EXCELLENCE IN COSMETIC DENTISTRY 2007

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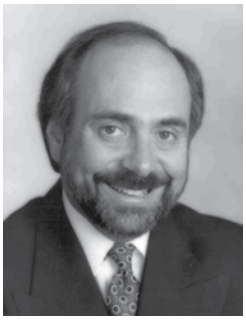
Interview with Dr. David A. Garber



by David A. Garber, D.M.D.
John F. Weston, D.D.S.

Dr. Garber is a member of Goldstein, Garber & Salama in Atlanta, Georgia, known as "Team Atlanta." He is a dual-trained clinician and professor in the Departments of Periodontics and Oral Rehabilitation at the Medical College of Georgia. Dr. Garber is a past president of the AAED. He also is past editor of The Journal of Esthetic Dentistry, *co-author of* Porcelain Laminate Veneers, Bleaching Teeth, Porcelain and Composite Inlays and Onlays, *and* Complete Dental Bleaching; *and has published more than 60 articles and textbook chapters.*

Dr. Weston graduated in 1989 with OKU Honors. A commissioned officer in the U.S. Navy, he completed a hospital GPR in San Diego and served two years in support of Desert Storm. Dr. Weston earned his AACD Accreditation in 2001. He is a member of the AACD's Board of Directors and is an Accreditation examiner. Dr. Weston's practice emphasizes cosmetic dentistry and smile design. He is owner and director of Scripps Center for Dental Care, a multispecialty dental center in La Jolla, California.

The goal of this section is to provide insights into the thoughts and perspectives of some of dentistry's premier educators. In this issue, AACD Conference Advisory Chair Dr. John Weston (JW) interviews Dr. David A. Garber (DG). Dr. Garber is scheduled to present twice at the AACD's Annual Scientific Session in Atlanta (Thursday, May 17; and Friday, May 18, 2007). For more information regarding Dr. Garber's presentations, log onto www.aacdatlanta.com.

JW: *Dr. Garber, you have been providing comprehensive quality dental care to patients for many years and are one of dentistry's most influential teachers. Do you have any predictions about the future of esthetic dentistry?*

DG: I have seen Dr. Ronald Goldstein's predictions regarding esthetic dentistry evolve so that today it is a major de facto part of day-to-day practice. We were taught in dental school that pathoses involved caries, periodontal disease, orthodontic malocclusions, and temporomandibular disorders; but with the incidence of these conditions decreasing, esthetics has evolved to become the cornerstone of any developing practice. This is the net result of more conservative, less painful, and minimally invasive treatment modalities. It is "wants-based" or "quality-of-life" dentistry (cosmetics), as opposed to the diminishing "needs-based" dentistry.

This has allowed patients today to realize that a smile may be the most important aspect of the face and that it can easily be enhanced and made beautiful.

Previous advances in therapeutics often involved individual aspects of the different disciplines: Porcelain veneers in restorative dentistry, nickel titanium wires and techniques in orthodontics, and minimally invasive periodontal plastic procedures. Now I believe the future will see a trend toward greater cross-disciplinary interaction between the restorative dentist and specialists as they cohesively blend the different disciplines to enhance smiles in a more *complete* sense. Dr. Goldstein predicted the advent of this team approach nearly 30 years ago, and the future of cosmetic dentistry certainly will involve an even more collaborative approach.

JW: *Most dental professionals who lecture began or continue as care providers. Do you see yourself first as a clinician or an educator; and is it important for educators to maintain a clinical practice, and why?*

DG: At Team Atlanta, we see ourselves primarily as clinicians. It is only because of this day-to-day interaction with our patients and their problems that we perceive the developing trends and so in turn can be effective as educators. Educators need to be in touch with the patient population at large, to convey the most current issues and then the necessary therapeutics required to the practitioner at large in a timely manner.

Team Atlanta believes that the podium comes with a responsibility to delineate between empirical information from our practice, and the realities of long-term research data for any therapeutic option. Obviously, both aspects are crucial to the ongoing development of esthetic dentistry, including its perception by the public.

