

## How long does a pediatric dentist practice?

**W**HEN EDITOR-IN-CHIEF DR. RALPH McDONALD asked me to prepare a response to the posed question, it seemed the answer was too obvious. This kind of data could be secured probably from the ADA Bureau of Statistics with relative ease.

Reason dictated that he had something else in mind. A word bothered me. Perhaps it was nothing more than a matter of semantics. Substituting "should" for "does" could put everything into a different context.

And, yet, something was still amiss. "Should" used in the obligatory or propriety sense suggests right or wrong, a definite time frame determined by pre-established rules leaving little choice.

Ordered retirement because of age can be faulty. The heroic captain of United Airlines Flight 811 who saved the lives of more than 300 passengers as a result of his skill and knowledge was forced to retire because of age less than a month after that frightening episode. What could or would the consequences have been had Captain David Cronin been retired four weeks sooner? It did not seem logical for our editor to pose such a dogmatic question. Reason, again, dictated otherwise.

If the operative word were changed yet again from "should" to "can", the substance of the question then becomes one of ability and judgment—not finite rules. That sounds more like Dr. McDonald.

So, how long **can** a pediatric dentist practice? I still have had difficulty in satisfying myself with an (or the) answer. Subjectivity now enters the scene. How is it possible to know the answer to such a personal decision?

I am reminded of a child's doggerel. "How much wood could a woodchuck chuck if a woodchuck could chuck wood?" There is no answer because no one knows enough about the physical talents or capabilities of the woodchuck to give an answer. Similarly, we really do not know the physical and/or emotional limits of "a" pediatric dentist. In the strictest sense, these are both rhetorical questions.

But, perhaps, at least for the question of prime interest to us, it is possible to find an answer that does make sense.

Aside from the physical capabilities of the pediatric dentist, other factors, such as goals, must be included in the equation. Goals that were established 40, 50, and 60 years ago by practitioners may not be the same as those dreamed of by practitioners starting 20 and 10 years ago. Lifestyles have changed. Second homes, virtually unheard of in the 1920s and even in the '50s, are today in the plans of many young professionals. Pension plans and retirement funds were uncommon. This is not to say that the younger practitioners are only money oriented. Rather, it suggests that priorities, ambitions, and aspirations change not just with the winds, but with the times.

Dr. McDonald called to mind three of our colleagues (and there could have been many others), who epitomized longevity—Harold Addelston and Benjamin Kletzky, of blessed memory, and ever-smiling Joe Keller. All of these were long-timers. Each exhibited enthusiasm, dedication, and skill until he stopped.

Dr. Addelston practiced for 37 years, the last 27 of which were committed to pediatric dentistry and teaching. His impact upon the lives of many of today's leaders in our field is legendary.

Dr. Kletzky, the model of decorum and a prime mover in the growth of the "new" Academy, practiced for 48 years, the last 42 in pediatric dentistry.

Dr. Keller, whose enthusiasm and effervescent smile are still with us, practiced for 44 years, 30 of which were in pediatric dentistry, and he continued teaching for yet another three years after retirement.

Long ago in France, Henri Estienne wrote these words: "*Si jeunesse sarait, si viellesse pouvait* (If youth but knew, if old age but could)."

These three colleagues of ours, perhaps old in years but exemplars of (and for) youth, knew, could, and did. Many of us have found in them role models who have molded patterns for us to follow. What a waste it would have been had the word "should" in our

question been imposed upon them and the years of their practice determined by fiat!

A popular television commercial of several months back by the John Deere Co., makers of farm equipment, asked, "How long does a John Deere last?" And then a voice replied solemnly, "That's a good question." So it is with the good question at hand. The implication, of course, is that a John Deere could last indefinitely and so might we infer from the examples set by those just mentioned. But, no, life is not quite like that. We know the mechanical, movable parts of a machine are more easily repaired or replaced than the comparable human components.

There must be other factors that determine length of practice. Goal setting has already been mentioned. Need (financial) to work may be a real reason. Need (personal, ego) to work may be a real reason. The inability to retire because "I'm not a gardener; I can play golf/tennis/racquetball, etc. only so many times a week; My spouse (usually wife) would kill me if I stayed around the house all the time;"—pick one—may also be a valid reason.

The truth is that nothing more complex than an honest desire to serve and to be with children, to accept the challenge pediatric dentistry presents of developing the healthy, happy child patient may be incentive enough to persuade one to stay with it as long as the parts hold together.

Pediatric dentists have long been in the vanguard of major developments in dentistry—fluorides, sealants, patient management, pulp therapy, esthetic dentistry, growth and development, hospital dentistry, patient and public education. All these evoke a litany of names of contributing pediatric dentists: Jennings, Sweet, Sr., Parkins, S. Kohn, McDonald, Korf, Starkey, Album, Wei, Faunce, D. Myers, Olsen, Massler, Teuscher, Ireland, Doyle, McBride, Barber, Easlick, Lawrence, Moss. The list could go on—and apologies to those omitted—but this is a mere sampling of our colleagues who have left their marks and the brilliant imprimatur of our specialty upon the profession and the children we all serve.

