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Opinion

Sanative Dentistry: The Roles and Goals of Dentistry; Bringing Sanity Back to Dentistry

Louis Zalman Glick Touyz*

Director and Professor Periodontics (Retired), Faculty of Dentistry, McGill University, Montreal, Canada

***Corresponding Author:** Louis Zalman Glick Touyz, Director and Professor Periodontics (Retired), Faculty of Dentistry, McGill University, Montreal, Canada.

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Abbreviations

AesD: Esthetic Dentistry; ComtD: Community Dentistry; CosD: Cosmetic Dentistry; CapD: Capitalist Dentistry; ConfD: Conformative Dentistry; ConsD: Conservative Dentistry; EmD: Emergency Dentistry; Endo: Endodontics; ForD: Forensic Dentistry; GD: General Dentistry; GA: General Anesthetic; MFOS: Maxillo-Facial Surgery; Orth: Orthodontics; OM: Oral Medicine; OP: Oral Pathology; OI: Osseointegrated Implants; PanD: All Disciplines of Dentistry; Perio: Periodontics; Prosth: Prosthodontics; Paedo: Paedodontics; RestD: Restorative Dentistry; PrevD: Preventive/Prophylaxis Dentistry; SanD: Sanative Dentistry; Soc D: Socialist Dentistry

Background

In the 21st century there is much personal anxiety, social, economic and professional confusion about Dentistry. Over 11 million Canadians, and many more North Americans, do not seek out dental treatment and continue to suffer. The reasons for this lacuna are complex. With socialized medicine being a reality in Canada, and an Insurance based system to assist with professional fees in place, both in parallel with a free-market capitalist fee-for-service at work, much pain, frustration, confusion and resentment obtains by the public, from the insurance companies, and in the profession. In essence emergency (EmD) and sanative dentistry (SanD), are driven by different principles of therapy, as opposed to pan-dentistry (Pan-D) which is driven by a dynamo of different disciplines in dentistry.

Aim

This appraisal outlines an old concept, but with novel insights into essential emergency dentistry (EmD), and 'Sanative Dentistry' (SanD). Elucidated here are also Capitalist Dentistry (CapD), and separately 'Socialist Dentistry' (SocD), which may include sanative, preventative, curative and essential dentistry, and also socialist, capitalist, cosmetic, esthetic and elective dentistry. Because principles dictate policy, hopefully this subjective insight, will help clarify understanding, clear up expectations, explain different types of dentistry, and simplify approaches to ameliorate the situation.

Crafting the problem

Principles dictate policy. Conflict and confusion arises in the practice of dentistry, when capitalist (direct fee-for- service with profit) principles, conflict with socialist policies (health care: indirect cost-for-service without profit). The former Capitalist Dentistry (CapD), is financed by paying patients, the latter Socialist Dentistry (SocD) is financed by citizen's taxes managed by Governmental Departments of Health. Private practitioners are motivated to provide a comprehensive socialist service, but are exploited as the private practitioner is responsible for sustaining the overhead cost and simultaneously expect to make profit (a living income). Most insurance companies do not define their limits clearly nor state what their guiding principles and enforced policies are. What is essential, emergency, palliative and preventive therapy? What is Sanative Dentistry (SanD), as opposed to elective, durable, esthetic dentistry, or abuse of socialist philanthropic dentistry services? What is included in Primary Dental care and Secondary or advanced dental care?

Generic groups of dentistry

To start there are different types, approaches, and funding levels of Dentistry.

Traditionally the type of expertise behind the professional technical knowledge, attitude and skills, determined what kind of dentistry was on hand. Accordingly these categories include General Dentistry (GD) and specialties of Orthodontics, Maxillo-Facial Surgery (MFOS), Periodontics (Perio), Prosthodontics (Prosth), Endodontics (Endo), Paedodontics (Paedo), Oral Medicine (OM), Oral Pathology (OP), Geriatric Dentistry (GD), Community Dentistry (ComD), Forensic Dentistry (ForD) and others (Theatrical Dentistry, Paleodontics, Zoo-dontics etc).

