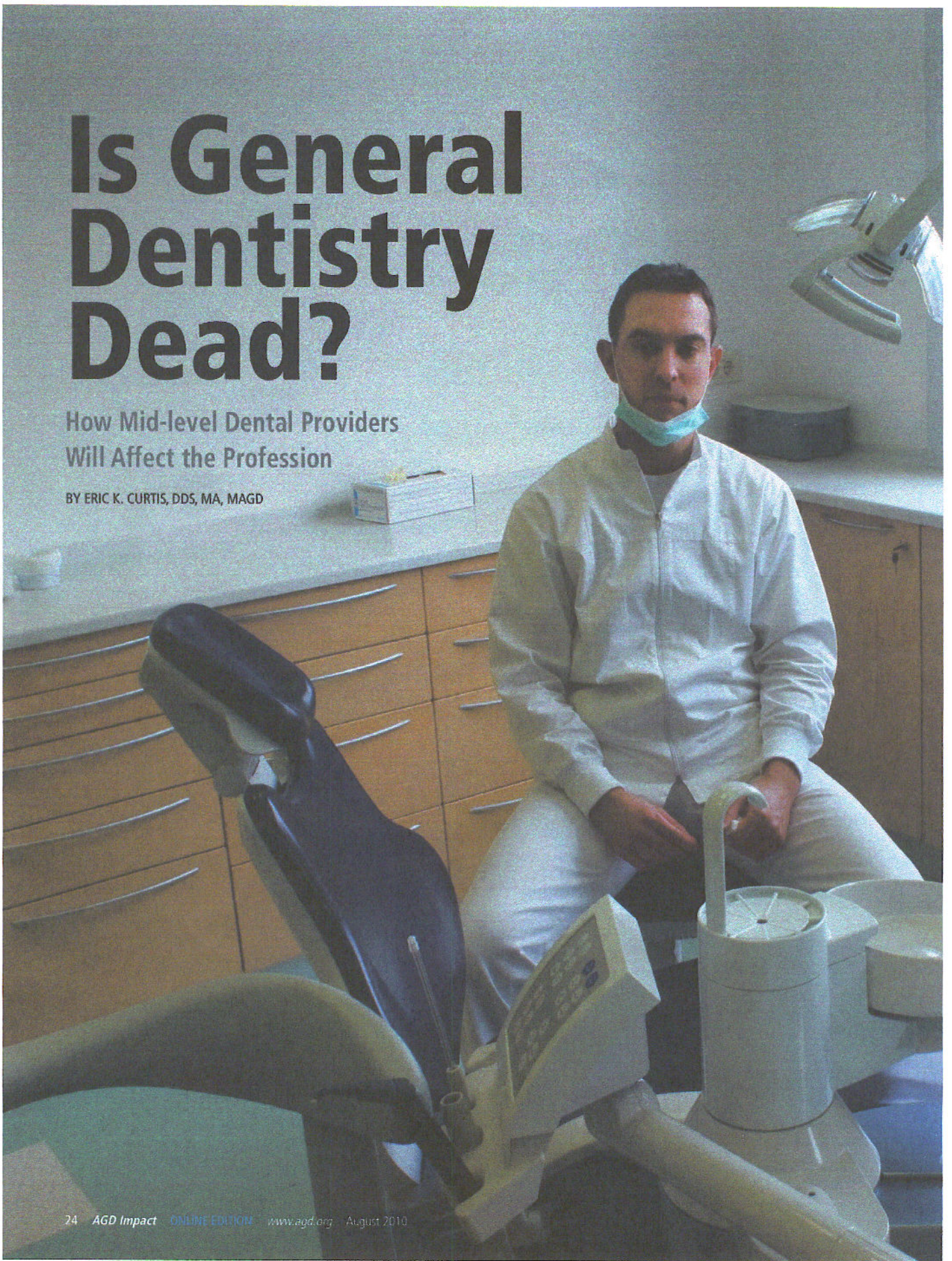


# Is General Dentistry Dead?

How Mid-level Dental Providers Will Affect the Profession

BY ERIC K. CURTIS, DDS, MA, MAGD



**A**n internist friend of mine is predicting the demise of his profession. "Primary care medicine," he says, "will be dead in five years." The reasons involve a complex, long-simmering stew of government machinations and shrinking third-party reimbursements, which threaten to squeeze the already-dwindling supply of American general internists, pediatricians, and family practitioners out of a job. The internist acknowledges that there will be mid-level providers to take his place. "I'm not going to be able to afford to practice," he says. "My job will be to watch over six physician assistants [PAs] and make sure they each see 40 patients a day." He foresees an increasingly scrambled health care structure in which nurses and PAs refer patients directly to secondary- and tertiary-care providers. "The system is upside down for primary care doctors," he says, some of whom now make less than some PAs. But he believes that the biggest losers in this brave new medical world are the patients, who face increasing costs and fragmented, overall lower quality care. "I look forward to the day," he says, "that a nurse practitioner operates on President Obama."

My friend is not alone in his worry: A 2006 position paper by the American College of Physicians, "The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care," begins by proclaiming, "Primary care, the backbone of the nation's health care system, is at grave risk of collapse due to a dysfunctional financing and delivery system." The potential failure of general medicine is an alarming development. But there's another one that might make you squirm even more: General dentistry could be next.

### **The death of dentistry foretold**

Is general dentistry a dead profession walking? Many fear that dentistry, the first specialty of medicine but also

its historical outcast, is finally going the way of primary care medicine, poised to sink with a sigh into a mire of competing providers. If the public's next physician will be a nurse or a PA, then its next dentist may well be a dental hygienist, a dental health therapist (DHT), or even a desperate internist. "The train has left the station," writes dental coach Marc B. Cooper, DDS, president and CEO of The Mastery Company in Ashland, Ore., in the online article "Mid-level

Many fear that dentistry, the first specialty of medicine but also its historical outcast, is finally going the way of primary care medicine, poised to sink with a sigh into a mire of competing providers.

