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PROSTHODONTICS
A SPECIALTY OR JUST "EXTRA" TRAINING

Prosthodontists have trouble in seeing themselves as specialists! Howard Landesman, with tongue in cheek, twice tried to clear up the dilemma with his "I"m A Prosthodontist, You're A What?" talks in 1981 and 1993. His remarks delved into the lay public's image of our specialty more than they addressed our own perceptions of our specialty. More than perceptual, it is what we do and how we fit into the scheme of things when needed by the primary care dentist, the patient with special needs and the financiers of dental care. Are we specialists or only super trained general dentists?

A basic misconception says that IF the specialist and the general dentist do the same things in treating patients: 1) the specialists aren't needed, or 2) the specialists don't have to receive greater reimbursements or have higher fees for special skills. This philosophy is flourishing in the medical insurance industry. We know the medical insurance industry cannot differentiate between the prosthodontic specialist and the primary care dentist, therefore the industry is more than willing to pay the same fee to both for the "same" treatment.

We know we don't do the same treatment. Historically the prosthodontist has directed attentions in treatment to things that the general practitioner could not or would not do. It's too bad, but additionally their energies are directed toward correcting and redoing treatments that the general practitioner should not have done. In most prosthodontic practices there has been no worry about doing the general dentist's "work"-- there is plenty of specialty treatment needed when receiving a referral. Usually there are additional problems discovered in the specialist's diagnosis and treatment planning that are sent back to the primary care dentist for completion prior to the specialty treatment. Easy recognition of the treatments that are <u>within</u> and the treatments that are <u>beyond</u> the primary care dentist's scope of training and experience doesn't show disrespect for them. It only clearly categorizes the system to work for the patient's best interest.

<u>Why then do we have a problem seeing ourselves as specialists?</u>

First, during practice "start-up" many of trained specialists feel underutilized. Later, the practice becomes excessively busy and treatments need to be expedited. In both instances treatments that the primary care dentist should very well be doing are quickly dispensed with by the specialist. After all the specialist was first a general dentist! A root canal and an extraction now and then won't matter. But in reality it does, and soon the referring primary care dentist hears of these extended treatments and they quickly see the specialist as a competing general dentist (with extra training, of course.)

Second, another source of the dilemma begins in the dental schools. A contemporary organizational structure in dental schools says that the departments of prosthodontics, "crown and bridge," endodontics and pediatric dentistry no longer have to be supported or maintained. These disciplines functionally are covered as things the general dentist does, and they are subsequently lumped into <u>Restorative Dentistry Departments</u>. This organizational

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philosophy is immediately understood by other specialties. Keep your ears open at one of our dental meetings and listen to a periodontist lecturer expound on the miraculous things he or she can do -- before he or she refers the patient to the "Restorative Dentist." Or listen to the oral surgeon elaborate on the great operative skills they use in readying the patient for the "Restorative Dentist." The periodontists and the oral surgeons and even the orthodontists do not do the same things that the primary care dentist does; but it seems they have a problem recognizing the prosthodontist as a specialist. They have difficulty with this recognition -- especially when their dental school hides the prosthodontic discipline in a Restorative Dentistry Department.

Finally, insurance companies, state legislatures, the American Association of Retired Persons (AARP) and allied health organizations all have analyzed the levels of training necessary to provide specific treatments. In their lobbying efforts, these groups state that:

- The prosthodontist and the general dentist do the same things -- therefore the specialist has to give up these things and the extra fee that comes along with them.

- The "non-dentists" who say they are doing the same things as dentists should legally be allowed to do them, and be paid a commensurate fee. Some dental laboratory technicians can "make" dentures, so why should dentists be the only legal entities who are allowed to make them? Dental hygienists can give anesthesia, so why should professionally trained people be legalized as the only ones who can give anesthesia? In the name of dollar savings, not only the specialist, but the primary care dentist as well is asked to relinquish treatment capabilities.

Just remember this -- If you give away the specialty and discipline, you later must give away the profession -- because as the aforementioned groups imply **you really don't have to have special training to do special things; and further, you don't have to have professional training to do professional things.** Lynne V. Cheney (Lynne V. Cheney, "Telling the Truth", Simon and Schuster, New York, 1995) summarized it well in her recent book "Telling the Truth"* when she said she was "struck by the arrogence that often exists among those who maintain that there is no truth except the one they would have us believe."

Never do we as prosthodontists have to apologize for the special skills and knowledge we have, the special skills and knowledge which are very different from those possessed by the general dentists who are produced by today's dental schools. And never, never imply that specialist in prosthodontics and the general dentist are doing the same tasks -- that the specialist just does it better. This simply is not the case! The strongest point of all is to remember that the specialist's skills and knowledge are not only of great value in patient treatment, but also they are of great value in assuming leadership in the economic, political and academic arenas. This latter use may very well determine whether our specialty survives!

NDW