The approaches are from providing assistance to the individual, benefitting them individually, their family, a community and society in general. General Dental Practitioners (mainly in private practice) deliver all forms of dentistry and specialists (mostly in hospitals but many in private practice), mainly relying on referrals

from generalists and providing advanced knowledge and skills. These dental practitioners implement all types of dentistry and may choose which guiding principles influence their judgment calls for treatment.

Financing for dentistry is from various sources: Different levels of thinking are at work make this system work: it derives from finance through individual private obligatory payments (fee-for-service with profit) to insurance policies (fee supplements with monetary management plans), and also government sponsored socialist services (service without profit).

Emergency Dentistry

Emergency Dentistry (EmD): The idea is to provide immediate emergency care to avoid morbidity and in rare cases mortality. With EmD, all and any skill needed is implemented to:

1. Control spreading infection;
2. Relieve pain and suffering;
3. Reverse and contain any effects of trauma;
4. Arrest and correct hemorrhage;
5. Stop allergic reactions.

Emergency Dentistry EmD, as outlined here, is a fundamental initial starting principle to practice policies of all dentistry.

Sanative Dentistry (SanD): Sanative Dentistry (SanD) embraces EmD, but attended to with pedestrian common dentistry techniques to render a mouth healthy, functional and stable for both hard and soft tissues. SanD treats primary gum disease (gingivitis) and primary decay (fillable Type 1 cavities) SanD will include prophylactic procedures like oral hygiene instructions, scaling, pit-and-fissure sealants and topical application of fluorides. SanD includes conformative (ConfD), as opposed to Restorative Dentistry (RestD), dental techniques. EmD and SanD is often passed off as Primary Dental Care, and frequently includes exodontia. Some authorities group reasons for treatment as appearance, function and comfort. For survival, looking good improves existence, but teeth are not needed for survival and food can be consumed successfully without teeth; also, comfort may be short-lived if other factors are not attended to.

Conservative Dentistry (ConsD): Conservative Dentistry (ConsD) embraces all forms of dentistry outlined here as EssD, SanD, ConfD, and RestD.

Conformative dentistry (ConfD): Conformative dentistry (ConfD), is being limited to techniques not replacing a cusp or incisal edge, but retaining a containing cavity. Repair is confined at-, and dictated to-, by the original morphology of the tooth. Typically Type I or Type II cavities.

Restorative Dentistry (RestD): Restorative Dentistry (RestD) is all dentistry techniques which restore lost dental tissue to its functional state, with improvement in morphology determined by concepts of the operator.

Surgical dentistry (SurgD): This branch of dentistry involves any surgery which may sever an arteriole and cause bleeding. This definition includes periodontal and muco-gingival surgery, surgical-endodontics, dento-alveolar surgery (which includes primary exodontias, meaning extraction without tooth fracture), maxillo-facial (Dentistry which involves complex exodontias, embraces impactions, fractures, and major orthognathic interventions). Cranio-facial and plastic surgery overlaps with Maxillo-facial surgery and often they are combined.

Orthodontics (Ortho): This area of dentistry involves bloodless application of forces to replace teeth into optimal occlusal positions for appearance, function and survival. SurgD is often called upon to facilitate Ortho and all ConsD should be completed before Ortho.

Socialist Dentistry' (SocD): This categorization must includes EmD and SanD, and may include aspects of all other types as co-payments are demanded for the extra services and treatments. SocD is subsidized dentistry, and fees are not paid for SocD in situations where the Government provides facilities and staff for SanD and SurgD service in dentistry. Patients under SocD who present pay nothing. Responsibility for provision of equipped premises, comprehensive tooling-up with adequately rewarded qualified professional and support staff for these services, and are totally paid with professional salaries, by full subsidies from the Dept of Health in Government. Accountability of the Professional staff is to their Professional Controlling Body as well as to the Governmental Hospital Administration. SocD should not be in competition with private practitioners.