Dental Providers and You." The arrival of non-dentists to perform extractions and fillings, he declares, is no longer an experiment, but a *fait accompli*: "Most private practitioners will perceive it as a threat to their survival. It won't matter. It's going to happen."

Bryan C. Edgar, DDS, MAGD, of Federal Way, Wash., chair of the American Dental Association (ADA) Commission on Dental Accreditation, likewise warns that the future has arrived. "The idea of a competing provider of dental services is very alarming to most of the profession," he says. "I am from a state where we view the reality of an independent mid-level as something that *will* happen, whether we like it or not."

Some believe that dentistry as now practiced will indeed soon be gone. Public attitudes are primed and grievances loaded. In the popular imagination, it is said that general dentists, whose average income approaches that of primary care physicians, make too much money. Dentists charge too much, a situation rendered all the more

visible by the fact that most third-party plans pay only a portion of the total fees. Dentists also are perceived as standoffish, even selfish, rarely playing ball with Medicaid and its state analogs, and never with Medicare. They don't work on Fridays and avoid practicing where people really need them, such as in community clinics and small towns. What's more, their work, although technical, is essentially easy. At least one university president has suggested that dentists ought to

be trained in community colleges. So, the thinking goes, let someone who can deliver the care more easily and cheaply—and, to scratch below the surface, more *sympathetically*—go ahead. The specialists will still be there to do the hard stuff.

General dentistry certainly will not die immediately among mid-level providers, but its traditional activities—and identity—may well be altered. Richard W. Dycus, DDS, MAGD, of Cookeville, Tenn., chair of the Academy of General Dentistry (AGD) Dental Practice Council's Workforce Subcommittee, describes the resulting shift in focus that my internist friend dreads. "When the federal government is involved," he says, "seventy percent of a practitioner's time will be spent on administrative tasks."

Dr. Cooper tells his dentist clients to embrace the inevitable change by preparing to become practice administrators rather than constantly bending over the chair themselves. Educators suggest that dentists may need to incorporate some part of the business model

into their professional training. Richard J. Simonsen, DDS, MS, founding dean of Midwestern University College of Dental Medicine—Arizona, identifies another change in emphasis: "Dentists will spend more time in diagnosis."

