



## Christensen 'embarrassed' by U.S. dentistry

By Laird Harrison, Senior Editor

October 28, 2008 -- The granddad of U.S. dentistry is ashamed of his family. "What we do in America is embarrassing," Gordon Christensen, D.D.S., M.S., Ph.D., said at the ADA meeting in San Antonio this month.

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With his *Clinicians Report* review, Scottsdale Center for Dentistry courses, frequent bylines in the *Journal of the American Dental Association*, and popular talks at dental meetings, Dr. Christensen may be the most influential U.S. dentist. So it means something when he deplores the state of the profession in his own country.

Dr. Christensen offered several unfavorable comparisons between dentistry in the U.S. and other countries during a panel discussion about controversies in dentistry, which he moderated at the ADA meeting. He also touched on such questions as mini-implants, cracked teeth, light-activated whitening, and articaine.

He mentioned his embarrassment in the context of choosing when a crown is appropriate. He said many U.S. dentists place porcelain fused to metal (PFM) crowns in cases in which he might recommend an onlay.

"We don't have to go hog wild with the crowns," he said. "The typical PFM crown in the U.S. is hideous, absolutely hideous. I go to Switzerland and I have to take my very best stuff because I'm embarrassed by a lot of the stuff we do in America."

The biggest dental organization in the U.S. had no reaction to this criticism. An ADA spokesperson said the association declined to comment.

Dr. Christensen did offer a saving grace with regard to U.S. crowns. "We're doing it at a very moderate level of cost: \$800 to \$1,000 is the average, where over there you will find \$3,000."

But in general, U.S. dentists are losing credibility, he warned. He showed results from a poll in which dentistry had dropped lower in comparison to other professions. "You can see where we are -- we're No. 5. We used to be, believe it not, No. 1. Are we going in the right direction?"

Dr. Christensen suggested U.S. dentists have gotten behind on technological trends. When he polled the audience to see how many were using electric handpieces, he noted that, "If I were in London right now or Zurich, all of you would raise your hands."

### Behind on implants

Dr. Christensen also argued that more general dentists in the U.S. should place implants. He estimated that only 6% to 15% of U.S. dentists are placing them now.

"I've been doing implants for over 20 years," said Dr. Christensen, who is a prosthodontist. "I find it's one of the simpler things that I do. There are so many things that are more aggressive and more threatening than doing an implant on a healthy person with good bones.... It's simpler than doing a third molar extraction. There is far more legal activity around third molar extractions than in implants. Yes, you ought to be doing it."

And once again he said that dentists in other countries are ahead of the U.S. "In Israel, a developing country, 95% are doing dental implants, in Latin America 50% to 60%."

Dr. Christensen added that dentists should not shy away from mini-implants. "Yes, they should be used," he said. "There are 40 million edentulous people in the United States, and I would guess at least two-thirds or three-quarters of them don't have enough bone for a normal implant."

Mini-implants can also save money for frugal patients, he added. "If one of them falls out, big whoopee. It has expanded the bone, and so when you take it out within even a few weeks, the bone has come back. It's not like a normal implant with a big hole you need to drain.... Move it over 3 mm and screw in again."

But technique is important when using these smaller implants. "They've got to be put in right," Dr. Christensen noted. "Two minis in a surface area of 1.8 mm equals one standard implant, 3.75 [mm]. So put in two for one and keep them low like a sports car, not like an SUV."

## Behind in radiography

Dr. Christensen also argued that "we're way behind other countries" in adopting digital x-ray equipment.

He uses digital himself, in part because of the ease of storing images. But he offered a less than ringing endorsement of the latest high-tech imaging systems, such as standard computed tomography (CT) or cone-beam CT.

"You lose the definition, the contrast," Dr. Christensen said. "You've got multiple shades of grey.... Almost every one of those that are digital [radiographs] is second class to an analog radiograph. Period. Exclamation mark. To make them as good, not better, you have to enhance color and texture and go from there."

He said he likes conventional (as opposed to computerized) tomography for planning implants, though periapical radiographs help him "a lot" and panoramic helps "some."

## Opinions, opinions

Dr. Christensen also offered his characteristic strong opinions on a wide range of other topics:

- **Restoration materials:** He pointed to a poll of the American Academy of Esthetic Dentistry. "When asked, esthetic dentists said in their own mouth on second molars, upper molars they want gold. First molars on the lower they want gold. First molars upper they want metal occlusals with porcelain facials. When they got to the premolars and forward, they started talking white." But in their patients, he said, the same dentists rarely use gold, but instead place white materials all over.
- **Light-activated whitening:** The lights used don't get hot enough to make a significant difference, Dr. Christensen said.

