Real change is difficult

There is a saying that you can't teach an old dog new tricks. My wife doesn't agree, as she says that even an old curmudgeon like me can change. Since my wife is usually right about things, she is probably right in this regard, but I would say that real change can be very difficult. It's easy for one to look at others and think of what they should do differently in particular situations, but it is much more difficult to recognize when one's own actions might warrant change. There is comfort in doing things the way they have always been done. And there is always inertia which prevents real change. People also resist change because it takes them to areas that might be novel, strange and uncomfortable. Sometimes, even when one recognizes the necessity for change, one continues to do things the same old way because of familiarity. While such is true in private life, it is also true in professional life. As a pediatric dentist, I recognize that there were areas of practice which took me a long time to change. Now when I look around, I find some of my colleagues still doing things the same old way, often rationalizing their old practices.

Consider the taking of full mouth radiographs with new patients. It was my standard practice to perform a full mouth radiographic survey with every new patient, regardless of age and regardless of oral condition. Then I learned that a radiograph was not to be taken unless it made a difference to the treatment and/or health of the patient. After a while, I began to follow the official policy of the American Dental Association and the AAPD in regard to radiographs, and now I no longer routinely take full mouth surveys. That change was difficult for me to accept because of my particular bias, but I made it more than two decades ago.

In the 1980's when the pulse oximeter was developed, many practitioners rationalized why they would not use the instrument. It was considered to be too expensive and not necessary. Now most pediatric dentists use the pulse oximeter for sedated patients, however, there are still some who do not use the equipment. They resist change and in so doing ignore AAPD guidelines.

Consider the rubber cup prophylaxis. It was my standard practice to perform a rubber cup prophylaxis to "clean the teeth every six months" and also to perform a prophylaxis prior to a topical fluoride application. Then in the early 1980's, clinical research demonstrated that it was not necessary to do a rubber cup prophylaxis prior to topical fluoride application. It was also found that such prophylaxis was damaging in that the superficial fluoride rich layer of enamel was being removed. In addition, I questioned the rationale for cleaning plaque with a rubber cup and prophylaxis paste every six months when within 24-48 hours the plaque would re-occur. So I changed my practice and now rarely use the rubber cup prophylaxis. Although I advocate the routine use of the handpiece on the first visit as part of patient training, and I would use the instrument to remove occasional staining, in most instances, I now use a toothbrush, and perform a toothbrush prophylaxis. In so doing I am able to reinforce oral hygiene with the child every six months. Whenever I have the opportunity, I reinforce with the patient what the patient can do, rather than have the patient rely on what the dentist can do. That practice of performing a toothbrush prophylaxis has been taught at our institution for many years. Nevertheless, there are still colleagues who find change difficult and continue to perform the rubber cup prophylaxis even though in most instances it is not necessary.

The same might be said for topical fluoride application. During the 1960's, stannous fluoride topical application was typically used every six months, even though it had a sour or bitter taste. Then there was a change to acidulated phosphate fluoride gel and, subsequently, there was change in that the gel was applied with fluoride trays to both arches at the same time. I made that change and it is now the standard of practice. However, some practitioners have attempted to abbreviate the four-minute procedure to only one minute with the use of "minute gel" even though there is no clinical data to substantiate that reduction in time. Colleagues will rationalize the use of minute gel as it is something with which they are comfortable even though there is a lack of evidence of effect. More troubling is the practice of using topical fluoride application in communities where there is a fluoridated water supply. Clinical research has demonstrated that there is no benefit to the use of topical fluoride in a fluoridated area unless the patient has a high caries risk. Yet colleagues still use topical fluorides in fluoridated areas. Others use the technique as a routine every six months, even for children with low caries risk, where that routine could and perhaps, should be modified.

Change is difficult, but it is vital. In private life it is important to be flexible in order to maintain the vibrancy of relationships. In professional life, change allows us to progress, to keep abreast of current knowledge and to move forward. Being open to change allows us to serve our patients best.