### **Conflicting perceptions of access to care**

A February 2010 paper published by the Pew Center on the States ("The Cost of Delay: State Dental Policies Fail One in Five Children") declares, "A 'simple cavity' can snowball into a lifetime of challenges." But the Pew Center estimates that more than 10 percent of the nation's population "has no reasonable expectation of being able to find a dentist." (In some states, it says, that figure rises to one-third of the general population.) Concentrating its interest on children, the Pew Center identifies three causative factors in "the national crisis of poor dental health and lack of access to care": lack of widespread sealants and fluoridation; lack of dentists willing to treat Medicaid-enrolled children; and its own conclusion that "in some communities, there are simply not enough dentists to provide care." The Pew Center's fourfold solution includes two preventive measures—more widespread school-based sealant programs and community water fluoridation—and two proposals to increase treatment: Medicaid improvements that would enable and motivate more dentists to treat low-income children, and "innovative workforce models that expand the number of qualified dental providers, including medical personnel, hygienists, and new primary care dental professionals, who can provide care when dentists are unavailable."

Such calls for mid-level dental providers clearly mark a response to social demand. "Society has gotten the word out," says Kenneth L. Kalkwarf, DDS, MS, dean of the University of Texas Health Science Center at San Antonio Dental School. "People would like improved access to oral health care, and they would like the cost of care to be more reasonable."

Dr. Dycus agrees. "Health care reform of all kinds," he says, "is happening because the public could not

get the care it wanted at the price it wanted." The perfect price point, of course, is none at all. "The American public believes health care should be free," Dr. Dycus says, explaining that external payment mechanisms during the past decades have lulled and confused policy holders. For example, 1970s-era laws allowing third-party payer checks to be assigned directly to dentists yielded an important unintended consequence: Patients nowadays don't understand the costs of care.

Some argue that the push for mid-level providers reflects not just dentistry's failings but its faults. Dentists have focused on individual practice growth through more expensive services, virtually ignoring the public health problems of restricted wider access to dental care. In a newsletter article, "Can't Get There From Here: The Futile Attempt to Resolve the Access Issue" (available at [www.masteryofpractice.com/](http://www.masteryofpractice.com/)), Dr. Cooper observes that within the context of private practice dentistry, dentists are acculturated to "doing highly technical work to restore health and beauty to patients who can pay for it." In this world, access really is not an issue. Because the perfectionist, one-on-one culture of private practice is so single-minded, dentists consider alternative providers—from denturists to independent registered dental assistants to foreign-trained dentists—to be not just competitors, but hacks. At the same time, dentists fail to recognize the inadequacies of volunteerism, efforts akin to pouring individual buckets of water into a burning building.

Dr. Dycus counters that dentistry's focus is not narrow, but realistic. Regardless of their proponents' good intentions, care-stretching medical models such as mid-level providers simply won't work for dentistry—which is, for the most part, surgery rather than medicine. "Legislators think dental mid-level providers will be like nurses," he says, "but dental practice is much more complicated than writing a prescription." Mid-level providers also may contribute to tiered treatment inequities, with the mid-level provider seeing patients from cut-rate plans, while the

dentist sees the "good" patients. What's more, mid-level providers don't provide a "dental home." "They are pain- and urgent care-focused," Dr. Dycus says, "not prevention-focused. That's why the ADA is experimenting with an alternative community dental health coordinator [CDHC] model. Prevention is the key to controlling caries and periodontal disease."

Dr. Dycus contends, in fact, that mid-level providers don't even benefit medicine, where efficiency has declined as a result in two key respects. The first is timeliness of care: "When people go to PAs and nurse practitioners first," he says, "diseases don't get treated as soon." The second is cost control: "MDs make less and mid-levels make more, and costs just rise and rise."

All this, Dr. Dycus contends, sidesteps the underlying reality: Mid-level providers are simply not needed. First, they are too limited in scope to solve the access issue. No mid-level will be able to provide definitive, final care. Second, in most circumstances, the problem is not that dentistry is unavailable, but that it is underutilized. Because dentists have become much more efficient than old delivery models recognize, the traditional dentist-patient ratios are inaccurate. "The dental office capacity we have now is sufficient," Dr. Dycus says, "and existing capacity, including better use of expanded-function dental assistants, could be expanded more inexpensively, safely, and efficiently than creating a new position." Increased utilization of dental services, he says, is a function of not only population growth, but of oral health literacy, financial incentives, and mandated care. In any case, the existing workforce is sufficiently elastic: "We can give care at a lower fee as long as the fee covers overhead."

