

The future of dentistry for children*

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What is the future of dentistry for children? If I had the vision of Nostradamus or the imagination of George Orwell perhaps I could guarantee you an interesting morning — one that would make your early arousal worthwhile.

Unfortunately, I have neither the perceptiveness of the former nor the insight of the latter. What I do have, possibly, is an awareness of the past, a comprehension of the present and an avid curiosity about the future. Based on this, I can project at least what I perceive — and pray that will make the effort worthwhile.

To begin with, what exactly are we talking about? Is the subject the future of *dentistry* for children — or is it the future of the *dentist* for children? Being perfectly candid, I would have to say that it is the latter which needs to be discussed — and which, so often, is avoided. In truth, it should be easy to differentiate between the two.

Dentistry for Children

The future of dentistry for children is secure. As long as there are children and dentists, there will be dentistry for children — in some form, of some consequence. There may — I said may — be fewer cavities to fill, there may be fewer teeth to remove and, with genetic engineering looming ever larger on the horizon, there may be even fewer patients needing — heaven forefend — orthodontic treatment.

In spite of these “disturbing” possibilities, there still will be dentistry for children. There will be some caries somewhere; there will be reasons to remove primary

teeth; there will be periodontal problems; there will be malocclusions, major and minor, to be corrected; there will be demands for cosmetic restorations. In short, there will be children who need dental treatment. It may be, as Arthur A. Dugoni, dean of the University of the Pacific School of Dentistry, observed, that the need for pediatric dentistry as we know it today will be reduced. But there will be a need for dentistry for children even though the need for the number of pedodontists may be reduced.

As of now, however, much of this is still theory. The great German philosopher Hegel said, “If theory and fact disagree, so much the worse for the facts.” But we work with facts.

I don't say this to be cynical, but it generally is accepted that roughly 60 per cent of the population still does not avail itself of dental care. Who is to say that the increased direct marketing efforts will not alter this situation? How could this affect demand?

To substantiate the point further, the 1980 census reported that 11 million children were living in poverty. You can be certain that the overwhelming majority of them are not receiving even minimal dental care — and you can be equally certain that this neglect begets pain which begets suffering which begets inattention at, and absences from, school. All of this contributes, in its microcosmic way, to the ongoing problem of children growing up inadequately prepared for the vicissitudes of life.

As national concern mounts about the deficient educational system we now know, every measure will be taken to improve that system. Along with changes within the educational system to solve the problem, I am convinced that extended child health care will be deemed essential to any improvement and that pediatric dentistry will be among the first care programs implemented.

Well, then, so much for dentistry for children. It does have a future.

The Dentist for Children

We must now ask what of the dentist for children — the pedodontist, the pediatric dentist. Does he have a future?

*This paper was presented to the Association of Pedodontic Diplomates at the American Academy of Pedodontics Annual Meeting, Atlanta, Georgia, May 31, 1983.

[Papers in the Forum section are current topics of interest related to pedodontics as well as dentistry in general. Because many of these papers represent authors' personal viewpoints, they are not refereed. Reader comment is encouraged.]

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If we are to believe the statistical evidence relative to a reduction in dental caries, it is obvious that traditional restorative dentistry is or soon will be a thing of the past or (at the very least) be modified severely. Dugoni and others make this point based on evident caries reduction, intensified preventive programs and the increased use of new and better composites. Another dean told me recently that as a pedodontist I was dead. In fact, as Mark Twain is reported to have said, reports of my death are slightly more than somewhat exaggerated although I must confess I feel myself aging a bit.

AAP Immediate Past-President Robert J. Musselman, in a letter to the chairman of the ADA Special Committee on the Future of Dentistry, made some definitive observations:

1. It generally is accepted that the declining prevalence of caries is due to the increased exposure of children to fluorides.
2. During the 1970s the mean DMFS index of children 5-17 years of age decreased from 7.06 to 4.77.
3. There is reason to believe nearly one-third of our 45.3 million school children (5-17) were thought to be caries free by virtue of a visual, tactile examination.
4. Our profession has a "busyness" problem.

All of this bodes ill for the pedodontist of the future.

With such irrefutable evidence available, what, then, is the future of the pediatric dentist? Does the answer lie in the current trend to become pseudo-orthodontists? Should we — or are we — following the definition of "genius" written by Ortega y Gasset, "Genius is the ability to invent one's own occupation." In that same vein and being fully aware of what is happening, perhaps the wisdom of the great scholar Hillel should be given consideration. He said, "If I am not for myself, who will be? But if I am only for myself, of what good am I?"

