©Operative Dentistry, 2018, **43-5,** 449-450

**Editorial**

# Thoughts on Dentistry—2018

JA Platt, Editor

What is a general dentist, anyway? Today, my answer includes at least three parts and is biased by what I have experienced in the United States: 1) we had at least a tangible idea of how to answer this question over the past 50 years or so; 2) we have little idea of what the answer will be 10 to 20 years from now; and 3) the question is critical as dental education grapples with its purpose and function. As I think back over my clinical career as a general dentist, I ask myself, "Why am I in academic dentistry today?" After 16 years of full-time practice, I joined the world of full-time academic dentistry in 2000. Several factors contributed to my making the change. Among those, I did not like the way insurance companies were driving us further and further toward a procedure-driven mentality instead of a total-patient care mentality. I believe there is no way to win the battle against this pressure if we do not lay the groundwork with our students. I find this battle has not become easier, yet I still believe it to be key to what a general dentist will be in the years to come.

During my years in academics, I have often heard discussion about the evils of procedure-driven graduation requirements. Procedures become education currency, and this creates a numbers game that drives students away from a total-patient care mindset, just as it can for private practitioners. And on the other side of the argument is the understanding that without an adequate number of procedures, students do not gain the surgical skills needed to predictably provide the care needed for our patients. Twenty years ago, there was a significant push in dental education away from discipline-based departments. Many schools created mega-departments with the belief that this would enhance our ability to provide total-patient care and decrease emphasis on procedures. But what goes around, often comes around, and some of those mega-departments have been deconstructed back into discipline-based departments where numbers can still reign. What does that mean for the training of our students and for the direction of our profession?

If someone had told me 30 years ago that, before my career was over, dental students would no longer be able to replace missing canines as a matter of routine, I would have truly thought that they had lost their mind. But that is the state of our world. In one sense, this is a result of our success. Many procedures that were commonplace during the majority of my career are no longer so. Oral disease has not been eradicated, but the utilization of dental care has been changing.[1,2] During the last quarter of the 20th century, many successful dental practices were based on the endodontic and prosthodontic needs of all segments of the population. As overall dental health has improved for the upper and middle classes, we now find a greater percentage of restorative needs in the lower socioeconomic class and the geriatric population. This is challenging our system and, therefore, the reality of what a general dentist will actually be. We need to figure out how to respond.

In the practice world, one response has been the growth of larger group- and corporate-owned practices. Yes, there are other factors that contribute to this, but I would suggest that the need to increase volume to maintain desired cash-flow levels is one of the contributing factors. A large amount of the disease that needs to be treated exists in a portion of the population that does not have the financial resources to pay for that treatment. A basic understanding of economics suggests that this negative pressure on fees will lead toward a need for increased volume. This also puts added stress on dental education as we traditionally think about it. You see, some of these patients are those that used to frequent dental school clinics to take advantage of a reduced fee schedule. Now, many school fees are not so reduced, and if these patients pursue care, they may do so for similar or marginally higher fees without having to invest the large amount of time that the educational environment has traditionally demanded.

In academics, I believe we are largely kicking this challenge down the road. In some institutions, this may be tied to the reemergence of discipline-based

clinics, at least for early clinical experiences. I believe these clinics help calibrate early clinical experiences and solidify basic concepts. But even as this occurs, more procedures are being handed to residents, while fewer procedures are available for pre-doctoral students. I have heard it argued that residents in prosthodontics and the increased number of operative dentistry programs are finishing their training with levels of restorative experience somewhat comparable to what pre-doctoral students had 30 years ago. And our pre-doctoral students are graduating with the hope that they will find some way to pay their debts. What is it that we truly expect them to do?

Part of the current environment is the increased number of training programs in operative dentistry that we now see in the United States. For most of my career, there were four such programs. Today, the number is now in double digits. I contend that these and other advanced training and postgraduate year 1 programs will become more important for the next era of dentistry as traditional pre-doctoral programs are less and less able to provide the repetitions beyond competency essential to the training of our next generation of clinicians.

Isn't it time to embrace our reality? I see some progress with the growth of interprofessional education—working with teams of other health care providers in an educational environment. Oral health is an integral part of total health. We must embrace our role as oral health care providers; we contribute to the overall health of the people who come to see us. A dental career that thrives on the traditional restorative approaches of our past is becoming more and more difficult to achieve and, educationally, is being driven into the hands of a fewer number of well-trained practitioners.

Where does that leave the general dentist of the future? When leaving dental school, more advanced training may be a necessity for each new graduate. If so, that training should be available in the graduate's desired area of emphasis. In addition, new dentists must leave school understanding that they are overseeing total oral health care that is a *critical component of the overall health* of their patients. Knowing how to guide treatment for each patient should be at the core of a general dentist's activity. In this issue of *Operative Dentistry*, you will find an invited article from last February's Academy of Operative Dentistry Buonocore lecturer, Falk Schwendicke.[3] Its content should stimulate thought.

So, why did I jump to academic dentistry? Toward the top of the list of reasons was the desire to help students think less about procedure-driven care and more about total-patient care. What do I see today? Dental education is struggling to cope with what total-patient oral health care looks like in a world where traditional dental diseases do not have a great enough prevalence in the right populations to support all of the dentists being trained, at least not in our historical way of thinking. This in the midst of a remuneration system that demands surgical procedures be accomplished to pay off debt and earn a living. We are at a crossroads, and great leadership is needed to guide us through this period of change.

## REFERENCES

1. American Dental Association (2017) Dental care utilization in the U.S. Health Policy Institute Infographic. Retrievedc online June 5, 2018 from: http://www.ada.org/w/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_1117_2.pdf?la¼en
2. Vujicic M (2018) Our dental care system is stuck *Journal of the American Dental Association* **149(3)** 167-169.
3. Schwendicke F (2018) Tailored dentistry: from "one size fits all" to precision dental medicine? *Operative Dentistry* **43(5)** 451-459.