

*The choice is not so much amalgam or composite, but whether to comply with the patient's wishes against your better judgement, or lose the patient.*

## Hobson's choice?

Currently the American Dental Association (ADA) has a problem with amalgam. The problem is not the material itself, but the difficulties members of the ADA are having when patients request tooth-coloured fillings for their posterior teeth in clinical situations where the dentist believes that amalgam is the better choice. The question is: when does patient choice override clinical judgement – and it is a question that is not going to go away.

This problem over the choice of composites instead of amalgam is not restricted to the USA, of course, but is a worldwide phenomenon. In this issue of the *BDJ* we are publishing a paper from Taiwan on the proportion of posterior teeth restored with amalgam as compared with composite and glass ionomer restorations. The paper shows that just over half the direct restorations in posterior teeth (53.3%) recorded in the National Health Insurance Research Database in Taiwan in 1997 were filled with amalgam. This is based on data taken from the database, and as 96% of the population have participated in the insurance plan and 80% of these had dental treatment we can assume the figure is reasonably representative of the population of Taiwan in that year. What the study cannot tell us is why? We do not know if the figures reflect patient request or dentist choice.

It is important to remember that this debate is not about the safety of amalgam. It is a debate about whether the patient's wishes should override the clinician's recommendation. The controversy surrounding amalgam as a restorative material is well known, and despite concerns by certain governments, pressure groups and individuals there still appears to be no real evidence to suggest amalgam is unsafe. We also know that composites and glass ionomers, despite dramatic improvements over the last decade in their properties, are still more difficult to manipulate and less proven over the long term as satisfactory posterior restorations. Yet aesthetics and possible safety concerns still prove attractive to patients. Which leaves us with this dilemma that is currently causing concern for the ADA - what do you do if your patient wants one thing and your clinical opinion suggests another?

Obviously the problem does not exist if the patient's wishes are clinically acceptable, or if there are a number of options and the patient selects one based on a

thorough knowledge of the advantages and disadvantages of the differing choices. For example there is no problem if a patient selects a denture rather than a bridge for economic reasons and is aware of the advantages and disadvantages of both options. The problem only occurs when the patient chooses a treatment option that the dentist feels is inappropriate or ill advised. For example a patient may choose an extraction, which the dentist feels would cause harm for the patient. In the case of amalgam versus composite for a posterior restoration the dilemma is not as clear-cut because we do not know whether composites will ultimately lead to damage for reasons still to be identified. In contrast amalgam has been in use for a considerable time and current scientific opinion continues to believe that amalgam is the material of choice.

Perhaps the real problem is not so much a concern over the differing materials but a commercial concern that if the dentist does not comply with the patient's request then the patient may go elsewhere. The choice is not so much amalgam or composite, but whether to comply with the patient's wishes against your better judgement, or lose the patient. It is not so easy to insist on principles when your livelihood is at stake, yet our professional obligation insists we should.

In the end it all depends on trust. If a dentist truly believes that amalgam is preferable and the patient's concerns over aesthetics can be satisfied (in other words the restorations are rarely visible if at all in normal social interactions) then surely the right thing to do is to express this view and hope that the dentist/patient relationship is one where the patient will trust the dentist and be happy to accept the clinical recommendation. Building both trust and respect in the relationship with patients is vital to all dental personnel, and is rarely taught in both undergraduate and postgraduate education as well as clinical procedures are, because it is so much harder to teach. Creating a relationship built on trust is not automatic but needs to be worked on - and surely this is where the ADA or any dental association should be putting its efforts.

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