Musselman, in his letter, quoted Irving W. Eichenbaum, Naomi A. Dunn, and Norman Tinanoff who said, "We should accelerate our preventive efforts, while at the same time anticipate the future with appropriate adjustments in dental curriculum, manpower, and practice."

But, in reality, this is not new. Prevention was, is, and will be the foundation of good dental health. In 1966, George W. Teuscher wrote, "Prevention offers so much for so little it is surprising the public seems unmindful of its possibilities. The pedodontist should play an important role in it."

So, now we come to the nitty-gritty.

More and more pedodontists are attempting to become, in their minds at least, the "complete" pedodontist by doing orthodontic treatment — but not by becoming orthodontists. Some have prepared themselves adequate-

ly; some have not. I do not need to detail the acrimony this has caused — and is causing — in certain areas. The truth is that general practitioners — family practitioners—also are doing more orthodontic treatment than ever before. Orthodontists understandably are not too happy with this turn of events. For all, economics has reared its ugly head.

Whoever attempts treatment, whether it be endodontics, oral surgery, orthodontics, restorative procedures, or whatever, must be qualified to render the best and must be prepared to stand behind his decisions.

Yet if the pedodontist ultimately is restricted from rendering comprehensive care — such as some aspects of orthodontics — where do the restrictions end? Will the pedodontist be told not to remove teeth? Will the pedodontist be told not to do primary or permanent tooth

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endodontics? Will the pedodontist be told not to construct prosthetic appliances? Where will it end? The result could be referring patients for virtually everything other than restorative procedures, the need for which (as has been shown) continues to diminish. It is my judgment that the public will not stand for this. The patient will not be served best. The child who needs the understanding and special training of the pedodontist will be the loser.

There must be some solution waiting to be found for this complex problem. Each specialist and generalist has a role to play and patients to treat. The pedodontist, because of his unusual type of practice, must be trained and eligible to render comprehensive care. The pedodontist is, has been and will continue to be a specialist in the care of children.

Does the solution lie in taking weekend courses, regardless of how many, or must we respect the sanctity of other postdoctoral specialty training just as we would have others respect us and our advanced training? To do less will prostitute our own specialty and, I believe, will jeopardize the existence of our Academy and the specialty itself.

Perhaps we — the AAP, the American Association of Orthodontists, and the dental educators — need to redefine primary dentition orthodontics as well as mixed dentition orthodontics. Is it possible we are hung up on semantics?

Since, by dictionary definition, orthodontia is concern-

ed with achieving proper occlusion, it is possible to infer that the prosthodontist, the periodontist, and the restorative specialist are also involved in orthodontia because their goals, also, are to obtain proper occlusion.

Facial orthopedics, a term used by some—is a misnomer. That same dictionary reveals that orthopedics deals with “the treatment of . . . bones and joints.”

It also defines pedodontia as “dentistry concerned with the care of children’s teeth.” If providing good care for young patients is not being concerned with occlusion, what is?

Perhaps, in the final analysis, the definition of pedodontics accepted by the ADA and its various concerned councils answers the question best. It is “the practice . . . of comprehensive preventive and therapeutic oral health care of children.” Surely, by implication, this includes achieving proper occlusion.

It should be obvious then that the professionals concerned must direct efforts toward affecting an accommodation, and design teaching programs so that our child patients will be the ultimate benefactors.

It is time to stop squabbling about who does what — provided “who” is qualified.

My guess — not my hope — is that there will be a different direction in postgraduate pedodontic training. It undoubtedly will lead to qualification for most candidates as an orthodontic pedodontist or a pedodontic orthodontist, hereafter referred to as the O.P. or the P.O. For the traditionalists (and perhaps, I am one) this may be difficult to swallow. But, as Mother used to say, “Eat! — Even if it tastes bad, it’s good for you.” And, maybe this diet will be good for dentistry and for the pediatric dentist. In spite of the dire predictions, though, there still must be some programs to train the pediatric dentist.