Capitalist Dentistry: Includes all forms of dentistry described above on a fees-for-services- with-profit basis. A full comprehensive proposed treatment plan, with every detail relating to hard-and-soft tissues: each tooth involved and procedure is stated, with expected fees involved, time needed for conclusion, payment arrangements, expected durability of the treatment and informed commitment to undertake the proposed professional therapy by the patient and provider of services. There is a profit component for the operator with accepted approved professional standards benefitting the patient in terms of improved form and function of their teeth. The patient is involved, informed and integral to formulating their Treatment Plan. Responsibility for provision of premises and comprehensive tooling for the service is paid for by the private practitioner without any subsidy from government.

Cosmetic Dentistry (CD): May improves appearance; is temporary in nature; assists in healing, but is temporary and will not last. Typically it is cheap, may require EmD for immediate urgencies, but is not ideal. CD tolerates compromise on appearance and function, and may invoke short term reactions.

Aesthetic Dentistry (AesD): Covers EmD, but AesD is placed with expectations to emulate pristine natural dentitions. It should be visually pleasing, function well within the limits of health and physiology, be optimally durable for half a life time. Most AesthD may last a lifetime, but natural wear-and-tear may demand servicing of replacements to optimize function.

Elective dentistry: This phrase refers to any procedure, policy or practice embarked upon, mostly with patient's informed consent. This definition applies to general dentistry and procedures done with a conscious patient.

Community Dentistry: This discipline in dentistry involves defining, refining and implementing community based strategies for oral and dental health. Included here will include be: obtaining and interpreting epidemiological data that influences decisions; ComtD will embrace advice on diet and nutrition, oral hygiene practices, fluoridation of water supplies, smoking and drug abuse. ComtD may include EmD, SanD, provide other insights to all aspects of dental health services, and derive information to wisely advise controlling institutions and Health Departments about policies.

Pan Dentistry: This refers to the whole comprehensive range of dental services available, all inclusive from EmD to AesD. Means of payment are assumed to be irrelevant, and attitudes, knowledge and skills are presumed to be affirmed present for each and any procedure.

Discretionary choices often need to be made by surgeons working on patients who are under general anesthetic; this responsibility must be discussed with the patients prior to operating and options resolved. In case of children, parental authority and approval should be procured usually with a signed consent form before doing any procedure under GA. Policies affecting communities may be decided upon by their elected leaders and experts in other related fields.

Discussion

Primary and Secondary Dentistry: There are many third party payers who claim to give comprehensive coverage for dentistry. When it comes to settlement of fees, it is obvious that they meant only EmD and SanD. Accordingly EmD and SanD are wrongly labeled, and these branches of dentistry are deemed as primary health care. All other dentistry is grouped as Secondary or advanced Dentistry. When these terms are used, patients should inquire as to exactly what is included and be aware of what services for which they are insured.

Emergency Dentistry (EmD) will be done by most health care workers but particularly by practicing dentists. Pulpitic dental pain is known to be intense enough as to ruin lives or drive people to suicide. Managing a mouth of 32 teeth is as complex and challenging as a champion chess joust, with all the chess moves demanding a limitless number of units for consideration. Choosing the right strategy and best therapy to max out optimum results for each patient is the challenge. EmD involves taking decisions to maximize benefits and minimize recurrence of pain, spread of infection, loss of teeth, reduction of function and spoiling appearance; this undertaking requires a diagnosis, treatment plan and judgment calls, all in the immediate and long-term best interests of the patient.

There are no 'simple extractions'. What is the reasoning substantiate this statement? Not only does it take skill, training and experience as an expert to remove a tooth, managing complications like (hemorrhage, infection, fractured jaws), but also assessment of the patients health is to be considered and adjusted for, before any extraction. For example diabetes mellitus, hemophilia, medications or a systemic infection can complicate extractions. Pre-op anxiety and stress, and Post-op care must also be properly managed.