The young, just starting pediatric dentistry, need not be intimidated by alleged reports that "dentistry for children is dead", as was told to me by a dean more than six years ago.

The Academy, in 1987, conducted a survey resulting in a 67% response. This survey indicated that there continued to be a strong demand for restorative services for children. From the survey, we learned that there remains a need for the pediatric dentist to continue providing restorative dentistry, prevention, the full spectrum of behavior management techniques, and to provide services to the medically compromised and physically handicapped patients. The survey further stated, "Although the management of the developing occlusion is a significant service provided by the pediatric dentist, it has by no means superseded the preventive and restorative activities of the specialty."

Of those who responded, 70% reported increased patient care demands and 50% of those in practice 20-30 years reported an increase in activity. Of particular interest was the fact that in a typical month, 94% were consulted by some health professional other than a pediatric dentist in regard to patient care.

It should be obvious, then, that there is still a strong need and demand for the services of pediatric dentists, although they be changing ones. In 1983, this author, in an article published in *Pediatric Dentistry*, made the following observation: "The future of dentistry for children is secure. As long as there are children and dentists, there will be dentistry for children in some form, of some consequence... My guess is there will be a different direction in post-graduate pediatric dental training... (and it will) lead to qualification for most candidates as orthodontic/pedodontists or pedodontic/orthodontists... There is today and will be in the future a continuing need for pediatric dentists to treat children... There are parents who simply prefer pediatric dentists just as they prefer pediatricians."

Who will provide the guidance and leadership?

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Who will supply the needed treatment and counsel? The neophyte pediatric dentists of today who become the Addeleston or Kletzky or Keller of tomorrow and stay in the trenches largely—if not solely—for the satisfaction of service well rendered are the resources for those yet to come. Peter O'Toole, the brilliant Irish actor, said at age 56, "There's always a hunger, when you're young, to go from peak to peak and avoid the valleys." Why should—or can—they not continue to ride the crest when experience and wisdom, acquired with such effort, make them the most valuable? Think hard of Captain Cronin—and his passengers.

Surveys conducted in 1987 by the ADA and the U. S. Department of Health and Human Services suggest there will be a greater need for dentists in the year 2000 than today. True though it may be that there will continue to be a reduction in the incidence of dental caries, the growing population will demand more dental care because they will be better educated, more affluent, and will have retained more of their natural teeth.

Recently, two articles by Dr. H. Barry Waldman were published in the *ASDC Journal of Dentistry for Children*. As professor and chairman of the Department of Dental Health, School of Dental Medicine, University of New York at Stony Brook, Dr. Waldman has written extensively on the demographics of pediatric dentistry, supply and demand of pediatric dentists, etc.

"As the decade of the 1980s draws to a close," he writes, "the outlook for dentistry, and, in particular, pediatric dentistry, appears far more favorable than it was at the beginning of the decade. Projected increases in the number of children, an increasing awareness of the need for and the value of dental services...and an increase in the percentage of children using the services of dentists—all augur favorably for the future of pediatric dental practice."

He further points out that since the early 1980s, there has been an increasing use of dental services by the growing population of children and that there will be a national decrease in the ratio of dentists to population in the 1990s.

Dr. Waldman observes that private dental insurance is spreading throughout the general population, particularly reflecting an increasing coverage for

children. A result of all these factors is that pediatric dentists and general practitioners are reaching segments of the population which may have never received dental services or for which those services may have been largely only for the relief of pain. Furthermore, national surveys have documented the increasing use of preventive dental services.

As a result of his data and that of others, Dr. Waldman concludes that a projected decrease in the total number of dentists available to serve a growing population could suggest an increase in the dependency on pediatric dentists to provide pediatric dental services.

Now let us re-address the initial question.

All of this suggests that there need be no "should" in our time vocabulary. The younger practitioner "can" have an unlimited time table if so desired. Why must one think of retirement as the ultimate goal? To retire means to go to sleep. Is that really the ultimate goal? Hardly. To be awake, alert, productive, of service—those are ultimate goals worthy of the true professional. Indeed, "*Si jeunesse sarait...*"

"Success," said H.G. Wells, "is to be measured not by wealth, power, or fame, but by the ratio between what a man is and what he might be." Each of us—the young, the old, those in between—need to strive to make the ratio as close to perfect as possible.

Dentistry, as the second most respected profession in America according to a Gallup poll, will continue to be a viable and highly respected profession. Bet on it.

Pediatric dentistry will be an integral part of that continuum. It follows, then, that the ultimate answer to the original question, "How long **does** the pediatric dentist practice?" is, in fact, relatively simple.

He should practice as long as he can.

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