem in the future. When we overtreat, we risk becoming common parasites rather than respected professionals who always place our patients' welfare above our own. That is not a risk worth taking.

When we undertreat, we run the risk of being perceived as careless or unaware–another risk not worth taking. Undertreatment most commonly occurs when we are procedure-oriented rather than comprehensively oriented. Just this week a patient from another practice presented for consultation about a recently crowned tooth that was sensitive. The offender was a maxillary first molar with a technically flawless porcelain-to-gold crown. The problem was that it was supraerupted into an unrestored mandibular space and there was a heavy balancing contact present. A major contributing factor to the patient's oral condition had not been managed, and predictable success was not achieved.

A major part of the joy of practicing dentistry is the knowledge that you serve your patients to the best of your ability, based on the best practices that science, experience, and statistics support. This is the true joy of service, not the false pride of vanity. The entire Quintessence "family" remains dedicated to publishing the best dental literature available, so that in the end we who practice and we who teach can see the results of our efforts through the benefits we deliver to our patients.

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