Dentistry as a trade?

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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 procaine (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 ground-breaking “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 gained 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 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 commutter 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 nonpredictable 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, pioneering the exchange of knowledge, was the American Academy of Oral Implantology.

By the 1970s, patients were reclining in highly adjustable ergonomic comfort, and practitioners were sitting at chairside instead of standing. The plumbing and power lines previously snaking to instruments were wrapped and wrapped. Operatories were more welcoming and comfortable. Dental companies developed innovative and ever-improving instruments and products. Gradually, the public...

IADFE to award fellowships

Members of the International Academy for Dental-Facial Esthetics will gather in New York City on Nov. 26 for an educational meeting and to award fellowships. Held annually in conjunction with the Greater New York Dental Meeting, the meeting will be the organization’s 23rd. Fellowship in the academy is by invitation to dentists, physicians and members of the dental-facial cosmetic industry who have distinguished themselves in their respective professions.

This year’s fellowships will be awarded at the iconic Sanford-White designed Harmonie Club at 4 East 60th St. (between Madison and Park avenues) beginning at 6 p.m. Fellowships will be presented to new members from across the globe, including Australia, New Zealand, France, Italy, Peru, Argentina, Canada, Mexico, China, England, Japan and the U.S.

For more details, you can contact info@ IADFEM.com or drdavidl@gmail.com.

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