JW: *Periodontal health is obviously an important topic when we talk about comprehensive treatment, but why is it important even for the most basic veneer case?*

DG: Periodontal disease is no longer regarded as merely a localized infection, but rather, as an inflammatory response that can have a definitive *holistic* impact on the patient. We now understand its relationship to problems including cardiac disease, low birth-weight babies, and diabetes. In fact, it appears that many diseases may well be evident in their earliest phases intraorally.

So evaluating it on a more localized level, it seems that an inflammatory response evident around our most essential veneer case is indicative of a change in the immediate milieu, which may then have systemic impact. Today, more than ever, a hygiene visit is no longer just a "cleaning," or even a prophylaxis. Rather, it is an ongoing process of localized but systemic infection control.

JW: *The more we educate ourselves about dental implants, it becomes obvious that there are many differences in philosophies, systems, and clinical approaches. In general, what methods or systems do you use, and why?*

DG: Today, implant dentistry is an evolving part of our armamentarium for tooth replacement, but utilized only after a thorough prognostic evaluation of the site to limit resultant implant esthetic compromises. Team Atlanta uses many different implant systems in different clinical scenarios as part of teaching and research, so that we are constantly evaluating and incorporating ongoing changes in techniques, technologies, and products. A typical example is the recent interest in a one-piece implant, and how we might incorporate it into our treatment planning. In computer-aided design/computer-aided manufacturing (CAD/CAM) imaging in implants, there is no panacea in fixture or philosophy; we use immediate loading, immediate provisionalization, or staged approaches, depending on the specific clinical needs of a case.

JW: *Do you consider implants to be the new standard of care to replace missing teeth; and, in your opinion, how and when should we bring implants into the discussion of our treatment regimen with patients?*

DG: We believe that with the potential for implants to mimic adjacent natural teeth in every nuance, they are rapidly becoming the standard of care; and, in fact, they may well need to be a part of our *legal consents* in discussing alter-

natives with a patient. Most patients, when they are offered these options and understand the implications of each different therapeutic modality, invariably opt for implants, and recognize it as one of the more conservative approaches due to there being no preparation of the adjacent teeth for a bridge. The decreased potential long-term sequelae to these teeth is similarly a factor, as well as the data now available on the longevity of implants as compared to standard fixed partial dentures.

JW: *Based upon your years of experience as a teacher, what do you see as the most critical factors that lead to success and satisfaction for clinicians in our field?*

DG: While dentistry has always been a somewhat rewarding career choice, I believe it has changed dramatically with the advent of cosmetic dentistry. The emotional return for patients in getting that all-critical smile is similarly emotionally rewarding for the clinician. Dr. Gordon Christensen has talked about how cosmetic dentistry changed the profession from being "needs-based" to "wants-based"—an elective, quality-of-life decision made by the patient.

JW: *The Academy has a goal to provide "Excellence in Cosmetic Dental Education." That said, do you see particular areas where we should be focusing our attention to better benefit our members and the patients we treat?*

DG: At Team Atlanta, we believe that the evolving realm for cosmetic dentistry seems to be "team dentistry," and again the effective use of new cross-disciplinary acumen to satisfy the subjective esthetic needs of a patient. In a 1991 lecture, Dr. Stuart Isler said that esthetic dentistry is no longer about restorative dentistry. Rather, it incorporates restorative dentistry along with periodontics, orthodontics, and implants "because esthetic dentistry today is about beauty."

JW: *Can you give readers a preview of the exciting program you plan to share with attendees in Atlanta?*

DG: The program, which I will present with Dr. Assad Mora, will allow attendees to wear special glasses to see how the use of three-dimensional microscopy may become an integral component of this multidisciplinary approach to esthetics. We will demonstrate the use of a new, innovative three-dimensional microscope that projects the real-time clinical image on a screen positioned in front of the dental chair, so that the clinician is actually working indirectly off the screen and not trying to see it through the limited field of a traditional microscope eyepiece. This new medium has a much lower learning curve than traditional microscopy, while providing even higher resolution to improve our ongoing cosmetic endeavors. Because the clinical field is so readily accessed and easily "zoomed-in upon" from full-mouth mandibular surgery to even a single preparation finish line, we will be able to demonstrate anything from a single-tooth preparation, through six veneer preparations or even molar-to-molar crown lengthening—all more easily and more efficiently performed. It is truly exciting.