NOTHING IS CAST IN STONE

A. Norman Cranin, DDS

A significant characteristic of race tracks and betting centers is the detritus of discarded losing tickets. The strident groans heard from the floor of the New York Stock Exchange at the end of a down day are a never-to-be forgotten sound.

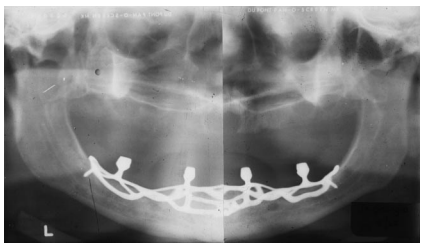
A lack of predictability is responsible for these phenomena. The most earnest and astute students of equine behavior or economic science do not have occult powers, nor do they keep hidden crystal balls. And despite their ardent research and intense desires to triumph, they can exert little influence on the results.

The reasons for this lack of predictability are related to a complex series of preexisting and interactive circumstances. Horses pull ligaments or have indigestion; the NASDAQ falls capriciously because Mr. Greenspan may have pulled a ligament, had indigestion, or perhaps failed to adjust the interest rate. The outcome of surgery, in a like manner, has an unclear prognosis. No one can, and, under most circumstances, no one does, offer guarantees of success.

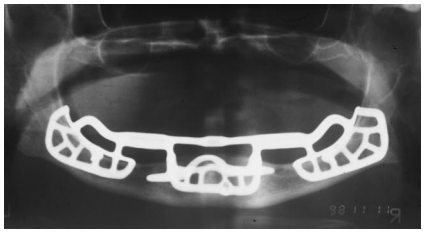
As every surgeon knows, the complexities that becloud predictability are myriad. Starting with co-morbid condition and covert disease, the threat of wound breakdown lurks at every step. A poorly placed incision, a dull drill, a clogged irrigation line, or an unexpected movement by the patient may contribute to failure. Although no one has been able to definitively equate levels of healing with genetic influences, some inherited problems (such as endocrinopathies, problems with mineral metabolism, or circulatory disorders) play an undetermined role in influencing the levels of success. Additional potential deterrents of surgical success include abuse of alcohol, drugs, and tobacco, particularly by closet users who will not admit they have a problem. Volumes have been written about the obstacles, contraindications, stumbling blocks, caveats, and dangers that putatively contribute to surgical disasters.

Irrespective of the flawless performance of the surgical team or the classical approach used in operating, failure can occur. Volitional choices contribute to the surgeon's chances for guiding a complicated case to a successful outcome. Because of the variables that exist in every clinical situation, rigid standards that might limit the levels of performance or the therapeutic decisions of a surgeon present the potential of additional and unneeded burdens. From time to time, helpful, flexible guidelines that are useful for many forms of surgery are changed to standards. Standards may serve a valid role in swaging pipes, fixing joists, or riveting I-beams, but they often perversely affect the outcome of surgery.

Below are two reproductions of radiographs. They represent markedly different designs, and each, in its unique manner, violates the philosophies of one or another group of prac-



A. Norman Cranin *is the editor of* Journal of Oral Implantology.



titioners. Yet each design served successfully and in a trouble-free environment for over 10 years. The stark and dramatic differences between them create a significant question in regard to the legitimacy of imposing specific design standards upon clinicians.

Far simpler procedures such as administering mandibular block anesthesia defy standardization. Some practitioners use the direct thrust technique, others use the three-step manipulation method, and a small but vocal group herald the reliability of the Gow Gates approach. The only aspect of these systems that can be standardized is the result: the accomplishment of profound anesthesia.

How many times has the reader heard from the lips of experts, teachers, and scientists, the words: ''in my hands, the technique works well''?

Surgeons are willful, freethinking, innovative, independent people. The imposition of standards has the potential of limiting their capabilities and diminishing the potential benefits available to their patients. ■

Editor's Note: Due to an oversight, the name of Dr Robert Buhite was omitted from our list of Editors Emeriti. Dr Buhite, now Associate Professor of Restorative Dentistry and Director of Implant Dentistry at The University of Buffalo, SUNY, School of Dental Medicine, served as editor of *Oral Implantology, A Quarterly Review,* then the official Journal of the AAID, from January 1973 through December 1974.