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SON OF
PROSTHODONTICS
A SPECIALTY OR JUST "EXTRA TRAINING"

In keeping current with certain issues of the day that pertain to our profession and our specialty, something occasionally jumps off the pages that sets off alarm bells. The report of the Educational Policy Subcommittee of the American College of Prosthodontists concerning The Institute of Medicine Study of Dental Education: Issues Affecting Prosthodontics (Journal of Prosthodontics, June 1996, Volume 3, Number 2, page 133) definitely created one of those alarm bell reactions.

The article's abstract explains that the "article presents the position of the American College of Prosthodontists (ACP)" in response to a request from the American Dental Association (ADA). Its purpose was to address the Institute of Medicine study on dental education as it affects the specialty and the practice of prosthodontics.

The report of the Subcommittee (referenced above) contained many observations, some agreements and disagreements, speculations, and a very few recommendations. Besides being very difficult to read its recommendations were vague and inconclusive; and a concrete proactive strategic plan that could be realistically carried out by the specialty of prosthodontics in cooperation with the ADA and the IOM was lacking.

Specifically, what in the report is so objectionable? A thinking specialist should openly object to two statements. First, the report says that "prosthodontic treatments should be considered primary care dental services." Second, the report's concluding paragraph states that "Treatment rendered by prosthodontic specialists should be considered primary care services" and to justify that position the subcommittee (and therefore the College) says that "appropriate insurance reimbursements for these services should be available."

Are we all of a sudden primary care dentists? Be careful! We're stepping on the toes of general dentist (primary care providers) and our compatriots in the discipline! Does the College wish to put the specialty in jeopardy after it so soon has become its parent? Does the College want to alert the ADA to another review of the specialty? No, no and NO!

Our position as specialists in prosthodontics should say that we are not primary care dentists, nor is there any justifiable reason to be. This position and the reasons for it was clearly set forth in the July 1996 ProsStars Newsletter. Can the position that we are a viable and necessary specialty in dentistry be expanded further in light of the report? Yes, and the specialty's response should have included statements which would clearly state the specialty's position. The ACP's report should have responded with:

•Dental Education

The ACP should have made positive statements which would establish the position of the specialty relative to dental education as viewed from the advanced education (specialty) level.

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This doesn't abrogate the ever present obligation of the specialty to nurture and support the discipline in every possible way. Rather it strengthens the discipline as it exists at the predoctoral level by indicating that the specialty is not highly separate and inattentive to education or the public. It further indicates that by parenting the discipline, the specialty has deep concern for the molding and development of total dental education, both predoctoral and postdoctoral. Finally such statements would show that the specialty is not in any way in competition with the primary care dentist, but clearly has a different mandate and mission in meeting the goals of the public in relation to their oral health.

•Recruitment of dentists into advanced education programs in prosthodontics

The report confuses supply of patients, levels of training, and the effect of managed care in education. The ACP should have pointed out:

The managed-care system may negatively affect the supply of patients for residents in postdoctoral training programs. It is doubtful that it would affect the "level of care [that is] provided." The level of care will be determined by established learning outcomes.

Recruitment of graduate dentists into training programs in the specialty of prosthodontics is difficult. Recruiting candidates from a variety of cultural and ethnic backgrounds requires financial support from government and private agencies.

•The need for specialists in prosthodontics

Specialists in prosthodontics are trained to higher levels of competency than primary care dentists; and specialists in prosthodontics posses higher levels of knowledge and skill in treatment than do primary care dentists. These higher levels of competency should be used to:

1) **Assess oral health [needs] in the general population.**
2) **Quantify and qualify treatment procedures [treatment outcomes] being carried out in the general population.**
3) **Carry out advanced treatments that are required by patients with special needs, those needs which cannot be met by primary care dentists.**

Specialists in prosthodontics must be fairly compensated for performing each of the above special needs.

•Curriculum reform

The specialty of prosthodontics is in complete agreement with Policy and Strategic Principle 4., 5., 6., and 7.

A continuing discussion of "curriculum reform" in the ACP Report is irrelevant. Curricula have undergone changes since the beginnings of formal dental education. Curricula are turbulent and should continually undergo change and should never be locked for any period of time. The concept of a "reformed" curriculum should be deleted from the ACP Report.

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Specific changes such as "Communications between the dentist and the dental laboratory technician must receive greater emphasis in the curriculum", ways in which to develop motor skills, innovative teaching techniques such as mannequin simulation, and other changes, ad infinitum, are out of place in this ACP Report.

•Faculty

The specialty of prosthodontics recognizes the need for tenured-track faculty positions that should be supplemented with other full-time nontenured positions in advanced education programs in prosthodontics. The provision of fair compensation to individuals in these positions should be planned and provided for, knowing that a sufficient level of compensation will increase the quality of the specialty, and this in turn will be reflected directly into the discipline. A strong discipline will create a positive contribution to Recommendations 9., 10., 11., 12.. and 13.

The key word here is compensation -- planned and provided for.

Recommendation 9 says "all faculty be critically knowledgeable about scientific advances in their fields, to stay current in their teachings and practice." These are just platitudes which need not be repeated. What needs to be emphasized is the requirement for the specialty and for specialists to be paid fair compensation from the dental school; and for the faculty to positively contribute to the dental school, the university, and to the public at large.

•The Report's weak points

The report should not contain statements which cannot be positively proven by statistics. It should not contain wishes without following recommendations on how to meet them. It should not contain old cliches which really can cause no future positive improvement in dental education. Some examples are:

"A weakness in clinical education is the number of clinical faculty who either do not practice in a fashion that would allow them to show a reasonable profit at the end of the year"

-Where are the numbers that show the percentage of faculty who do not practice?

