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"[We] Don't Get No Respect"

Rodney Dangerfield's famous by-line, "I don't get no respect" certainly is applicable to our prosthodontic specialty community. Asked recently by two top orthodontists (former students schooled at Georgetown University) "how are applications into prosthodontic training holding up", I had to confess that the applicant to opening ratio in prosthodontics simply isn't holding up!

We know that the applicants into the specialties of orthodontics, oral surgery, periodontics and endodontics all far surpass numbers wanting prosthodontic training. What is probably more important (and which sadly reflects on us all) is that the best and most skilled graduating dental students usually select specialties other than prosthodontics.

Why? Let's be frank! The dental community knows that general dentists can carry out most of the demands of "restorative dentistry." We know that most dental schools have renamed and restructured their departments so that prosthodontic departments no longer exist. But beyond that, maybe we can't see what the dental school administrators really do see; and that is general dentists actually can accomplish the needs and demands of restorative dentistry for the great majority of the population! The insurance companies have understood this and have quickly added a great big "DITTO!"

Further, even though the general public might know that there are those of us who can accomplish fantastic things to improve function and appearance, they have made the decision to practically do without those things. They can practically do without the perfections of specialty prosthodontic treatment because:

- Prosthodontic specialty treatment takes an inordinate amount of time. The busy schedules and workdays of many patients do not include that kind of time.

- Prosthodontic specialty treatment is very expensive. Prioritizing a budget to put oral appearance and/or function ahead of a 4 wheel drive utility vehicle, a 200 MHz, 2.5 GB computer, an Internet subscription and a cellular telephone (all very necessary) just isn't what will be done.

- They learn to compensate for their oral deficiencies on a day to day basis. They accept their body alterations. They get gray hair and may not dye it; they get flab for abs; they get wrinkles for peaches and cream and they get big buns for tight buns. They can live just as well with their oral imperfections, and certainly they don't need to put oral perfections in a non-perfect body, at great expense.

So what are we specialists supposed to do? Give up specialty treatment and join the "primary care provider" ranks? Do away with specialty training programs, or downgrade their competency and skill levels so low that they are meaningless? Stop seeking and preparing the best dental school candidates for recruitment into the prosthodontic specialty training programs? Admit to dental school administrators that available training hours should go to the "important" courses in oral medicine, ethics, and community and hospital dentistry? Not point out to these same

administrators that the deficiencies they've created in the discipline should be compensated for by a transfer of support to the advanced education programs in prosthodontics? The answers should be no, no, no and NO!

Ok--let's do something now to help develop a better sense of direction for our specialty! Looking to a more positive and enduring future for prosthodontics, consider these observations:

1. First and foremost, there are very definite needs and demands for the knowledge and skills possessed by a specialist in prosthodontics. These needs and demands and yes, wants will increase with time. The population will become larger and older. Accidents, trauma, destructive diseases and developmental defects will be present in greater numbers. In keeping with the desire to improve and maintain health, and to improve body image, definite demands will be made for the best possible restoration through prosthetic replacement. This means that there will be a requirement for training, skill levels and competency well above that of basic dental education. The specialty organization (the American College of Prosthodontists) must determine the additional skill levels and competencies necessary to meet the increased demands; and the American Dental Association will periodically verify these levels of training with recertification of the advanced training programs. It must be emphasized that all of these determinations and outcomes must take place within the confines of the recognized specialty. We as trained prosthodontists must guard against the toleration of unrecognized sub specialties and the creation of new spinoff departments which confuse the training requirements, take the best candidates out of the recruiting pool and siphon off much needed resources.

2. No more and even less emphasis will be put on prosthodontics (the discipline) in the basic dental school curriculum. Cutting inappropriate and inadequate training in prosthodontics will become more common.

The need will become greater, but it will be met more by the specialty and less by the general dentist, much like orthodontics. Two important responsibilities are laid on the prosthodontist specialist when this happens. First, the dental school administrator must be made to understand that the limited resources gained must be put into the advanced education programs in prosthodontics. Second, the specialty will have to understand that it has the added obligation of finding ways to treat all of the problems of all of the population and not just address the luxury wants of a select prosperous few!

3. The recognition problems of the specialty begin in the dental schools. Is the specialty recognized for its worth when it is buried in a department of restorative dentistry? There are only so many assets available in a dental school. The department or division heads may not be specialists; but in any case, they most certainly have a greater access to the Dean; and they have a greater say in the budget and they have most control of the distribution of resources. Will these resources be distributed to the advanced education program when it lies under the discipline, and the discipline priorities receive first emphasis?

Let's look at orthodontics again. In most dental schools there is minimal, if any, orthodontics taught at the dental school level. The entire thrust of the department is "specialty oriented." Who talks to the Dean? The specialty! Who budgets and gets the money? The specialty! Who gets the recognition? The specialty!

How will the great value of prosthodontic specialty training ever be recognized by the profession or general public when it lies under the control of the discipline; or worse, it languishes in a department or division under the control of an administrator who

is a not a specialist? It's now time to see, clearly address, and set this problem right!

4. Our prosthodontic literature is not a true reflection of what the specialty is. Our prosthodontic literature will have to place greater emphasis on prosthodontic research, clinical evaluations and reports, morbidity and mortality reports (clinical successes and failures), delivery of care and the development of techniques that are applicable to better treatment of the public at large (prosthodontics in public health dentistry.)

