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# Implications of the American Academy of Pedodontics* future of dentistry report for pedodontic educators

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I am taking this opportunity to share with you my reactions to activities in several areas which will affect our teaching of dentistry for children and handicapped individuals. Specifically, I have been asked to identify the impact of the American Academy of Pediatric Dentistry (AAPD)* Future of Dentistry for Children Committee report on pedodontic education. My comments are influenced by discussions at this meeting with pediatric dentists with officials in the ADA, and with many of our orthodontic colleagues.

Dr. Vincent N. Liberto, 1981–82 president of the AAPD, received a request from the ADA for reactions to the work of the Future of Dentistry Committee. A studied reaction required establishing our own Committee on the Future of Dentistry for Children. Since the committee activities would overlap our two terms of office, Dr. Liberto and I shared the responsibility for appointing and giving the charge to this committee. Dr. Charles H. Rosenbaum was chairman of the committee.

Initially, there was some feeling that the ADA Future of Dentistry report would lay the groundwork for the elimination of the specialty of pedodontics; other specialties felt even more threatened. These reactions were fueled by consideration of changes in the ADA requirements for Recognition of Specialty Areas in dentistry. The guidelines being considered would no longer permit recognition of specialties in areas that did *not* provide direct care to patients.

All of the specialties rallied behind the specialties of oral pathology and public health dentistry which appeared most susceptible to this change. That joint support was successful in softening the change; even if the ADA no longer recognized oral pathology or public health dentistry, these specialties would continue to be "recognized" by both general dentists and other dental specialists.

Our study of the ADA Requirements for Recognition of Specialty Areas in conjunction with the work of our Future of Dentistry for Children Committee reminded us that it is critical that we have a strong and active AAPD representing a majority of the pediatric dentists in the United States. The first ADA requirement to recognize a dental specialty is that the specialty "must be represented by a sponsoring organization whose membership is broadly reflective of the area and recognized by the profession at large for its contributions to the art and science of the area."

It is my conviction that a majority, if not all of the pedodontic specialty education programs, emphasize the importance of becoming Diplomates of the American Board of Pedodontics. Many advanced education program directors spend time preparing their students specificly to pass the Board examinations. Emphasis also must be placed on the importance and value of membership in the American Academy of Pediatric Dentistry. For our specialty to remain strong we need every new pedodontic graduate to become an active member of our Academy.

At the Orthodontic Section meeting here, concern was expressed about the small percentage of orthodontists who had completed their Board examinations. Suggestions were made to aid in increasing the percentage of Board-certified orthodontists. A similarly small percentage of pediatric dentists have completed our Board examinations. We in pedodontic education should find methods to increase the percentage of pediatric dentists who become Board certified.

These two general suggestions relate to pedodontic postgraduate education. In the AADS Pedodontic Section it has been traditional first to consider issues concerning pedodontics in undergraduate dental education. Following are four recommendations which

* Now the American Academy of Pediatric Dentistry (AAPD); all references to the Academy have been changed to reflect the new name.

I propose now for the purposes of discussion and action. The study material from our Future of Dentistry for Children Committee was an important source of information for these recommendations.

**1. Adolescent Dental Care**

In the first edition of the Pedodontic Undergraduate Guidelines[1] prepared by this section several years ago, Dr. Cosmo R. Castaldi recommended, and all of us agreed, to include the teaching of skills needed to provide dental care for the adolescent. Many undergraduate dental education programs may be inadequate in this area and the Department of Pediatric Dentistry has the responsibility to see that general dentists are adequately prepared in this area. Developing a consensus definition of "adequately trained" in dental care for the adolescent would be an appropriate future activity for the AADS Pedodontic Section.

**2. Preventive Dentistry**

Dr. Stephen H.Y. Wei[2] recently has held a symposium on fluoride use in clinical preventive dentistry. A similar conference was held 10 years before, but, many new fluoride-containing preventive dental products have been introduced since then.

Ten years ago a major portion of our Academy meeting was devoted to the discussion of pit and fissure sealants. Yet, in December, 1983, NIH held a Consensus Development Conference on the use of pit and fissure sealants. Pit and fissure sealants still are not used widely in practice.

How up-to-date is our teaching of preventive dentistry for children? This Pedodontic Section should be developing methods to support the efforts of each institution to present information and develop clinical competence in the most effective and modern techniques to prevent dental disease in children.