In fact, most competent general practitioners can perform the technical aspects of dentistry for children. Except for relatively minor details, a Class II amalgam is a Class II amalgam. The same applies to most other aspects of restorative and preventive dentistry. The im-

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portant difference lies in pedodontists’ concerns with and interest in the special developmental, dental, and personal problems the child encounters. It is in attention to these factors that pedodontists stand apart now and forever.

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It is because of these factors that educational institutions will be compelled to continue to teach pure pediatric dentistry and produce some bona fide pedodontists.

Approximately 15 per cent of U.S. practicing dentists are specialists in one of the ADA-recognized specialties. Of this number, probably less than 2 per cent are pedodontists. From these figures it is obvious that routine dental care for children is being provided for the most part by general practitioners. Even with the declining birth rate, it is estimated that there will be 61 million children under the age of 18 in 1985. If there are approximately 2,000 pedodontists by that time, this would provide a ratio of one pedodontist per 30,500 children. If we accept the information that only 40 per cent of the population visits dentists regularly, this still would mean a ratio of one pedodontist per 12,200 children. It is obvious, then, that general practitioners will continue to be the principal providers of dental care for children.

Nevertheless, there is today and will be in the future a continuing need for pedodontists to treat children. These patients are not little adults; they need special attention and consideration. You know this and, believe it or not, so does the rest of the profession. There is now and will continue to be a need for someone to treat the handicapped, the emotionally disturbed, and the physically incapacitated. And strange as it may seem to others, there are parents who simply prefer pediatric dentists just as they prefer pediatricians. The average general practitioner caught up in the throes of a busy reconstructive practice is neither educationally nor emotionally equipped to work with many of these patients. The truth is, it cannot possibly be economically feasible for him to do so. And, certainly, the new O.P. or P.O. will not be inclined to do so. Besides, who knows how many of this new breed will want to divert time from the more lucrative aspect of orthodontics to struggle with these problems?

At least six of the eight specialty areas are specialties because they relate to specific areas of treatment or diagnosis. Pedodontics is the major exception. As we all know, the pediatric dentist must be qualified to some degree in most of the other specialty areas. He is expected to render general dental care for the children he sees. This leads some to say that pedodontists are really only general

practitioners for children. Of course, this is an oversimplification for, in fact, we are specialists in the care of children. A cynic has said that the specialist — any specialist — learns more and more about less and less until he learns everything about nothing. Not so, my friends; the true specialist is a continuous student and endeavors to learn more and more about his craft, the people he serves and himself.

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A Hindu proverb tells us that there is nothing noble in being superior to another man. The virtue is in being superior to your previous self. This concept applies to the future of dentistry in that it reminds us of the imperative of continuing education. We cannot afford to be less than the constant student. This is why the AAP, the ASDC, and the many other special interest groups in dentistry continue to provide extensive continuing education courses. Note the words continuing education. To me, this doesn't suggest learning an entirely new field.

This Hindu proverb causes me to wonder aloud if the loosened bonds of the ADA Code of Ethics will not be tightened again. I have yet to be convinced that advertising by professionals makes for better, less expensive patient care. It seems to me, in contrast to that proverb, there are too many out there trying to prove their superiority over others rather than over their prior selves.

An article in *USA Today* on February 16, 1983, stated, "Recent ideas to hold down medical costs made by politicians largely responsible for them are mere Band-Aids.[®] The real cure is the free market. Repeal laws that keep nurse-practitioners and doctor's assistants from providing services. Open medical school to all who can pay their way; let doctors compete and offer better service at lower costs."

Does the author of this so-called solution really believe this? Should the learned professional hawk his wares and alleged skills in the marketplace? Can he demonstrate that the free market is really the answer in the health professions, where continuing education is essential? Does the mere ability to pay tuition qualify him to be a physician or dentist? Are there not intangibles?

This brings me to the content of a letter I received from Delmar J. Stauffer, assistant executive director of the

ADA following a conversation we had. Del is knowledgeable, has no ax to grind and has given me permission to discuss his observations which are personal rather than official.

He raised the touchy issue relative to the name of our specialty and said "Past surveys and numerous questions from the public indicate a low awareness of what the term 'pedodontist' means." He added that there are now discussions concerning the most appropriate name for the specialty which limits practice to the care of children, and indicated that any action along these lines should come from within the AAP. We have debated this idea time and time again. Often pure emotion has carried the day. Perhaps it is time to look realistically at the matter.

