GUEST EDITORIAL

# The Changing Face of Dentistry and the Specialty of Prosthodontics

Dentistry is entering an interesting and perhaps critical era, and it appears there is a pending realignment of influences within our society, one that will have tremendous impact on dental education and private practices, creating future disruptive change. Current U.S. politics is moving toward an attitude of universal health coverage as the new moral high ground, generating an overriding expectation and attitude toward accessing comprehensive, quality health care for every individual. While dentistry has responded with various outreach programs, dissatisfaction prevails from the underserved, and their voice has become more resounding and has been complimented by the current political and economic environment. This outcry has been reinforced and the issue compounded by cuts in federal and state dental programs. For example, there is substantial reduction in adult dental care (Denti-Cal) available in California (http://www.denti-cal.ca.gov, http://www.medi-cal.ca.gov, http://www.dhcs.ca.gov).

Another factor influencing the future of dentistry can be readily observed with the ever-expanding line of dental procedures being allocated to dental auxiliaries. Even though dental practitioners are very caring, there has been a slow erosion of diagnostic accountability among dentists, and an expanding emphasis on procedural-based care. This has accompanied the constant evolution of expanding dental procedures to ancillary providers, taking away from the direct professional expertise anticipated by patients. As many of these procedures generate a lowered practice profile, the stage is set for the transfer of more of these responsibilities to non-dentists.

All these activities appear to be converging factors and have created opportunities to change the entire landscape of dental care. Following the non-dentist provisions allowed in Alaska, the Minnesota legislature recently approved new "mid-level" providers. Pressure from the governor and support from other sources, such as the dental hygiene association and the medical counterpart of mid-level care community (physicians' assistants and nurse practitioners), there has been a substantial supporting voice in the political arena. This culminated with the proposed establishment of a state licensed profession, the "dental therapist" and the "advanced dental therapist." An initial and necessary response came from the Dean of the University of Minnesota School of Dentistry, ACP Past President Dr. Patrick Lloyd, who looked into international models as they currently exist (Reference: ADA News; June 1, 2009; "University of Minnesota reviewing applications for nation's first dental school-based dental therapy program"). Dr. Lloyd appropriately recommended that a program be developed within the dental school, whereby diagnosis and treatment planning, using the oversight of dentists, would allow for a 2-year graduate as a dental therapist. This effort was necessary and done to fulfill the demands and shortfalls of access-to-care as perceived by the Minnesota state legislature. Unfortunately, this saga has continued to evolve with the dental hygiene community offering an advanced dental therapist program, thus eliminating the oversight of the dentist and allowing for access to *total* dental care. In an effort by the Minnesota Dental Society to curtail this movement, it was suggested to the legislature that no independent practice could survive under a total reimbursement model. The legislative response was to allow such practitioners to accept up to fifty percent of their patients as full payers.

So, why should Prosthodontists have concern? It should be apparent. First and foremost, we should be concerned about the quality of care provided for patients. Meanwhile, other states are looking at enacting this type of care to remedy their access-to-care needs. I refer you to a *California Dental Association Journal* article of May 2009, "Issues Faced by Community Health Centers," by Jane Grover, DDS, MPH. Her graphs from the US Census Bureau (2000) depict the active dentists per population ratios, and Minnesota is not as underserved with dentists as 18 other states are. Some dental schools, such as Loma Linda University School of Dentistry, have felt compelled to form an evaluation committee so they may have a knowledge-based response to the pressure of such change. Second, aside from the important issue of quality care, the dynamics of increasing the unrestricted, licensed dental practices of dental therapists will be enormous. Such impact will certainly change the competitive edge of the DDS and DMD, as these providers will be availing the entire range of services from oral surgery to implant management. Should Prosthodontists surmise that these evolving mid-level care providers pose a severe compromise the professional aspect of dentistry? In time, will dentistry become a true commodity-based trade? As this mid-level community develops, is it not probable that general dentists, as we know them today, will be expanding even more into the specialty fields of endeavor with fervor in order to survive . . . an encroachment we have already witnessed in our own specialty?

