Future of dentistry: Profession or trade?

By David L. Hoexter, DMD, FACD, FICD
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Today’s average dental student graduates with massive debt, closing in on $300,000 for dental school alone — not even including additional borrowing to cover basics such as rent and food. New dentists start careers under tremendous professional and financial pressure. They must find a way to practice what they’ve trained for — while also retiring the debt.

Postgraduate studies in a specialty can add $300,000 more in debt, again without even including living expenses. Many new specialists are starting careers with more than $700,000 in debt. Against this backdrop, new schools are opening and entrance standards are toughening, all while tuition, total admissions and students per classroom keep increasing.

The trends look great for the schools, but what about for everybody else, especially when viewed with other changes?

Answering that question requires some historical perspective — stretching back to 1905 and what could be viewed as the dawn of modern dentistry: synthesis of the anesthetic pro-caine (later marketed as Novocain), which ushered in a new era in patient comfort. Around the same time, William H. Taggart patented his lost-wax casting machine, enabling dentists to fabricate fillings and crowns with precision. Another leap came with standardization in amalgams and operatory procedures pioneered by G.V. Black, author of the groundbreaking “Operative Dentistry.”

In 1948, the National Institute of Dental Research (renamed in 1998 as the National Institute of Dental and Craniofacial Research) formed in the U.S. as the third National Institutes of Health. In this post-World-War-II era, dental schools attracted a generation of students helped by the GI bill. Participants felt proud, and the public benefited from more dentists and improved oral health. New dentists earned respectable incomes and respect as valued leaders in growing communities.

Parallel to advancements in materials and professionalism, dental chairs and operatory equipment were improving. The American Dental Association became an organizing voice, standardizing professionalism and products while building on dominance it achieved over competitor societies though its early support of amalgam. Dental equipment of the era was durable but not friendly. Dentists stood for hours with one leg and foot bearing most of their weight, all while subjected to high-decibel whirring from belt-driven machines — conditions that deterred many from the profession.

Still, dentistry, like most work then, was stable. Most dentists were male, solo practitioners treating patients on their own. It wasn’t until the 1960s that dental auxiliaries and dental hygienists began gaining greater acceptance. The first hygiene school had opened in Connecticut in 1913. But it was later, with schools such as Forsyth and leaders such as Drs. R. Lobene and J. Hein, that dental hygiene emerged as a true profession, dominated by women. Dental assistants, through specialized education and certification, also were gaining recognition for their value.

Dental schools grew in number and class sizes, parallel to expansion of the U.S. and global economies — and dental equipment became ever easier to use. The G. V. Black foot pedal had given way to belt-driven equipment, which in turn was replaced by air-driven, high-speed equipment. The profession was becoming less strenuous. The spittoon disappeared, and practitioners no longer had to stand fixed on one side of the chair. Why did we have a spittoon by the chair anyway? Studies showed patients used it mainly just to take a break from the procedure.

As the profession advanced throughout the world, so did an international market for dental products and the exchange of ideas across borders. But it was the computer and internet age that fully opened global distribution channels and borderless educational opportunities. The Seiker brothers and, later, the Henry Schein company, created networks that today are making dentistry at its highest level available to all.

In the 1960s, dental implants gained momentum. But materials, sizes and shapes lacked consistency and predictability. Acceptance by the public and academic community was tentative. Successful outcomes with endosseous implants (including root forms), subperiosteal implants and blades were extremely technique-sensitive and not easily transferable. Subperiosteal implants required specifically trained laboratory technicians and special casting techniques with a titanium alloy. Less-than-precise work could easily result in contaminated castings prone to fracture. Before titanium, some metals in use weren’t well accepted by the body. Rejection and unpredictable outcomes weren’t unusual.

Helping the profession through these early days were dedicated implantologists, such as Drs. Leonard Linkow and Isaiah Lew. The first national organization in implantology, prompting the exchange of knowledge, was the American Academy of Oral Implantology.