- **Cracked teeth:** There are many types of cracks -- superficial cracks in enamel, cracks that extend below the gingival, and cracks that go below the bone. "So here's my approach: I'll tell the patient I don't know where this crack is. I haven't the slightest idea. I'll show the patient a video. It shows them these different kinds of cracks," he said. He then prepares the tooth. A crack that extends below the gingiva but not the bone will fly off during the preparation.

"If it's down further, slightly under the bone or more under the bone, I don't know if I can heal it or not. So I'm going to cut the crack and put a provisional on it with Eugenol cement," Dr. Christensen said. Three or four days later, he asks the patient to bite on a pencil. If the tooth still hurts, he gives the patient a choice between root canal therapy and an extraction.

- **Evidence-based medicine:** "I get nauseated when I hear this phrase," he said. Although physician David Sackett, M.D., the father of "evidence-based medicine," originally incorporated clinical experience into his definition of the phrase, Dr. Christensen complained that too many people in dentistry have forgotten that aspect. "We have got it totally wrong in dentistry right now," he said. "It's as if we never had evidence before.... Third parties are using it to our disadvantage."
- **Articaine:** U.S. dentists have more problems with paresthesia than European dentists, Dr. Christensen said, because they work too fast and use too large a dose of the anesthetic.
- **Bruxism:** Dentists should be making more splints, he said. "One-third of the world's population has aggressive chewing habits. We're negligent if we don't say to the patient, 'You're chewing your teeth down. Look at mine, I'm 90 years old and mine are long. Look at yours, they're little bloody nubbins.' "

What if the patient balks? "A typical bruxing person chews his or her teeth up to six hours a night. A normal person has only a few minutes of tooth contact a day," Dr. Christensen said. "So I often say, 'You're going to have 50 or a 100 days' wear on your teeth tonight. You need something in there. And if you don't wear it, you're going to have teeth looking like this' -- and I show them a picture."

The session ended at that point, but Dr. Christensen looked ready to offer opinions as long as anyone would listen.

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### Forum Comments

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**10/29/2008 2:01:37 PM**

**Allan Farman**

I share Dr. Christensen's frustrations with the poor quality of dentistry that can be seen in some - or perhaps even many - patients treated in the USA... and also in countries on the other two continents where I hold licenses to practice. What I object to is the misconception that US dentistry is, or has ever been, the torch bearer for dental healthcare internationally. Why should Dr. Christensen be shocked to find excellence in dental care in Switzerland, or for that matter, Sweden, Germany, Italy, Spain, Japan or China? There are excellent training programs in many parts of the world, and in

many instances the time spent in training is longer than in the USA and the dental institutions providing the training are extremely well-equipped.

In the USA it is only a recent trend that Dental SCHOOLS have also been viewed as having an important role in dental healthcare for the community. That has happened largely due to state funding drying up and Deans finding that clinical income is often more reliable as an income source than grants and contracts for research. Further, we have essentially reached the limit to the levels to which tuition can be increased given the present state of the economy. Elsewhere, the Dental HOSPITAL has been a center of the highest standards of dental care and a valuable assistance for dental practitioners faced with cases too difficult for them to handle. The equipment comes largely for healthcare rather than for training new dentists alone, and the student dentists get a tremendous exposure to a variety of patient needs and conditions.

So, yes, some dentists in the USA do provide suboptimal care - as do some dentists in most other countries, but nobody should be surprised that excellence in dental care can be found in countries other than the USA.

Allan G. Farman,  
Louisville, Kentucky

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**10/29/2008 6:30:36 PM**

**powers**

**This critical observation is right on the point.**

**Evidence-based medicine:** "I get nauseated when I hear this phrase," he said. Although physician David Sackett, M.D., the father of "evidence-based medicine," originally incorporated clinical experience into his definition of the phrase, Dr. Christensen complained that too many people in dentistry have forgotten that aspect. "We have got it totally wrong in dentistry right now," he said. "It's as if we never had evidence before.... Third parties are using it to our disadvantage."

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**10/30/2008 7:40:21 PM**

**Marty Jablow**

Although treatment should not be dictated by insurance companies, in reality it is. So the costs and skill level is greater for inlays/onlays then it is for a crown. Yet, the insurance companies will be pay more for crowns then for inlays/onlays. So we wonder why more crowns are done then inlays or onlays. This is just economic reality for most patients and dentists.