A survey of the most recent eight issues (two years) of the Journal of Prosthodontics (September 1994 through September 1996-- March 1996 not included) shows the following distribution of article subjects:

	No.	%
Dental Materials	38	43
Implant Dentistry	9	10
Maxillofacial prosthetics	5	6
Computer Science	1	1
Clinical Technique	17	19
Laboratory Technology	9	10
TMD Related Subjects	2	2
Dental Education	5	6
Practice Management	1	1
Other (Reports etc.)	2	2
TOTAL	89	100

Dental material's research and reports thereof probably do not effectively demonstrate what our specialty is. Dental Education discussions perhaps should find their way into other journals. Yes, implant dentistry is a great part of prosthodontics. Why do organizations that represent interests not recognized as specialties take most of the implant literature away from us?

Our publishing objective should be: Say in our literature what it is that a specialist can do, what exactly specialty treatments are, and what specialty treatments can predictably achieve. The literature should prove that specialty treatment is effective, cost conscious, and useful to the patient population at large. The literature in our prosthodontic journals should always answer this basic question, "does the specialty solve the prosthodontic problem?" The answer must always be, "Absolutely!"

5. We as specialists must nurture dental students and very recently graduated dentists. This is our best and primary pool of recruits. This is where we can be strong and this is where we can have some enjoyment in seeing the fruits of our labor.

New York University and the University of Maryland -- others probably -- have excellent programs directed at 4th year dental students. "Honors" programs if you please. The faculties (fully trained and/or boarded prosthodontists) in these programs are strong, enthusiastic, and great role models. They impart perfectly the interesting and stimulating ways one's talents in dentistry can be applied more effectively by being in prosthodontics. These faculties and their programs work and this concept should be applied in other dental schools!

In addition, we know what a satisfying and rewarding specialty we are in. There are many ways to apply one's talents in prosthodontics! And it is not boring! Can you possibly imagine wanting to bend wires and hook up little springs all day long every day? Or better yet how about twisting and turning little files and reamers? Of course there is always the possibility that one would want to fight daily for turf with the physicians on admittance privileges or operating room priorities. That does sound like fun! Why don't we routinely discuss these things with students and new dentists?

6. There is money out there for stipends and scholarships. There are certainly funds which have not been tapped. There are individuals in the specialty (and elsewhere) who would feel great satisfaction in donating to the educational goals of the

specialty -- if the goals were clearly identified; if the charity was correctly named and recognized publicly; and if the money was channeled directly into the need. It goes without saying that there are many capable and competent individuals in the specialty who could manage and promote growth in charitable foundations whose sole purpose would be the support of advanced education programs in prosthodontics.

Foundations are commonplace today. Almost every dental organization has one. Use caution in believing that they used for their stated altruistic purposes. In actuality they have vague hidden purposes and their control is usually under recent past officers who wish to see the foundation's money used "for the good of the organization." Even the great Education and Research Foundation, which was established by the Academy of Denture Prosthetics bit the dust when a few individuals wanted to use it to launder money for a recent Research Symposium. Too bad -- when it could have directed its every effort and every dollar toward recruitment to and support of advanced education in prosthodontics! Where are the scholarships emanating from these foundations? Where are the stipends? Where are the moneys that are given but don't surface for the intended purpose? Is the support of one or two "recipients" a year at $1,000 or $5,000 the best these great organizations can do?

OK--how about direct donorship? We have patients who are so gratified with their specialty treatment they are more than willing to come forth with large donations to specialty programs. Right, and just try to work it by the Dean who can see dollar signs for his own special programs or priorities.

And speaking of direct donors, what good does it do for specialty education to have one's name engraved above the door or a department named for one's self, the donor, and then have the money used for "other school projects?" A different slant on this is a very recent anonymous donor's gift of a quarter of a million dollars to one school to be used for research in maxillofacial prosthetics. The school has wisely used it in exactly the manner intended.

<u>Two recommendations:</u> 1] We should demand that any foundation that asks for our money, in turn should clearly state the spending goals for that money during the next year; and we should demand that they provide a spending statement at the end of the year showing how they met the goals.

2] In our independent giving and with our independent financial planning we should establish charitable trusts and/or foundations that are dedicated to educating our specialists. The trusts should be set up in such a way that each dollar is used only for the scholarship or stipend assistance of students in advanced education programs in prosthodontics.

<u>7. Self respect.</u> We are respected! Few in dentistry (or in the medical world) can do what we do. We are the "clean-up batters, the quarterbacks and the slam dunkers" of dentistry. No one in dentistry has our skills, can equal our solutions to the problems of diagnosis and treatment planning, or can achieve our results in treatment. The rest of dentistry knows this--with envy!

Let's not be our own worst enemy. We should speak and write and show our skills as specialists. We should nurture the discipline at every turn of the road, but we should clearly and frequently define our distinct differences from the discipline. Humility-yes. Self depreciation-**no.** Riding the coat tails of the insurance industry's solutions to prosthodontic care-**no.** Directing all assets, talents, writings, dental school curricula time to the specialty-yes. Building respect by demanding our gifts and our donations directly strengthen the specialty-yes. Self respect--**most certainly!**

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