All dentistry is elective. Most people only seek help once they suffer intolerable pain. The best treatment of dentally-sourced pain remains prevention through prophylaxis, that is preventing the morbidity and pathological sequelae of neglect. In this sense all dentistry is elective and proposed treatment and responsibilities should be discussed before therapy. Assumption is the mother of all foul-ups. Sanative Dentistry SanD is the backbone of serviced dentistry and regular visits to a dental professional for monitoring and maintenances is not exorbitant and pays huge dividends in the long run. As a result more people now retain their own natural teeth into old age today (21st Century North America), than in the two centuries before.

People seek out acknowledged professional for help when problems arise from their teeth, gums and jaws. EmD, is an emergency, essential and palliative form of dentistry, but it is not the same as SanD, SocD or ConsD. EmD would be done by any and all of the dental profession, and most would deliver these services for minimal fee-for-service with profit, or pro deo. EmD is to relieve pain, stop infection, reverse trauma, arrest bleeding and limit allergic reactions. Often SandD precedes and overlaps into, all other forms of dentistry and an extra fee is not included. They are different, and demand different principles that affect execution policies. The definitions here clarify socialist, preventive, capitalist, sanative and essential dentistry, but also cosmetic, esthetic and elective dentistry.

Frequently neglect to attend to replacing CosD with Aesth D, leads to complicating the whole oral situation with deteriorating options; like waiting too long to create space for lateral incisors to erupt, and canines moving mesially to the centrals. Another example is placing Osseointegrated (OI) implants under existing full prosthesis, and waiting too long to expose the OI with resultant peri-implant bone loss, development of peri-implantitis and often this demands trephining out the implant, and followed by new bone grafts and replacement of the OI.

SocD, CapD and volunteerism should not be confused. SocD and CapD must be separate. Private practice does not belong in a State Funded Hospital, and CapD should not be allowed in SocD Hospitals, charity based Institutions or teaching and training hospitals and Schools! Many SocD set-ups are used as ongoing schooling educational scaffolds for training dentists and specialists. Soc-D may also be a community service but should be constrained by the disciplines of training and development. Patients who voluntarily attend SocD clinics accept they will be used as teaching cases, and that training and teaching prolong time taken. Consultations and treatment from hospital based specialists on patients which commands a fee or payment from an insurance company should ensure that fee be paid into the Institution coffers, not to the operator who is an employee of the institution.

Similarly Professional 'volunteers' should be paid full market value for their services at the same rate as full time tenured professionals. Volunteers who do not wish to accept fees for their volunteered service, should accept the fee as income, and donate it back to the Government. All too frequently Administrators keep down remuneration from full-time committed staff by saying that "for the full pay of one adequately paid professional, I can employ numerous underpaid 'volunteers' ". This practice is reprehensible, morally corrupt, devalues the worth of a full time employee, undermines goodwill, motivation for excellence and building successful careers. To compensate for underpaying full time staff, 'limited private practice' is allowed within the institution. It is the opinion of this writer that this practice is wrong. This framework is ethically a distortion of real value of professional services, is a conflict of commitment and leads ultimately to a serious conflict of interests. Volunteers usually make enough income from private practice, but by working as a volunteer 'for free' in an institution, they undervalue the market value of themselves, their work, and emasculate the bargaining power of talented in-house staff to improve wages and enforce upgrades of equipment.

Insurance Companies should be obliged by law to state what a procedures they will pay for, and what their payments and co-payments for procedures will be. These benefits should be made easily available for clients wishing to take out that insurance with dental coverage. There should be compulsory full universal coverage for EmD with Government sponsored dental services, which should cover EmD and SanD.

Accessory services and other auxiliary support therapies, like pre-medication, pain control, counseling on diet, bleaching, smoking quit programs, vaccination discussions, addiction counseling, acupuncture, hypnosis; among others need to be discussed, deconstructed and formalized by the profession. These topics are important and may be discussed elsewhere but don't belong in this discourse.