By the 1970s, patients were reeling in highly adjustable ergonomic comfort, and practitioners were sitting at chairs instead of standing. The plumbing and power lines previously snaking to instruments were wrangled and wrapped. Operators were more welcoming and comfortable. Dental companies developed innovative and ever-improving instruments and products. Gradually, the public’s attitude toward dentistry changed from being fearful visits prompted by problems to positive visits focused on maintaining good oral health. In the United States, more and more top-caliber students — growing numbers of them women — entered dental schools and the profession.

The 1970s also brought the first society dedicated to esthetic dentistry. Companies were formulating restorative materials that not only functioned but enhanced appearance. Patients weren’t just looking for relief; they wanted to look good.

By the early 1980s, implantology had gained broader acceptance. Improvement in the quality of life of implant patients across the world was undeniable. In Sweden, Dr. Per-Ingvar Brånemark pioneered use of root-form implants to more effectively secure full dentures in edentulous patients. (Photo/Provided by the European Patent Office)

The 1980s marked the formation of international dental societies such as the Academy of Osseointegration. And the exchange of ideas became less localized with the internet age.

The practice has fewer products to try, yet patients are constantly hitting the market. There are tanks that scan every detail of a full arch in seconds, transferring an image to the computer and lab or in-office 3-D printer. What once took days is almost immediate. Patients don’t worry about gagging. The practice has fewer products to buy and store. There’s far less clean-up. The patient’s attitude toward dentistry is dramatically different.

Just one notable advancement in the world of dentistry: In the 1980s, in Sweden, Dr. Per-Ingvar Brånemark pioneered use of root-form implants to more effectively secure full dentures in edentulous patients. (Photo/Provided by the European Patent Office)

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Rarity is becoming the norm, light years beyond bulky molds and air bubbles in plaster of Paris.

The fully digital practice is becoming commonplace, but at a cost that can be prohibitive for small-practice practitioners burdened by student debt. Soon, laser handpieces will be common, producing quality results in ever-quicker time. Costs of advancements are justified through efficiency and effectiveness gained.

Dental labs and highly trained technicians are setting the pace with much of this technology, but their roles are evolving as in-house options for practices become easier to master.

Underlying these trends, people are more active, more mobile and living longer. The idea of long-term — even multigenerational — relationships between patient and local dentist is fading.

Today in the United States, more than 70 percent of dental-school graduates are women. The impact of marriage, parenthood and spouse’s occupation on dental careers is changing. Dentists are less likely to be anchored to one location for an entire career.

At some point, licensure law must catch up. I’ve never understood restrictions on dental licensing based on state borders and reciprocal agreements. Changes in our industry are putting pressures on licensing to transfer across state lines more like a driver’s license. Massive student debt and flexible, mobile career paths are feeding another trend: large-group practices owned by non-dentists with dentists as employees. Patient relationships with oral-health providers are becoming more brand-based instead of practitioner based.

Economies of scale enable such businesses to keep pace with advancements, wield big advertising budgets and hire professional staff to run the business side of the operation.

Practicing dentistry today is big business — structured around financial concepts — with dentists being incorporated into the new model. There’s nothing wrong with that as long as patient care remains guided by a commitment to ongoing, high-quality professional education, and the labor — dentists — earn incomes that cover student debt and provide a quality of life such work deserves.

Nothing indicates these trends will slow. More top-students are being attracted to a growing number of schools that are squeezing more students into every class, but tuition and student debt keep rising (remember that $300,000 or even $700,000 or more for a specialist). Dental patients are demanding the speed and convenience of the latest digital equipment. And giving patients what they want requires large practices with big budgets and staffing strategies aligned with the flexible career paths desired by today’s new dentists — who are performing more dentistry, faster.

As if created to perfectly serve these trends, a growing mantra among cost-sensitive practices and patients is: Fix it with an implant. Compromised teeth are being extracted and replaced with implants, often in a single visit. Major non-dental financiers have purchased some of the largest implant manufacturers and distributors. Business is good.

Change is the norm. Adaptation to change is our profession’s challenge. Are we a profession or a business? Are the people we treat our customers or our patients? Is there a way to curb the exponential increase in the cost of education, treatment and business? These trends might be shifting us away from our role as deeply trusted lifelong advisors to our patients and as pillars in our local communities, both core concepts that help define us as professionals.

About the author

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