### **The players: Who stands to gain from mid-level providers?**

Regardless of dentists' existing capacity, other parties see opportunities—and profits—in developing mid-level providers. Large group clinics and HMO-centered practices may employ mid-level providers to leverage

their facilities. State dental practice acts typically allow physicians to practice dentistry, so primary care MDs and DOs—even emergency rooms and urgent care centers—could hire dental mid-level providers to supplement income. Insurance companies also may anticipate a possible profit center as the presence of more providers encourages more potential plan enrollees. Hygienist groups hope to use the

mid-level position as a springboard to expand their scope of practice or move toward independent practice.

Dental educators also may have a vested interest in training mid-level providers. The University of Minnesota, for example, educates non-dentist dental therapists alongside dental students, while the University of California, Los Angeles—according to recent changes in California law—

trains expanded-function registered dental assistants to place restorations. Yet, understanding that a non-dental school-based alternative exists for each of these mid-level directions as well—Metropolitan State University in Minnesota and Sacramento City College in California—could turn even doubting dentists into philosophers. "Isn't dental education best accomplished in a dental school?"

---

## PROPOSALS FOR INCREASING ACCESS TO DENTAL CARE WITHOUT A MID-LEVEL PROVIDER

1. Extend the period over which student loans are forgiven to 10 years without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;
3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as the Indian Health Service (IHS), programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
7. Actively recruit applicants for dental schools from underserved areas;
8. Assure funding for Title VII general practice residency (GPR) and pediatric dentistry residencies;
9. Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
  - a. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees
  - b. Eliminate extraneous paperwork
  - c. Facilitate e-filing
  - d. Simplify Medicaid rules
  - e. Mandate prompt reimbursement
  - f. Educate Medicaid officials regarding the unique nature of dentistry
  - g. Provide block federal grants to states for innovative programs
  - h. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
  - i. Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments
  - j. Utilize case management to ensure that the patients are brought to the dental office
  - k. Increase general dentists' understanding of the benefits of treating indigent populations;
10. Establish alternative oral health care delivery service units:
  - a. Provide exams for 1-year-old children as part of the recommendations for new mothers to facilitate early screening
  - b. Provide oral health care, education, and preventive programs in schools
  - c. Arrange for transportation to and from care centers
  - d. Solicit volunteer participation from the private sector to staff the centers;
11. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups, to establish and provide service;
12. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
13. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
14. Provide information to dentists and their staffs on cultural diversity issues which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
15. Pursue development of a comprehensive oral health education component for public schools' health curricula in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
16. Increase the supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
17. Expand the role of auxiliaries within the dental team that includes a dentist or is under the direct supervision of a dentist;
18. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
19. Strengthen alliances with the American Dental Education Association (ADEA) and other professional organizations such as the Association of State and Territorial Health Officials (ASTHO), the Association of State and Territorial Dental Directors (ASTDD), the National Association of Local Boards of Health (NALBOH) and the National Association of County & City Health Officials (NACCHO);
20. Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
21. Increase funding for fluoride monitoring and surveillance programs, as well as for the development and promotion of a new fluoride infrastructure.

Source: AGD White Paper on Increasing Access to and Utilization of Oral Health Care Services, 2009

asks Midwestern's Dr. Simonsen. Midwestern University investigated the development of a mid-level training program but chose not to pursue it.

Dental education is again a growth industry, albeit one with results more modest than practicing dentists might expect. According to a 2009 article in the *Journal of Dental Education*, "The Impact of New Dental Schools on the Dental Workforce Through 2022," authors David Guthrie, Richard W. Valachovic, DMD, MPH, and L. Jackson Brown, DDS, PhD, describe how, following a spate of dental school closures between 1986 and 2001, three new dental schools opened between 1997 and 2003, and eight more are in various stages of development over the next decade. By 2022, 8,233 new dental graduates will have joined the U.S. workforce, adding about three dentists per 100,000 people. The authors conclude that this jump in new dentists likely will result in a stable dentist-to-population ratio, but not one that by itself will noticeably increase access to care for low-income or rural populations.

