Guest Editorial

What Happened to the Magician?

Good magicians have a lot of tricks. They select an appropriate trick for their audience: one set for kids, one for teenagers, and another for adults. But what happened to the magician in dentistry? A generation of periodontists and restorative dentists were well-trained in a comprehensive approach to therapy and patient management. They had all been well-mentored to create and maintain successful clinical practices and to educate those who would follow. Is this knowledge and capability being passed on? I don't think so.

Where have we lost the ability to be magicians, to have a hat full of tricks to address a myriad of problems and the ability to select the correct one at the right time? To be able to treat the entire spectrum of dental disease, incorporating interdisciplinary therapy with our colleagues in a logical sequence of treatment? We must not see dental disease through only one type of glass, but must be comfortable in offering a varied armamentarium based upon our patients' needs.

For the past 7 years, I have served as Director of Dental Education in a nine-resident GPR program and have interacted with graduate periodontal students from several programs. I am concerned that the art of complete case diagnosis has been replaced with prescription periodontics. So often, I hear: treat the mandibular left quadrant, add some gingiva on the mandibular premolar, place an implant in the central incisor region, or crown lengthen the first molar. We can fall prey to the ease with which these requests are given and then carried out. Doesn't it still make sense to first control the factors that cause the disease, before correcting the deformities that resulted? What about the rest of the mouth and the total treatment plan? I recently observed a young periodontist surgically treating a young patient who had adequate attachment around the teeth, but a loose and depressively mobile posterior dentition. Was regenerative therapy the correct treatment, or should the cause of the disease process have been identified and controlled prior to surgical intervention? Why were the teeth mobile?

Where is the failure? Some of it lies with our educational system. Do we provide students with the opportunity to learn both classic and contemporary approaches to treatment and become comfortable enough to incorporate them into a treatment plan? Or will the graduates of today and tomorrow be prescription therapists, not concerned with the sequence of therapy and etiologies of disease? What will these mentors pass on to their students? What is best for our patients? If the cause of disease is not controlled, what longevity is to be expected from treatment?

Undergraduate and graduate students must be exposed to all modes of dental therapy. They must know when and how to use different procedures: root planing; occlusal therapy (including orthodontics); resective, regenerative, and mucogingival therapies; stabilization; and when implants are necessary and may even be the preferred treatment. Restorative dentists must be capable in all the restorative procedures available. They must know the limitations of each procedure and be ready to perform the proper one with the appropriate materials.

The educational problem is multifactorial. It is difficult to recruit full- and part-time faculty. Financial and time constraints limit the activities of both the administration and department chairs. There are space constraints. It is time to again consider the use of volunteer part-time faculty. Educators and dentists in private practice must work together to permit the participation of this important group of teachers. The other side of the coin is that practitioners need to recognize an obligation to share the clinical knowledge gained from their mentors as well as from years of clinical practice.

Where would we be without the knowledge gleaned from the master clinicians of our time? We have a debt to repay. The time is now. VOLUNTEER, RECRUIT. Train dentists to have a full bag of tricks.

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