Patient expectations: EmD services can be traumatic, but most dentists will try help out with this whenever and wherever possible. But to do any other form of dentistry there is a basic necessity to be tooled up and trained for the purpose. SanD is the bread-and-butter of a community dental service. Patients assume all dental services are available under SocD; this conception is an illusion and frustrated expectations, on behalf of the patient, arises when the reality of costs are explained. Affordability by the individual, impacts on personal value systems and discretionary disposable income. Private priorities affect personal decisions of spending. Choices between luxuriating items and dental health services remain solely with the recipient patient. Values systems become major players in determining priorities. Vacations, fashioned clothes, jewelry, luxury transport, even restaurant dining are all known to increase quality and pleasure in life; but choosing to pay for healthy teeth seems to be relegated to the last choice of preference by many who complain about dentistry costs. Collectively North Americans spend more cash on superficial facial cosmetic products than all the services for dental care combined.

More advanced dentistry, and all cases referred from a GD to a specialist which demands SurgD, can be specified, and the costs incurred to be determined, as to whom is responsible for payment. Referral from GD's for surgicals involving teeth may be part of SocD, as should jaw and facial lesions demanding surgery. Treatment Planning and pre-op costing is essential to avoid confusion and shocks arriving for professional fees, after a procedure is completed. More advanced dentistry demands more advanced tooling, higher training, progressive skills and sophisticated intellectual skills of diagnosis, treatment planning and patient management. " When people want spectacular dentistry, they must be prepared to pay spectacular prices." Most people are born with excellent dentitions; prevention of loss by decay or gum disease is preferable to any repair through dentistry. SanD encourages prevention.

Concluding Remarks

Universal health coverage for universal health care is a socialist concept that demands definition and limitations with regard

to dental services. EmD may be claimed as a human right, but no other forms of dentistry: And when somebody seeks out dental treatment…. nobody is entitled to a full, free, mouth-rehabilitation, because they neglected their oral hygiene with all the negative consequential sequaelae. Morbidity from a developed cavity and resultant pulpitis, abscess and spreading cellulitis is best managed by prevention. Yet, people do not need teeth to survive; mastication of food can be done by a food grinder and swallowed in liquid form. Extraction of teeth for those who cannot afford Primary health care is tragic, and severe, but ultimately an acceptable form of therapy for relief of pain and survival. But everyone wants a "Hollywood" perfect smile. There are no free lunches and one gets what one pays for. If an inordinately ugly mouth wants to be transformed into a magnificent smile, patients must expect to provide inordinate payment, personal sacrifice, co-operation and commitment to pay for this privilege. This service is not a right, and SocD, although mainly philanthropically based to relieve pain and suffering, should not be expected to provide it. The goals and roles of dentistry, as outlined above should clarify approached to the service, and provide some understanding about what to expect. The vast social confusion about what to expect from the Dental Profession arises from a lack of knowledge about the working active driving principles of philanthropic and charitable motives, as opposed to the quest for emulating natural ideals of appearance and function. In essence emergency and sanative dentistry, are driven by different principles of therapy, as opposed to pan-dentistry which is driven by a dynamo of different disciplines in dentistry.

All other forms of dentistry, that is PanD excluding EmD and SanD, need to be placed on a different rung and costs to be negotiated with insurance companies. Socialist dentistry is geared towards prevention and maintenance of a sound healthy mouth with functioning teeth. EmD and SanD, but not SocD, can be a right, but extraordinary procedures will demand extra-co-payments for extra-ordinary treatments.

Different types of dentistry exist and delivery of each type must have the community setting which prevents conflicts of commitment and interests from arising. EmD may be regarded as a human right and people have an inalienable claim to be pain and infection free; but all other forms of dentistry are privileges and have a cost. SanD may be provided through political social philanthropic arrangements. Basic SocD is available in most socialist states, and CapD when used must be paid for by the individual user. SocD and CapD must be kept separate and Social Health institutions must exclude monetizing their social welfare services and keep Soc D exclusive and away from private practice.

Author's Statement

The author has no conflicts of interest or commitment to declare.

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