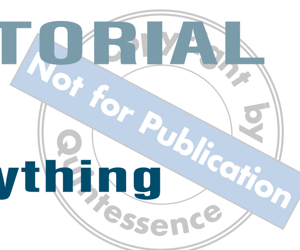
EDITORIAL



Perspective is Everything

Even though most of us make a sincere effort to establish an unbiased treatment plan philosophy based on validated data, it is nearly impossible to avoid introducing personal bias into your treatment philosophy. This bias is usually based on the type of patients that present to your practice and your short- and long-term experience using various treatment modalities.

For example, the training in operative dentistry I received at my alma mater was as good as it gets. Keep in mind that the emphasis in those days was on amalgam restorations. I felt very comfortable restoring teeth with amalgam even with the most severe instances of coronal destruction. As a beginning practitioner I did what I knew best (a typical shortcoming of a not well-rounded clinician), I restored almost every clinical situation with amalgam. After one or two root canal-treated molars restored with "amalgam crowns" failed, I realized there was a good reason why I was also taught to prescribe an indirect full cuspal coverage restoration after a root canal. My inexperience and limited perspective created a bias, which was soon reversed by the clinical reality.

Bias, however, does not occur only in the inexperienced. It can be easily found in highly trained practitioners, ie, the specialists. As clinicians complete their postgraduate training, their treatment is now focused on selected types of clinical situations, and their view of dental treatment planning is being done through the thorough, yet narrow, viewfinder of the specialist. Following the completion of my postgraduate training I have put a lot of emphasis on fixed prosthodontics in my practice. Most of the patients that were referred to me had numerous, extensively broken-down teeth, usually with existing broken direct restorations (amalgam or composite resin). When the only teeth you see in your practice are teeth with failing operative dentistry procedures you start to develop a bias, sometimes unconsciously, and all of a sudden you may lose your trust in operative dentistry. All teeth begin to appear as great candidates for fixed partial dentures. When one knows the literature, it is obvious that operative procedures are extremely predictable, but due to the limited nature of my practice, I may find myself biased.

A classic example of such a bias, and one I have repeatedly encountered over the years, concerns post-and-core buildup in root canal-treated teeth. Post placement is a procedure completed for one purpose, providing retention for the core buildup. As with many procedures, it is a predictable and successful approach when done properly. From my personal experience, my endodontic colleagues seem to, said gently, dislike post-placement procedures. They look at it as a recipe for root fracture. The reason is simple: no patient has ever scheduled an appointment with an endodontist to fix a successful post that was placed by another dentist. They always seek help when a problem, usually an irreversible one, arises in a tooth in which a post was placed. When the only thing one sees is failing teeth with posts in them it is easy to develop a bias. To avoid using this treatment approach, some have started advocating the use of a core buildup with no post if a sufficient ferrule of 1.5 to 2 mm exists. This is a misunderstanding of both the term and the role of the ferrule. The remaining amount of ferrule is indicative of the overall restorative prognosis of the tooth. It does not indicate if sufficient retention exists for the future core buildup. When indicated, post placement is an important and predictable procedure. It should not be judged by those who see only the failing portion of this procedure.

This is only one out of a very long list of clinical biases we all have. Think hard for a second or two about the procedures you avoid doing and, subsequently, avoid prescribing to your patients. If everyone else is doing it and seems to be happy with it, and if the literature indicates a positive outcome, you may have a bias that is worth looking into.

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