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A few years ago I took part in one of the most successful dental programs I can recall, the annual meeting of the American Academy of Fixed Prosthodontics. It was created by program chairman David Garber, DMD, and it was entitled a "Failure Festival." Dr. Garber assembled a lineup of internationally known clinicians who each gave a short presentation showing a dental failure, how they rectified it, and how to avoid it in the future. It was one of the most educational and valuable programs I have ever attended. Each dentist showed the step-by-step sequential procedures of complicated cases and explained in detail what failed. The stories were often painful for both the dentist and the audience, but we all make mistakes and we all have failures. These failures are most relevant when we acknowledge the cause, learn from it, and do not repeat it.

Why Must We Focus on Failure?

Noted British clinician, Michael Wise, BDS, authored an entire book on failures. When I present a full-day course on esthetic failures, my goal is to help dentists avoid making costly mistakes not only for themselves but also for their patients. With the national total dental market approaching \$80 billion, I estimate that approximately 10%, or \$8 billion, will be spent by patients on correcting esthetic or functional failures. Whether it involves replacing a fractured porcelain crown or laminate to having defective margin redecay, failures may well happen to every dentist if he or she practices long enough.

One type of failure that seems more prevalent today involves a

Curbing Your Failures

patient who receives an incorrect occlusal relationship. For instance, I recently consulted a new patient who complained that she had returned to her former dentist's office 40 times trying to get her bite corrected after having her teeth all crowned for "esthetic purposes." She had also been on daily pain relievers and anti-inflammatory drugs for 2 years. Many occlusal problems have been and always will be a challenge for restorative clinicians; managing to reconstruct a new occlusal relationship can be a difficult feat for even the most qualified specialists.

In fact, the subject of occlusal problems causing failure was addressed to me following a course I gave last year at the University Southern California. I was asked to comment on the increasing number of cases the dentists in California are seeing because of "missed bites." My answer was that there are 2 factors that play a role in this problem. The first is that of poor or faulty technique, and the second—which is a much more serious problem—is attempting to manage a case that exceeds the dentist's capability or expertise. This sparked a dialogue among the graduate students, faculty members and general dentists at my presentation. One faculty member accurately pointed out that there is a vast difference between a dentist who graduates from an accredited 2- to 3-year prosthodontic program at a major academic university, and the dentist who "graduates" or completes a 2-week program at a "so-called" teaching center or institute. Nevertheless, short courses can be and have been of tremendous value in raising our educational and technical skills. Team Atlanta, which has its own teaching facility called the Accelerated Dental Learning Center in Atlanta, Georgia believes that a graduate of a 2- to 3-year specialty program should be more capable of diagnosing, recognizing, and treating a complex prosthodontic patient.

I am certainly now aware of my own limitations, and this came about partially by experiencing

Table—Let's Get Back to the Basics

- Beware of questionable occlusal theories, some have been disproved years ago only to resurface again but with more marketable advertising copy.
- Think twice before arbitrarily opening the vertical dimension of a patient who may not be able to tolerate the opening. Instead, plan on a trial period even using a removable or fixed appliance over the natural dentition for a 3- to 6-month period to see if the patient can adjust to the new bite.
- Do not let your patient rush you. Take your time to make certain you will have a successful result.

some failure along the way; but these failures helped me to better predict and recognize when to refer and when to treat. As a result, after 45 years of practice, I am much more cautious in accepting a patient whom I think may have a greater problem than I am qualified to handle. Instead I am much happier referring those patients to colleague with greater expertise in a particular area.

Although I practice with a team of specialists, I also outsource a considerable number of patients to other offices, depending on the individual circumstances. Even the 4 dual-degreed specialists in the practice often work with other specialists outside our office. We all have the same goals—trying to avoid a failure and wanting the patient to have the best possible result.

When I finished Emory University School of Dentistry in 1957, I had the good fortune of practicing a summer with my father, Irving H. Goldstein, DDS, who was an outstanding dentist and teacher. Then I spent 2 years in the US Army Dental Corps at the Pentagon. Being in Washington DC, I was able to observe some of the area's finest dentists. One of them, Jules Minker, DMD, was a graduate of Morton Amsterdam's and Walter Cohen's 3-year periodontics-prosthodontics program at the University of Pennsylvania. My eyes were opened not only to a higher level level of clinical dentistry but also to an understanding of diagnosis; this experience left me with tremendous respect for the depth of learning taught in that program.

Despite the fact that I took virtually every course available in func-

tion and esthetic dentistry, the more I learned, the more I realized I did not know. When you spend weeks at short courses with Morton Amsterdam, DDS, ScD, Lenny Abrams, D. Walter Cohen, DDS, Charlie Pincus, Bob Stein, Earl Pound, Alex Koper, Peter K. Thomas, David Shelby, John Pritchard, [QA. Need degrees please.] and a host of others, one thing is certain: I was learning from the true masters of dentistry in my time. Nevertheless, I never felt that I could conquer the world and handle any case that came along. Instead, I always had respect for my teachers and the prosthodontists/periodontists that they graduated. I felt confident that if a case presented with more difficulty than I had been trained to treat, I could refer (and have done so) in my city, my state, and other states. As a result, I have had a career that I think has been blessed with a minimum of failures.

No one better stated my third cause of failure than Gordon Christensen, DDS, in an excellent article concerning overtreatment. It has been published in several leading journals including the *Journal of Esthetic and Restorative Dentistry*. In my opinion, it should be included in the curriculum of every dental school to help instill the importance of 'doing no harm' to our patients.

When Michael Buonocore, DDS, called me more than 40 years ago to help create the esthetic techniques for a new dental material that eventually was to be called composite resin, the fact that we could make a 1-appointment esthetic transformation for a patient was exciting. We did it conservatively, with little or no tooth

reduction, making the procedure reversible. Although many esthetic corrections can and should be done in this fashion, today the sad reality is that far too many esthetic transformations are being performed with huge amounts of tooth reduction resulting in pulp loss and eventually even tooth loss.

At the recent Quintessence Ceramics Symposium in San

Diego, California, Tom Trinkner, DDS, said it best when he pointed out just how long the more conservative bonding techniques can last when they are done well but that it was indeed harder and more meticulous to accomplish. It reminded me of the dentist who bragged to me just how many crowns he was doing monthly (more than I was doing in a year) and when asked

why, he said it was so much easier and, besides, he received more insurance reimbursement per crown. I do not remember ever hearing a more offensive remark from someone in our profession.

Summary

Some courses have almost an evangelical message given to each participant that “graduates” from a



Figure 1—Preoperative image. Although orthodontics was the ideal treatment for these multiple spaces and lingually inclined posterior teeth, the patient opted for a compromise restorative plan which was accomplished without tooth preparation.



Figure 2—Postoperative image. Porcelain laminates plus an interim resin bonded bridge were used to help improve this young lady's smile.



Figure 3—An occlusal view. This view shows how porcelain laminates were used to build out the posterior teeth labially and close the anterior spaces. Note also how the interim resin bonded bridge improved the space problem on the right side.

2-day or 2-week course; they are inevitably applying a technique—often learned in an inappropriate situation—and the problem remains that they do not know what they do not know. I know there are reasons why my academic colleagues at USC prompted the discussion of what to do about so many missed bite failure cases—and I realize the reason we have also been witness to the mounting number of failures seen in recent years. However, the obvious answer to me may not be as obvious to others. ■

Acknowledgment

The ceramics in the 3 figures were performed by Pinhas Adar, CDT.

