On the Challenge of Human Frailties in Our Discipline

The poet's offer to his beloved to "Come, grow old with me, the best is yet to be" is unlikely to be made by any experienced prosthodontist to all aging patients in his or her practice. This is because the physiological parameters of old age, which still include functional abilities and remedial potential, are frequently eclipsed by pathological ones in the frail and elderly. All too suddenly, formulaic dental management strategies become passé. They must be replaced by management strategies that are very rarely an integral part of undergraduate or continuing education curricula, and may in fact be infrequently employed in routine general practice.

Clinical experience reveals that it is one thing to cope with the technical challenges of elderly patients' dental needs, but quite another to manage those of frail elders. The former's oral health maintenance requirements largely demand subtler variations on the theme of traditional ingenious dental salvage skills. And this truism applies irrespective of whether the clinical initiative involves teeth retention or their replacement. However, not all elderly patients' needs can be perceived as merely ones of older adults. After all, the duration and magnitude of local and systemic diseases must also be assessed in a frequency and time-dependent context plus the increased likelihood of significantly challenging sequelae. Their management demands greater clinical experience together with a high level of clinical and interpersonal skills. As a result, the maintenance of oral health in the frail elderly involves an even higher level of professional expertise together with an equally higher level of convergence of both dentist-, and patient-mediated, desires and realities.

Frail elders, when managed dentally, are very likely to require stronger doses of compassion, common sense, and clinical pragmatism. Their expectations (and often those of their caregivers) of comfort and adequate function are unlikely to include "herodontic" interventions or major esthetic concerns. Consequently, the clinician's traditional knee-jerk response of selecting from an extensive repertoire of so-called state-of-the-art and ideal treatment plans (ranging from a full complement of teeth—so-called 28-tooth syndrome—to perfectly aligned and preferably white ones) needs to be revised for this very special group of physically brittle and fragile individuals. Frail elders are unlikely to be suitably managed by a dentist with his or her own brand of frailty—that unique combination of professional conceits and treatment convictions which preclude an easy reconciliation between the simpler and least-invasive clinical techniques and the individual patient's real needs and expectations.

There is very little rigorous evidence that enables us as dentists to suggest optimal routine treatment decisions for the majority of our frail elderly patients. We have to rely upon personal and borrowed best practice evidence from our dealings with similar oral health challenges and disease outcomes in patients with more robust systemic health pictures. However, even the most prudent and sensible experience must be driven by the compelling need to ensure comfort and function, and the avoidance of any risk of additional morbidity.

There is probably no other dental-patient demographic (with the exception of the maxillofacial patient) that demands so much wisdom, compassion, and clinical skill from our discipline. And yet, both the necessary knowledge base and its potential for dissemination are far from readily available. It is also dismaying to realize that many colleagues still think it is very much the 'sine qua non' of modern prosthodontics to engage in ongoing anecdotal exchanges about platform switching or mini-implant designs, rather than humanitarian drive that reaches out to those whose chronology and systemic health militate against their needs being regarded as mainstream. It is our obligation to acknowledge that a high-tech mindset is not the exclusive way to approach this special patient cohort; and that our discipline only shows its true worth when it balances technical brilliance with humanitarian priorities.

It is therfore reassuring to find out that four of our colleagues from the international prosthodontic community are about to launch a first book on the subject. Michael MacEntee, Jane Chalmers, Frauke Müller, and Christopher Wyatt are coauthoring and coediting a new text entitled *Oral Healthcare for Frail Elders*. It will be published by the middle of next year and will hopefully demonstrate that all it takes is one well-articulated idea or concept to catalyze interest and development in a sorely needed topic. I hasten to wish the authors the best of luck in their seminal undertaking and to alert this journal's readers to the invaluable and opportune information package that will be forthcoming.

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