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**11/6/2008 8:22:46 PM**

**Hershey**

Why is this news? The educational institutions in this country both Public and Private are charging top dollar for inferior education, using information from books that get cover facelifts but not content facelifts. I am a new graduate and I had to relearn dentistry in the past three years using European Texts and Journals. Heck the board exams practice unethical behavior by making practitioners create cavitations in sound teeth that only have radiographic evidence of minor dentin demineralization, how archaic. GV Black techniques are still performed, and this is supposed to be a modern profession? I speak to older dentists and I ask them about the benefits of Glass Ionomers and they look at me with a blank stare! I explain that restorative dentistry for non cavitated lesions is not indicated and could be actually doing harm to the patient and I get angry stares. Yes Insurance companies are dangerous for the single reason that they must show profit growth to Wall Stree every quarter, and of course they like crowns because that allows them to raise premiums which is a dirty way to show positive growth on Wall Street. Dentists love it because they can bang out crowns from China with huge profit margins, everybody is quite happy. Until the patient shows up in 12 months

with lots of problems because we failed to treat the underlying disease of pathogenic bacteria. Now we have patients that have lost confidence in this profession because we became salesmen and lost our way of acting like DOCTORS. We need to shape up real fast, start treating the underlying disease and stop thinking that restorative dentistry is a cure for anything, its NOT! Restorative dentistry fills things, replaces things, it DOES NOT CURE anything. There would be no specialty of Endodontics if restorative dentistry cured dental disease remember that fact. We need to place pressure on insurance companies to start reimbursing for PREVENTION AND HYGIENE. Lets give young men and women advice to learn about Dental Hygiene send them to appropriate schools, lets expand our practices to focus on bi-monthly, tri monthly hygiene to actually improve the oral health of our population. Lets push insurance companies to reimburse for Fluoride Varnish treatments. Lets put pressure on the pharmaceutical industry to perfect fluoride and chlorhexidine delivery systems to get our high risk patients under control outside of the office. Lets face it, patients are only in our offices for a few hours per year, we are not really changing their oral health, its what they are doing outside of the office that is changing their health. We need to REFOCUS our way of practicing to meet the future of changing ECONOMICS and DEMOGRAPHICS so that we can regain the confidence of our patients that we actually treat their diseases with long term strategies that are effective. JASON HIRSCH DMD MPH.

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**11/6/2008 8:42:41 PM**

**Flatinfifth**

I am a new member and I signed up after I read the article on Chistensen's "embarrasement" with regards to U.S. dentistry as opposed to other countries' examples of dental care. HOW CAN HE GENERALIZE like that!!!! I am enraged by his comments. It demonstrates a complete lack of understanding of the complexity and multifaceted dilemma facing American dentists in today's market. He is out of touch. It is 7 PM and I am still at my office finishing up my clinical notes. I began the day at 7 AM. I won't get home much before 9 and I won't make it to the gym today. Why?? Because in many American cities unfortunately, insurance companies control the market and we as care givers have to jump through hoops in order to comply. In order for me to "make it" and do what is right for my patients I have to see many patients during the course of a day. And the reason is quite simple; because the fee they "grant" us per service (dictated by the insurance mafia) is extremely low.....an insult in fact. I do end up treating my patients with more difficult and time-consuming restorations (inlays, onlays) even when the fees are lower than for the crown.....because it is the right thing to do. You don't want to get me rolling in that direction.....

That kind of statement makes me sick. A terrible way to end my long day. What kind of an ambassador do we have representing U.S. dentistry?? Who made him our ambassador?? I certainly didn't vote for him to fill that role..... Aren't any of you absolutely disgusted by his posture and pontification?? Isn't it time that dentists begin to crawl out of their holes and make a stand?? I happen to have lectured abroad as well and I have seen a MUCH LOWER LEVEL of care IN GENERAL in other countries than here in the U.S. Dr. Christensen is dealing with the "elite" of dentistry; those dentists are not the rank and file we find in the trenches. I have seen first hand TERRIBLE examples of dentistry in Europe and Asia.....TERRIBLE; assistants placing composite restorations without bonding, archaic stainless steel crowns sold as permanent restorations, assistants actually preparing teeth and more; why doesn't he mention that...If I've seen it, certainly he must have seen it abroad!!!!!!!!!! I am sickened by what I see. It's an outrage.....

Flat

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