While some interested entities are simply opportunists looking to cash in on a trend, the direct catalysts for the creation of mid-level providers are institutions further removed from dentistry. "What makes this a very complex issue," says Dr. Edgar, "are the dynamics of various groups outside our profession wishing to push their 'solution' to access." He identifies two such groups in particular—state legislatures and non-profit charitable foundations. "We all know that the economics of dentistry will not allow an independent mid-level provider to solve the access problem without some meaningful funding, such as increases in Medicaid rates or tax incentives," he says. Any increase in access to care requires funding, and lawmakers nowadays are suspicious of handing over the cash to dentists. "The legislatures are beginning to view our scope issues as turf protection rather than public protection," Dr. Edgar says. Certain foundations, for their part, are flexing their money muscles as change agents. The Pew Center's February

2010 paper calling for the development of mid-level providers identifies three philanthropies networked in that intent: the Pew Center, the DentaQuest Foundation, and the W.K. Kellogg Foundation.

### **Threat or opportunity? Responding to mid-level providers**

Dentists, deeply conflicted about the existence and role of mid-level providers, also are divided in their response. Dr. Dycus says, "One camp wants to draw a line in the sand, dig deeper moats, and build higher walls. The other side, citing the argument that you're either at the table or on the menu, says that we have to be on board with the concept, or the government will impose something on us without our input." What dentists on either side can't afford to do is ignore the situation. "If we don't stand up, no one will," Dr. Dycus says. "The AGD needs to be clear that demand can be met using the existing structure of auxiliaries more efficiently. Expanded function dental assistants could perform reversible procedures, such as placing restorations."

"A lot of people can do certain dental procedures cheaper than dentists," Dr. Kalkwarf says, "including dental assistants, hygienists, denturists, and dental students. It's a matter of who is in control." Dr. Edgar agrees that dentist control is crucial. "We need to push as hard as we can to retain supervision over these new providers and make them truly 'team members,'" he says. "We need to maintain a credible peer-to-peer accreditation process of any educational system that trains these individuals." Dr. Simonsen sees the Minnesota programs as accomplishing that aim: "They are putting the mid-level under the license of the dentist, which leaves the dentist in total control."

Mark I. Malterud, DDS, MAGD, of St. Paul, Minn., past president of the Minnesota AGD, says that once a mid-level law was passed in his state, dentists were obligated to support it. He says, "Even though we don't believe that there is a need for a dental therapist and that the impact will

remain minimal for quite some time, we wanted to be sure that the training and testing of these para-professionals would be adequate and that they also would be able to join into a team concept so that the patients receive the quality of care that they deserve."

The first question for any proposed change in dentistry is how the public will fare. "A self-interested point of view has no place in determining what's best for the public," says Dr. Simonsen. The priorities, Dr. Kalkwarf says, must proceed in this order: "What is good for society comes first, then what is good for patients, and finally, what is good for self."

Dr. Malterud sees potential advantages to society in a mid-level provider. "There are situations," he says, "where rural access clinics with a heavy load of patients may benefit from this, too, as long as it is within a team concept." But he also worries about the risks. "In a non-team environment," he says, "I see the potential for the general public to actually be open to injury. There are so many inter-operational diagnostic situations that come up that move a 'simple' procedure to another category outside the mid-level's scope of practice. If a mid-level provider is functioning outside the dental team, resolution of such situations cannot be completed safely."

In "The Disappearing Dentist," a segment of *Slate* magazine's 2009 five-part analysis, "The American Way of Dentistry," author June Thomas calls not just for more dentists, but for more *general* dentists, to improve access to care. "Just as in medicine," she writes, "there are too many specialists and too few general practitioners." Ms. Thomas reports that in the 1980s, about 20 percent of dental graduates pursued specialty programs; by the turn of the 21st century, the figure was closer to one-third.

Dr. Malterud thinks that help from a few mid-level associates might free up those general dentists to perform more effectively. "Working in a team concept can facilitate delegation of duties that would allow the lead dentist to provide higher levels of care and accomplish more difficult procedures,"

he says. "This can open up avenues of education for the general dentist to get advanced training to help more patients with more complex cases."

Dr. Edgar also thinks mid-level providers could provide an unexpected boon to general dentistry. "In some other countries that have dental therapists, dental education programs have been expanded to train dentists in more complex patient care," he says. "The same could happen here."

