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Guest Editorial

Dental Education From a Private Practicing Dentist's Point of View

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Dental education in the United States has gone through several major changes from the beginnings of dentistry as a trade or vocation learned through apprenticeships or on-the-job training or practiced by self-taught barber surgeons to the current system of dental school training. The evolution to the pinnacle of excellence in restorative and preventive arts did not happen overnight or by accident. Dr Horace H. Hayden and Dr Chapin A. Harris, two dental practitioners in Baltimore, Maryland, were instrumental in founding the first dental school in the world, the Baltimore College of Dental Surgery, in 1840. This served as a prototype for the formation of dental schools in other American cities, which, in turn, led to the development of a formal foundation for dental education in America.

These early dental schools were two-year programs with nonstandardized requirements for acceptance or graduation. As technology and new procedures were developed and curriculums expanded, dental schools developed into four-year upper-level degree programs associated with colleges and universities. National standards for acceptance into dental school and graduation from dental school were adopted. Because specialty disciplines did not exist, early dental schools had a general restorative focus, and few specialty disciplines were incorporated into a general dental curriculum. Students were taught to do specialty procedures as general dentists. Deans of dental schools were typically general dentists with a broad understanding of restorative dentistry done in a private-practice setting. There was an unobstructed vision to teach dental students to practice competent comprehensive general restorative dentistry. The schools also had an excellent relationship with the private practicing community, and used private practitioners as part-time instructors. In addition, state/university support for dental education was at a much higher level than it currently is. Most graduates went into solo general restorative practices.

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Now most dental school deans are specialists and have little or no private practice/general restorative dentistry experience. This, the author suspects, is due in part to the fact that universities recruit deans that have advanced degrees. Because of the decrease in state/federal funding, deans must concentrate a large part of their time on developing revenue sources for the dental school to avoid the situation in the 1970s and 1980s when a number of dental schools closed because of funding cuts. In the past few years, however, there has been a resurgence in privately funded dental schools. At the same time, many dental schools have dramatically increased their commitments to research, shifting resources

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away from a primary mission of teaching general restorative dentistry. Research grant money from government and industry is a significant source of funding and support for these programs. The size and scope of specialty residencies and departments have also increased. The net result is that more influence for curriculum development comes from a specialist perspective. Though restorative/operative dentistry was at one time the backbone of dental education, many dental schools have limited or eliminated these departments, absorbing them into other departments.. The unintended consequence of this refocus is a disjointed educational experience for one of the foundational skill sets for general private practice. Combine this situation with a significant national decrease in the pool of dental school instructors and you have a crisis within dental education in this country.

The downside of all of this, and it all boils down to money, is that the current graduate has less understanding of complete comprehensive restorative treatment and how to organize an effective long-term treatment plan right out of school than his or her counterpart of 30 years ago. Current graduates need more exposure to the art and science of ethical needs-based treatment planning. They need a better understanding of the consequences of all restorative options along with the technical skills to deliver all available restorative options with competence. They need dedicated time to learn from and be mentored by ethical and competent private-practice restorative dentists in an ethically sheltered environment.

The author suspects that new ideas within nontraditional frameworks will be a familiar theme in dental education well into the future. Dental schools will need to have an increased emphasis in general practice and become even more community based within their clinical facilities. This will be a better fit with government-funded mandates for access to care programs and with the overall needs of dental students and the public at large.

Dental schools should take advantage of the full eight years most students spend in college and dental school combined. By restructuring and by emphasizing different areas within the first two years of college, a revised pre-dental curriculum can be created that could be completed during the first two years of undergraduate college. Students could then be accepted into dental school at the completion of the sophomore year of college. This would give six years for a combined dental school and upper-level college curriculum that would lead to both a BS and either a DDS or DMD degree. Incoming class sizes could be increased to compensate for those who decide not to continue to the DDS/DMD or are found to be unsuitable to continue to the DDS degree after achieving their BS degree.

The benefits of moving dental school into the last two years of college are multiple. Most important there would be a longer learning experience directed by the dental school. Liberal arts, humanities, and business classes could be more effectively incorporated into an overall strategy for developing a dentist with a balanced life approach to the art and science of dental practice. Another benefit is that upper-level science classes, such as organic chemistry or genetics, could be tailored for dental students. This would give dental students more meaningful information and would eliminate time spent duplicating basic science instruction, which is what happens in the current dental school curriculum. In addition, this program design would give dental schools more time to better evaluate a student's ability to continue to the DDS degree. The added two years would allow for a shift from the current emphasis on grades to a total evaluation of the student's intellect and character for determining future ethical success within the profession. It should also give dental schools better options for taking responsibility to eliminate those who do not have the skill sets to be competent or ethical dentists. Thus, it should allow for better selection of those persons who would make great teachers.

Within a dental program such as this, the first three years would be preclinical and the last three years would be devoted primarily to clinical training. Students could also have clinical exposure during the first three years by assisting fifth-year students in the clinic and starting to have patient interactions in other ways. The fourth and fifth years would be completed in a traditional dental school clinic setting. These two years would be similar to the traditional dental school clinical experience. Students would learn the art and science of restorative dentistry and would be required to pass competency evaluations in all disciplines by the end of the fifth year.

The sixth and final year of the curriculum would be spent away from dental school in a community clinic. Students would be under the supervision of credentialed ethical private-practicing dentists in the area. Depending on the size, a clinic would have one or more full-time dental school instructors from a supporting dental school. Their job would be to monitor treatment, teach, and the run the commu-

nity clinic on a day-to-day basis. By spending the last year of dental school in a community clinic under the supervision of private-practicing dentists who would act in a mentoring role, dental students would have a more meaningful transition from the academic environment of dental school to the practical world of private practice in an ethically mentored environment.

These clinics would need government funding. Federal funds could be used to build the facility with federal/state support to operate the clinic. Revenues earned from fee-for-service and Medicaid patients would remain with the sponsoring dental school. Because this would not be a residency program, but the last year of dental school, students would not be entitled to stipends. These three conditions—government funding, fee-for-service collections, and no residency stipend—should make the clinics at least revenue neutral. Benefits again should be obvious. The government would get the most benefit for the use of taxpayer dollars. Dental schools would have an additional funding source, at least to the point that the clinic would be revenue neutral. Students would have the benefit of a full year's exposure to ethical, private-practicing clinicians and a more meaningful transition into private practice. Access to dental care for the underserved would be improved. Finally, the community at large would gain an asset.

CONCLUSION

The future of dentistry in the United States remains fluid. By developing patient-centered solutions for how dental students are selected, trained, and licensed, dentistry will be positively affected. If solutions are not developed that bring dentists and dental students into communities where they become part of the solution to access to care, those outside of dentistry will fill the void. Public opinion will force government policy makers to make changes that will fragment the profession. As a consequence, oral health and general health will suffer in America.