This is a challenge that the Prosthodontic community cannot afford to let pass. Prosthodontists remain well-positioned as we, above any other dental specialty, have the training and experience in the critical areas of diagnosis, treatment planning, and complex dental care and, as a specialty, have the greatest involvement with clinical procedures as they are carried forth in general dentistry. We need to respond accordingly:

First, we must keep the *quality of care* issue at the forefront. Recognize that if there are legitimate (state-licensed) practitioners entering the field of dentistry, we must assist with the evolution of evidence-based dental outcomes relative to both favorable and unfavorable patient care. We must become proactive toward the further development of parameters of care as

appropriate and aid in the oversight of state and regional boards of examiners and organized dentistry's peer review process. We must offer our consultation services to general dentistry's peer review needs involving prosthodontics. And we must continue to offer oversight to the educational aspects promoting quality health care outcomes as was stated in the recent position article by the ACP on denturism.

Second, we must let our voice be heard. Join in organized dentistry at all levels, especially the ACP. Let the public be more aware of our specialty profession. Individual opportunity does exist and is far more pronounced at the local community level. Join in the National Prosthodontics Awareness Week (NPAW) and promote who we are . . . I suggest using the ACPs "Oral Cancer Screening CD" as one venue you may wish to consider.

And finally, because we are a small specialty in number, it is extremely important to invest our precious resources wisely. The ACP Education Foundation is undoubtedly our best investment. If you are unable to provide financial support, provide personal services and personal time directly to our educational programs at our various teaching facilities where we continue to struggle for sufficient numbers of talented faculty. The bottom line is, "get involved." These challenges will not go away, and their potential impact on each of us may be significant.

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*The comments above do not necessarily reflect the opinions or position of the American College of Prosthodontists, either the organization or individual members, and are that of the contributing author.

Dr. Pfeifer acknowledges the input and help of Dr. Charles Goodacre, Immediate Past President, American College of Prosthodontists and Dean, Loma Linda School of Dentistry

*Editor's Note: I asked Dr. Patrick Lloyd, Dean of the University of Minnesota School of Dentistry to respond. He graciously did so. His remarks are below.*

RESPONSE

## The Changing Face of Dentistry Calls Us All to Get Involved

What has and is happening in Minnesota should be on the minds of dentists across the country. In many ways, it is a wakeup call that requires the attention and response of general practitioners and specialists alike. Driven by a host of converging factors—a dental workforce older than most other professional groups, an aging society with little or no dental insurance, an ever-increasing number of people who depend on public programs for their dental care, and fewer dentists willing to care for the poor and disenfranchised—state legislators are taking action. They are looking for solutions to help their constituents to access dental services, and if they do not get help from the dental profession, then they are going to come up with their own solutions.

In Minnesota, we chose to get involved. Partnering with legislators, our state dental association, public health officials, and citizen groups, we helped shape the legislation that created a new member of the dental team—the dental therapist. Although that is not how it all started, that is how it ended. Minnesota is proud to be the first state to launch a dental school based dental therapy program. Founded on a principle of "one standard of care," we emphasize a team approach to caring that matches the patient with the appropriate level of educated practitioner. It is a health care model similar to the physician assistant, where patients are cared for by a physician or a physician assistant, depending on the level of treatment needed.

Although people may argue that the scope of practice for dental therapists in Minnesota is too broad, few could complain about the level of supervision legislated. But what most people do not know is that the legislation also requires that at least 50% of a dental therapist's patients must be from underserved populations. And, to ensure that dental therapists are part of the solution to the access-to-care challenge, a set of service outcomes will be monitored by our state dental board and department of health. These requirements did not happen by accident. They were the result of hard work and dedicated effort by the profession to help shape legislation that will have a greater chance of serving the public.

So that the *JOPR* readership is not confused about what is taking place in the country and in Minnesota, I need to correct a few factual errors. Let me start with what *is not* going on in Alaska. There are no dental therapists practicing throughout the State of Alaska. Although some would like you to think that is the case, mid-level providers in that state are limited to providing care for Alaska Natives on tribal lands. Furthermore, the model that the Minnesota legislature adopted is very unlike what is going on in Alaska. Ours are degree-granting programs that range in length from 28 to 40 months, depending upon the educational experience of the student. Finally, there is no "dental hygiene community offering an advanced dental therapist program" in Minnesota. What the state legislature passed was a provision that would allow licensed dental therapists who practiced for 2000 hours and who completed an advanced dental therapy program to be eligible for a license in "advanced dental therapy." And just like the basic dental therapist, these practitioners cannot treat patients without a dentist completing an examination, making the diagnosis, and formulating a treatment plan.

Dr. Pfeifer's closing recommendation that prosthodontists "get involved" could not have been better said. I view the changing face of dentistry as a lead-or-be-led opportunity, and everyone has an obligation to get involved. If we do not, someone else will, and they may not have the best interests of our patients or the profession in mind.

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