### **The future of dentistry: Where will we be in 10 years?**

Neither planners nor pundits can predict to what extent the public's unmet dental care needs actually translate into demand. "Access to care is a multi-faceted problem that needs to be addressed on many fronts and on several levels," says Dr. Simonsen, noting that mid-level providers represent only one of many approaches. Dr. Kalkwarf suggests that the survival of mid-level dental practitioners, much less their widespread entrenchment, is not assured. "There are a lot of pieces in play," he says. "Because mid-levels are trained less, they may be able to provide care less expensively. It sounds good in theory, but the marketplace may direct something else."

The mid-level concept is amorphous. Potential mid-level providers include a cumbersome assortment of health care figures encompassing a broad range of training, from dental assistants to supervised or independent dental hygienists, to dental therapists of either undergraduate or graduate status, to nurses, to primary care physicians. It is largely untested. And it is fragmented. "This is a fifty-state issue," Dr. Dycus says, "one that will be fought state by state. Mid-level dental care is not a national issue *per se*, because dental practice acts and insurance rules are different in each state." What's more, there is no guarantee that mid-level providers will end up working with the underserved populations any more than dentists will, as legislatures and foundations envision.

While Dr. Simonsen characterizes the acceptance of mid-level providers

as potentially "painful" to dentists, Dr. Edgar minimizes the threat. "I don't believe that dental therapists as they currently exist will kill general practice," he says. "Mid-levels are constrained by both the narrow scope of treatment procedures allowed and the limited populations that they are able to treat. Dentists will remain the leader of the team."

Dr. Kalkwarf also believes that reports of the death of dentistry have been greatly exaggerated. He describes a study in the 1970s that predicted there would be no future need for endodontists or pediatric dentists. Instead, he says, "Those specialties evolved, broadened their scope, and they have continued to be successful."

General dentistry itself has been written off before. In 1984, *Forbes* magazine published an article, "What's Good for America Isn't Necessarily Good for the Dentists," which announced the end of the profession. As fluoride cut the decay rate in half—cavities, *Forbes* declared, "are going the way of polio and smallpox"—and dental schools pumped out too many graduates, fees and incomes would fall. Dentists would work on salary, and the profession would dramatically contract, attracting less qualified students who would lower overall standards of care.

Obviously, dentistry didn't die. It didn't even contract. In 1999, David Plotz wrote a *Slate* essay, "Defining Decay Down: Why Dentists Still Exist," concluding that dentists prospered in the face of predicted extinction because they evolved. They made dental visits more pleasant, advanced their skills in esthetics and implants, and changed patient attitudes. "Americans under age sixty believe keeping all their teeth is an entitlement," Mr. Plotz observed. "The transformation of American dentistry... is ... a case study in how a profession can work itself out of a job and still prosper."

Many observers believe general dentists will again figure out a way to thrive in the face of mid-level challenges. "While the details may evolve and may not be all chairside,

smart dentists can develop a quite satisfying career for themselves," Dr. Kalkwarf says. Dr. Edgar sees dentistry's future adaptability as being based firmly in education. "What I do in practice is very different from many of my colleagues because of the educational opportunities that the AGD has offered me," he says.

"When I was in dental school thirty years ago," says Dr. Malterud, "a lecturer on the future of dentistry predicted the rise of a new level of practitioner that he termed a 'super-generalist.' I have kept that in mind and used it as a target for my education. I believe that many of our AGD members are positioned to become super-generalists already by achieving their Mastership in the AGD." Regardless of the future of mid-level providers, Dr. Malterud contends, AGD super-generalists are poised to flourish. Dr. Edgar agrees: "I see comprehensive general dentistry in ten years thriving beyond our current expectations."

The mid-level challenge places dentistry at a crossroad. "We can either get in control of our profession and find models to provide greater access to care," Dr. Kalkwarf says, "or we can keep doing what we have been doing and see the erosion of the profession." The profession's movement as it approaches the puzzle of mid-level providers feels something like that of the International Space Station circling Earth. Some worry that dentistry is plummeting, while others have faith it can remain aloft, safely, usefully, and indefinitely. It's important to realize that a freefall and an orbit are the same thing. In orbit, however, the craft is also moving forward. The difference is control. ♦

---

Eric K. Curtis, DDS, MA, MAGD, is an adjunct associate professor at University of the Pacific. Dr. Curtis holds a certificate in professional writing from the University of Arizona and is certified by the Board of Editors in the life sciences. He maintains a private general dental practice in Safford, Ariz.

COMMENT

