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The making of a pediatric dentist, 1991 and beyond

We have an exciting opportunity to create the image of the pediatric dentist of the future when the *Standards for Advanced Specialty Programs in Pediatric Dentistry* are revised by the Education Committee's Subcommittee on Advanced Education Guidelines. Some of the preliminary emanations from the subcommittee suggest that this revision will be different from earlier rewrites which have been little more than Monday's hash of the old standards:

- In San Antonio, the Board of Trustees added another private practitioner to the subcommittee
- The subcommittee is armed with the results of recertification
- Other specialty standards recently have been revised and provide some direction on overlap and other turf issues
- Our standards of care near completion and approval, providing some direction for the scope of practice
- The special committee of the Commission on Dental Education to look at the overlap between orthodontics and pediatric dentistry has issued its preliminary report
- We have for the first time in recent years significant and current data about the character of both pediatric dental practice and dental disease.

The dilemma before the subcommittee is to determine a starting point. Do we "zero base" the standards, or keep the essential building blocks of the old ones and simply alter the time and experience devoted to each block to meet contemporary practice? Is it major overhaul or just fine tuning?

The former approach is clearly the more challenging, both intellectually and politically. The implications of a major revision are significant for both education and practice. We in education may be faced with a new product which many of us cannot produce. Programs may be faced with compliance with educational requirements for clinical and didactic experiences which cannot be met with current patient populations or faculty. Increasing the orthodontic experience, for example, may be difficult for programs which serve low SES populations, but which need to generate income from procedures aimed at dental caries. Some programs may not have either the orthodontic skills and knowledge or the relationship with the orthodontic community to provide more rigorous training. Other similar problems may arise for care of special patients, hospital dentistry, and sedation. An increased research requirement will pressure some marginal academic and hospital programs which are largely clinical in emphasis.

The practice community needs to be invested in this process — and investment is the word. As we gray as a specialty, we look to those coming out of training to help us and, hopefully, assume our practices. The Board of Trustees showed wisdom in its insistence on practitioner input, but perhaps more important is the scrutiny of the membership at large as stockholders in pediatric dentistry futures. This opportunity for demonstration of the partnership between educators and practitioners will come in May, in San Antonio, when every member has the chance to comment on the proposed standards and contribute to the dialogue that must occur.

Perhaps the biggest challenge, putting political issues aside, is to define what we are. Several people are taking a stab at our definition and it will be open to debate with the standards. Do we define ourselves based on the dental needs of children or on some set of practice characteristics? One must also ask the question, "Is what we are the determining factor in how we are trained?" Go into a pediatrician's office and do an analysis of the routine procedures performed, then follow a pediatric resident through three years of training in a major children's hospital and you become confused with the contrast in complexity. Our specialty would present a similar contrast. We should not be seduced, however, into diluting our training to reflect what is commonplace — even with the added temptation that the standards are *minimal requirements*. Our experiences with recertification, the changing picture of behavior

management, the changing caries patterns, the remaining plight of the dental patient with a handicap, and a host of other immediate and long-term problems demand that we continue to produce a broadly qualified pediatric dentist.

We might take a lesson from the American Board of Pediatric Dentistry which some time ago determined that the Diplomate was a pediatric dentist who had a broad range of skills, rather than a narrow focus. Our definition should tell the rest of the profession what we are proficient to do and our training programs should impart those skills; our practices of pediatric dentistry should be multi-faceted subsets of those skills, based on the environments in which we function.

If I had to define a pediatric dentist, I wouldn't look to the great names in pediatric dental education or practice. My model would be the part-time faculty members who teach the residents in my program. They are successful practitioners, teachers, and clinicians who have the skills and knowledge to manage the needs of the children of their community, yet can provide the tertiary level service required in a major children's hospital. They have seen it all; they've had to be innovative and synthesize the science available to them in the community to keep pace with changes in care. They are lifelong learners who can document both organized education and also provide a CV of real-life learning experiences. They haven't skewed their practice to one extreme, but provide a balance of services, recognizing the needs of their community, professional relationships, and their own skills and background. They can provide their knowledge and skills to other professionals and their patients.

If what we do defines what we are, then I'm comfortable with a definition that embodies the full range of capabilities of the pediatric dentist. It would be naive to ignore the political milieu in which we exist as a specialty, but our definition and standards should at most provide only clarification of questions of overlap in scope, support for survival of weak educational programs, and justification of individual practice preferences. They should first reflect what we are — and perhaps what we can be — now that dental caries has been rendered more manageable.

My advice to the subcommittee as it deliberates comes from the oft-heard advertisement by the Army, which should apply to our specialty at this important juncture. Be all that you can be!

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