Del went on to report that suggestions are being made to have pedodontists consider expanding their scope of practice and/or referral base to include more handicapped, medically compromised, and even geriatric patients. Demographic projections suggest that increasing attention will need to be given to those requiring special care. Maybe our specialty will become one for all special patients. We might even form the American Academy of Special Patient Dentists.

Lastly, and my pulse quickens as I say the words again, Del discussed the feasibility of either combining pedodontics and orthodontics or promoting postdoctoral education programs to provide dentists with the necessary training to qualify for both specialties. In regard to what I said before, he added that there appears to be an increase in the number of questions concerning the need for a specialty limited almost exclusively to children. Sadly, this concept is not new. In 1973 an editorial in the *Journal of the Academy of General Dentistry* question-

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ed the need for most dental specialties — particularly pedodontics. Three years later when I served as president of our Academy, a meeting between the officers of the AAP and the AGD resulted in another editorial in that journal which modified the aforementioned position.

Perhaps it would be wise to pause here briefly and discuss the relationship between the AAP and the ASDC. In fact, I was asked specifically to comment on this. I am pleased to report that both organizations are, today,

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strong and thriving.

Unfortunately, during the last three or four years there have been some rumblings of discontent and various claims of dominance. This need not be the case. There is room and need for both organizations, each following its chartered path and often traveling the same road. We have — or should have — the same basic objectives.

I have maintained for 10 or 12 years that the AAP should be the organization to represent pediatric dentistry to the profession, to allied professions and to the various elements of government. ASDC, because of its outstanding public relations program, printed materials and diversity of membership is equipped uniquely to relate to the general public. Once, our two organizations came close to such an agreement. But close doesn't count, and we have continued our separate efforts in most instances. Of course, we cooperate in many areas but we can do better — no, we must do better. There were plans for us to meet jointly this year. Why didn't we?

There are those who not only wait in the wings to pounce upon the providers of health care, but who do so. Surely we do not need to fight among ourselves. We must stand together. The story is told of two young boys who bet their friends they could walk along the railroad rails without falling off even though others had failed. Each stood upon a rail, extended a hand to balance the other and covered the distance to win their bet. We in dentistry also can win against our adversaries, but only if we extend our hands to support each other.

The AAP and the ASDC simply cannot afford to be at odds. There is too much at stake — and the odds, ladies and gentlemen, if push comes to shove, favor survival of ASDC simply based on the observations and statistical information previously given.

Remember what Ortega y Gasset said. Maybe we really do need to invent our own occupation.

Yes, there have been rumors around for years that pedodontics, as a specialty, eventually will disappear —

perhaps sooner rather than later. Many of my colleagues have taken this rather lightly. Yet, on page 10 of the blue section of the draft paper prepared by the ADA Commission on the Future, there is a specific recommended action which states, "Phase out, merge or redefine selected specialty areas with the anticipated result being that, in the future, some specialties will not exist as they do today." Is the commission talking about us? No, pedodontics is not named, but it does not take an overactive imagination to read between the lines.

It may be that this Chinese proverb says it best, "If we don't change our direction, we're going to wind up where we're headed."

The practice of dentistry — whether it be for children, adolescents, or adults — is alive and well, growing, and developing new vistas as old ones close. But dentistry needs, as does a child, a legal guardian. We are that guardian. How well we exercise our responsibility will determine how healthy our "child" will be. Haphazard, random growth is not productive. Discipline and nurturing are essential. Learning makes for understanding and intellectual maturity, both of which help the child grow. Let those who want to become correctors of malocclusion follow the path of growth and development and not travel the twisted road of short cuts filled with hidden dangers — dangers to themselves and to others.

So now what of that Chinese proverb? Do we need to change direction to avoid going where we are headed? In truth, we must change constantly, to tack — to have the winds of forward movement at our backs so as not to lie still in the waters of progress. Pedodontics has met the challenge in the past and, since the past foretells the future, it — we — will do so again. Let us project the need for "pure" pedodontists and challenge our schools to produce them. Let us project the needs for "pure" orthodontists and O.P.'s or P.O.'s and challenge our schools to produce them.

Derek Bok, president of Harvard, said, "The quality of science depends on the quality of scientists."

To paraphrase, the future of dentistry for children and the future of dentists for children are irrevocably intertwined. Their quality will depend on the future quality of our schools, our training programs and of pediatric dentists. They — and we — can be great.