PEDIATRIC DENTISTRY/Copyright ©1984 by
The American Academy of Pediatric Dentistry
Volume 6 Number 3

EDITORIAL

Reduce the first-year residency programs in pediatric dentistry?

The report of the ADA, Special Committee on the Future of Dentistry includes the recommendation that first-year positions for specialty training be reduced by one-third. In the Forum section of this issue we have two excellent reports presented at the Pedodontics Section of the American Association of Dental Schools (AADS) meeting held in Dallas in March. Our readers are urged to review these reports by Drs. William E. Brown and Robert J. Musselman, both past presidents of the American Academy of Pedodontics, since they include pertinent information related to the future size of pedodonticresidency programs and the future role and responsibilities of the pediatric dentist.

The question of reducing the size of first-year dental school classes and first-year postdoctoral training classes is a complex one. Most schools have reduced the predoctoral student class size and others are planing to make a major cut in admissions. About 20% fewer first-year dental students are enrolled today than there were five years ago. In three to four years, as a result of class size reductions, there will be fewer applicants for postdoctoral programs. The reduced applicant pool should result in a reduction in the number of postdoctoral students in all specialty areas.

A review of data included in recent Annual Reports of the ADA Council on Dental Education indicates that there already has been a 22% reduction in first-year pedodontic postdoctoral students. In 1980-81 190 students were enrolled in residency and postdoctoral pedodontic programs, while in 1983-84 the number had dropped to 149.

In my view, it would be extremely difficult to reduce the size of the current hospital-based pedodontic residency programs. In addition to preparing for a specialty practice in pediatric dentistry, the residents provide a much-needed service in the treatment of dental problems of chronically ill and handicapped children. Who would treat these children if the pedodontic residency programs were reduced significantly? The hospitals probably could not fund full-time pediatric dentists to provide dental care for the child patient.

It is true that there has been an increase in the number of specialists in pediatric dentistry, but we should also be aware that the child population is increasing. In addition, according to the 1980 census 11 million children are living in poverty in the United States. We can be certain that the vast majority of these children are not receiving even minimal dental care, and we can be equally certain that this neglect has far-reaching effects on their general health and ability to achieve in school.

Currently, many dental schools are experiencing a reduction in the number of clinic patients. This reduction has been particularly serious in pedodontic patients. Community fluoridation and other preventive measures have resulted in reduced dental needs in child patients. At the recent AADS meeting it was reported that 70% of the dental schools are experiencing a shortage of child patients, and in 13 schools it is believed that education in pediatric dentistry will be compromised as a result of that shortage. Thus, today's dental graduate may not have the clinical experience in treating child patients that students had a decade or two ago. The new graduates may believe that they lack the experience necessary to manage other than the very routine dental problems of the child patient and thus may refer a large number to the pediatric dentist. So, with the increasing child population and the reduced clinical experience in pediatric dentistry at the undergraduate level in some schools, we may well see increased demand for the services of the traditional pediatric dentist. Thus, program directors should be cautious about over-reacting to the alleged oversupply of pediatric dentists.