The hole and the whole

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EDITORIAL

It is strange but pleasing how from time to time a set of circumstances conspire to prompt new thoughts and associations. Just such has happened recently in relation to material that we have been considering and scheduling for the journal in coming issues and it seems appropriate to ponder these with you.

Late last year and early this, we published a series on minimal intervention in dentistry and we will be running a further series in 2014. These various papers jogged a memory of one of the first humorous pieces that I ever wrote for the *BDJ* in the series 'View from the chair' way back in 1993.[1] Entitled *The hole truth* it poked gentle fun at our apparent inability as a profession to be able to identify when a cavity was a cavity, or when a hole was a hole. Yet the fundamental dilemma which made the central smirk sustainable then, those twenty years ago, has if anything deepened further as our ability to detect demineralisation at an earlier and earlier stage has increased. Coupled with that has been the development of various ways of removing carious hard tissue that are far more discerning than the steel brutality of the bur. Gels have been around for a long time but air abrasion, lasers and even rubber burs now provide us with a range of options to treat a hole, when we can recognise it as such and decide that it needs operative intervention, as truly conservatively as possible. This alone would not be entirely satisfactory were it not for the materials that have been developed in parallel which by adhesion give strength, form and function to the restored tooth.

A RAFT OF INSECURITIES

But it was while pondering this matter that another circumstance entered the frame and built on the coalition of ideas. The research paper in this issue on the adoption (or not) in dentistry of digital technology made me realise that our innate suspicion of change has also affected our ability to embrace some of the innovations that could make our patient care better and arguably more efficient.[2] It is an observation rather than a criticism because our reticence is based not solely, or indeed not at all, on a belief that any change might be for the worse but on a raft of other insecurities. The cost of innovation is often not inconsiderable and the collection of previously purchased gadgets and equipment gathering dust in a cupboard under the stairs, the loft or the garage attests to the reality that only some of the applications either work effectively or are themselves quickly superseded by 'the next thing'. It is, of course, quite impossible to know what will stay the course and what will fall by the wayside but the longer we wait to find out the longer we delay the possibility of moving forward, or worse risk the catastrophe of being left behind.

This is where the third of the ideas joined the confluence of thought. More and more of the content being submitted to the journal revolves around the concept expressed by a word which sounds exactly the same but could not have a more diametrically opposed meaning; whole, or more specifically the whole patient.

The links between oral and systemic diseases have been suspected for a long time and common sense has always suggested that poor health in one part of the body cannot possibly be good for the whole. However, few can have failed to notice the flood of research both clinical and epidemiological which has been investigating possible links between, particularly, periodontal disease and a range of other conditions. Notably these are also mediated by inflammation. This seems to be the still illusive but gradually more explainable association and certainly links periodontal disease to diabetes but also possibly and most dramatically to cardio-vascular disease, rheumatoid arthritis, and problems surrounding pregnancy and child birth.

So, while spending more of our detailed time assessing the smaller and smaller perimeters of the hole, we also need to plan ways in which we can focus more on the whole of the patient in terms of their general health and wellbeing. One of the routes to this may be a greater intervention on our part in diagnostic and preventive general health measures. Many of us now include tobacco counselling and, increasingly, alcohol advice in our discussions with patients but the future might also rekindle the possibilities of taking blood pressure, recording cholesterol and carrying out tests based on saliva sampling. These options are hovering on the horizon and while to some extent made possible by technology are also long held notions of overall patient care by putting the mouth back into the body. But that, I suppose, is replacing the hole in the whole.

1. Hancocks S. The hole truth. *Br Dent J* 1993; **164:** 148.
2. Van der Zande M M, Gorter R C, Wismeijer D. Dental practitioners and a digital future: an initial exploration of barriers and incentives to adopting digit technologies. *Br Dent J* 2013; **215:** E21.

DOI: 10.1038/sj.bdj.2013.1148