-Considering faculty, is reasonable profit from practice a goal of education? Reasonable compensation for educational activity in the dental school should be one of education's primary goals!

"It is therefore inperative to stay current with the evolving health care system."

-Is this different than it ever was?

-Haven't we always been attempting to stay current with the existing health are system?

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"The need for curriculum reform is long overdue, but experimentation with different education modalities should proceed with caution and not at the expense of the consumer."

-Have these most conservative of all colleges and schools, those of dentistry, in our universities been "experimenting" with the curricula?

-Have past well thought out changes in the curricula turned into experiments?

-Have we become so entrenched in our curricula that "reform" is long overdue?

"Dentistry must proceed with caution to not be caught in the undertow of managed-care systems and national health care plans."

-Should dentistry [and the specialty] proceed with caution in order to not be caught in the undertow? This doesn't work in swimming in the ocean, and it probably won't work in affecting modern day medical and dental education or health care delivery.

-Is using "technological advances through development of informatics with an online searchable database" proceeding with caution? Where is the funding coming from for this?

-Speaking nautically--perhaps the specialty and dentistry should "bow wave" their ideas and plans in order to be leaders in every proactive sense of the word.

"Supply of funds and patients for our postdoctoral training programs is necessary."

-We can't--repeat can't--wish funds by simply stating that funds must be supplied. In today's world when we discuss funding, we have to say where, how, and when. Let's get real!

Finally, we must realize that the task of reporting on dental education by those in dental education is a difficult task. It further complicates itself when those who report are specialtists who owe their positions in education to general dentist administrators in their very own schools. How difficult is it to clearly state the causes of the specialty when you are beholding to a general dentist? Very difficult!!

NDW

•The opposite of having a subject is no subject. An example of this would be emphasis on the "polish of a denture, rather than emphasizing what it is being polished and why.

II. The second principle of esthetic judgment is *clarity*.

•Art must be fully intelligible. Art should not be ambiguous, elusive, opaque.

•Art without clarity is like reducing language to grunts. paintings to smears, sculpture to slabs, and music to noise.

•An arrangement of artificial teeth which "stylizes" nature and adds to the beauty of the individual is not the same as producing dentures which look like one to the other, which are bland, and which do not enhance the patient's image.

III. The third principle of esthetic judgment is *integration*.

•Everything included in an art work acquires significance by virtue of being included.

•Anything accidental works to make a new reality unreal--a good guideline is to say "nothing in this composition of teeth and their surrounding matrix is accidental."

Summarizing then:

•Like "goodness", beauty is not in the object or in the eye of the beholder--it is objective

•It is in the object--as judged by a rational beholder.

•It is not a contradiction to say 'This is a great work of art, but I don't like it." The statement means a purely esthetic appraisal has been made, but a deeper philosophic level which includes more than esthetic values has been applied.

What is esthetics?

It is art.
It encompasses philosophy.
It needs a creator and a viewer both with philosophies.
It is what counts in life!
Saying: "I have omitted, rearranged and emphasized the data of reality -- to create a dental composition--seen as beauty, without artificiality, and with character, and naturalness!!"

N. D. Wilkie, December, 1994

ESTHETICS

Esthetics (good and bad) has been a particular interest to me during my time in dentistry. I taught the only course in esthetics at the School of Dentistry, Georgetown University. That course formed the basis of 4 to 6 hours of lecture in esthetics given to the residents in prosthodontics at New York University. My interest as adapted from Objectivism: the Philosophy of Ayn Rand by Leonard Peikoff © 1991 continues below:

What is this "esthetics" we are taught and deal with each day in prosthodontics? To paraphrase Justice Potter Stewart: "I can't define [good] esthetics, but I know it when I see it."

Esthetics is defined as the philosophy of *art.*

- In any human activity two factors are involved: 1) the nature of the activity, and 2) what is its philosophic basis, i.e. why is the activity proper?

Is what we strive for in dentistry (prosthodontics) *art*?

- Man guided by his/her own value judgments selects those aspects regarded as "a vision" of that which exists and then embodies them in a sensory - perceptual art form.
  - --"this is what counts in life as I the artist see life"
  - --the artist omits, rearranges, emphasizes the data of reality to create a universe anew
  - --art enables man to contemplate "his view of the world" in the form of an existing object
  - --art converts abstractions into specific entities--perception

Further, is what we ascribe to esthetics in dentistry *art or science*?: [Many lecturers you will hear in dentistry will attempt to make esthetics a science!]

- art clarifies a man's grasp of reality
  - --but art is a selective re-creation of reality
  - --the artist is not to remain neutral--a mere transcription of reality is the job of science, journalism, or photography
  - --in life, one ignores the unimportant; in art, one omits it

- the artist chooses from his or her observations
  - --he/she slants the data in a calculated manner
  - --the artist "attends" to reality; the artist does not fake reality; reality is "stylized"

- the task of the artist is to provide man with a definite experience an experience of not thinking (conceptual information), but of seeing

- the purpose of art is not to teach, but to show

- it is the artist's *sense of life* that controls and integrates his or her work

- it is the viewer's *sense of life* that creates an approval or a rejection of the artist's work

As I see in these writings, three paradigms which are absolutely applicable to esthetics in dentistry:

I. Art must have a *subject.*

- The artist must make a conscious rational choice of subject. "Style " is secondary. Art is not for art's sake, but for man's sake.