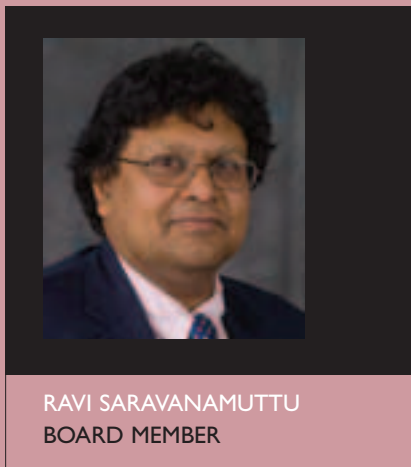


Restorative dentistry: a misunderstood specialty



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Restorative dentistry is often rather misunderstood and we in the speciality are often asked what it is we do. It is often puzzling for our colleagues outside to appreciate what skills a specialist in restorative dentistry would have beyond that found in an experienced and skilled dental surgeon. It is also unclear to many how a specialist in restorative dentistry can master all the skills necessary to cover such a wide area in dentistry. I believe the answer to this question depends on two things – perspective and training.

Perspective

As dental surgeons we are used to thinking of ourselves in surgical terms. We undoubtedly have acquired operative skills, which are somewhat specialised and often out of the envelope of routine general dental practice. However, there are probably few of these skills that would not be found within monospecialist practice in periodontics, endodontics or prosthodontics, or indeed within the

realms of a skilled general dental practitioner.

What then makes us different? The answer is in our skill mix and the breadth of our training (of which more shortly). This puts us in a position to look on complex dental problems from a wider perspective. In a way, we are mirroring the role of, say, a consultant physician rather than a consultant surgeon. A consultant physician would be available to assist a general medical practitioner with advice on the management of cases that he or she considered too complex to manage him or herself; or to manage the most difficult conditions, often of a chronic and incurable nature.

Many dental conditions managed by restorative dentists are also chronic and long-term, with lifetime planning for the dentition a necessity. Many of these can be managed by the skilled (mono-) specialist or general dental practitioner with appropriate support, the operative element being less important than appropriateness of the management plan. There will also be some cases that because of their rarity and unfamiliarity would best be managed by the restorative dentist, who would have received training in such management.

Training

Restorative dentists are clinically trained on what I believe is a unique patient population. As long as the publicly funded health service continues to regard dentistry as part of essential health care, those considered as having conditions such as congenitally acquired or developmental orofacial anomalies such as

cleft lip and palate, and dentofacial deformity, orofacial malignancy, severe orofacial trauma and aggressive periodontal disease will require to be treated. Restorative dentists, often as part of multidisciplinary teams, play an essential part in such rehabilitation.

The NHS (at present) provides comprehensive care for patients in these groups regardless of the ability to pay, thus providing an incomparable training environment for trainees in restorative dentistry. Trainees are exposed to sufficient case mix and volume of these rare conditions to become aware of the particular requirements of these groups. They also become competent in their management.

Restorative dentists are also expected to have been trained to specialist level in the monospeciality restorative dental specialities of periodontics, endodontics and prosthodontics, to fulfil their advisory role to primary care practitioners and other hospital specialists within medicine and dentistry: this may explain why the specialist training is at present five years.

Education

Restorative dentists being comprehensively trained across a broad area are in a unique position to educate those training to join the profession and those acquiring more specialised skills. They may see things in a broader context and be able to provide perspective to translating research into clinical practice. They may serve as useful conduit for continuing professional education and development – perhaps in this regard they are underutilised.