**3. Orthodontics**

For some time it has been recommended that more clinical experience and orthodontics study be included in the undergraduate curriculum.[3] This recommendation is difficult to implement for obvious reasons. The Pedodontic Section should be supporting the efforts of our colleagues in the Orthodontic Section to strengthen undergraduate training in some aspects of orthodontics. This is an area of overlap where we must work jointly to assure the highest quality of care for children.

**4. Curricular Guidelines for Undergraduate Pedodontic Instruction**

Next year we will be reviewing the guidelines for undergraduate pedodontic education. We should make changes which will allow programs to reduce the teaching of undergraduate students in some areas of pediatric dentistry. Areas of reduction to consider will be steel crown fabrication, anterior crowns, and pulp therapy for primary teeth.

These four recommendations, which have resulted from my study of the Future of Dentistry for Children Committee report, are painted in broad strokes to encourage discussion. To borrow from the recently debated guidelines for Specialty Education in Pedodontics, we might call these the "scope" of the implications for undergraduate pedodontic education — scope meaning range with room for unrestricted development of each area.

## Postgraduate Pedodontic Education

Here I find myself juggling a number of issues. Also, I have not differentiated between the issues pedodontic educators should work on through our Academy and the issues we should work on in this Pedodontic Section.

1. The American Academy of Pediatric Dentistry has been developing sedation guidelines for several years as we are concerned with the best and safest care for children. Last year we refined these guidelines with the aid of representatives from the American Academy of Pediatrics. These guidelines were brought before our membership at the 1984 Annual Meeting. The Pedodontic Specialty Education Program Directors then will have them to utilize in guiding their teaching and postgraduate clinical experience in sedation of children for dental treatment. Our joint effort with the pediatricians has been significant. We asked their group for assistance rather than the other way around. Our specialty provided leadership in identifying sedation as an important issue of concern in the dental care of children.

2. In a similar way our Academy presently is participating in the development of a Health Policy Agenda for the American People, sponsored by the AMA. Again, we have joined with the pediatricians to influence the recognition of children in this Health Policy Agenda. Collaboration between our two specialties will continue to be important. We should seek the same increase in collaboration with pediatricians in our Pedodontic Specialty Education Programs.

Experience in physical diagnosis of children and in developing an appropriate health history of the child and their families will be important clinical skills which we can learn from the pediatrician. We must each evaluate our advanced specialty education programs to assure that we are taking maximum advantage of collaboration with pediatricians.

3. Another area we need to develop in advanced pedodontic education is a consensus concerning preventive dentistry. Specifically, we need to be developing ways to find the 20% of the child population

which has 60% of the caries[4] and then develop strategies to reduce the caries in these children. We also should look at toothbrush prophylaxis, recall appointments, and methods to prevent bottle mouth caries.

4. One specific recommendation which our Academy made to the ADA Future of Dentistry Committee was that all specialties strengthen their education and clinical experience in treating handicapped individuals. Because we have the expertise in this area we should be prepared to assist other specialty educators at each of our institutions in meeting this challenge.

5. Pediatric dentists have an obvious interest in and ability to treat some types of malocclusions. We support the orthodontists' dedication to the highest quality of orthodontic care. It is in the specialty education program that our overlap can best be explored and the parameters of this overlap delineated. It is not productive to debate this overlap in arenas where we are considering guidelines for either of these outstanding and important specialties. Pedodontic and orthodontic specialty educators should work together in their individual institutions for the best interest of the children we treat.

In his report to our AAPD Committee on the Future of Dentistry for Children, Dr. Frederick M. Parkins[5] clearly noted that the public is becoming much more involved in making decisions concerning their health care. It is logical and appropriate that the public should expect the specialist in pediatric dentistry to provide the highest quality of dental health care for children. It is up to us in pedodontic specialty education and it is up to the American Academy of Pediatric Dentistry to assure that this responsibility to the public is met by every pediatric dental specialist.


1. Nash DA, Musselman RJ: Curriculum guidelines for predoctoral pedodontics, a report. Pediatr Dent 2:223–27, 1980.
2. Conference Set, Using fluoride today: what they do, don't do. ADA News, p 1, February, 1984.
3. American Association of Dental Schools Curricular Guidelines for Orthodontics. J Dent Ed 44:223–25, 1980.
4. The Robert Wood Johnson Foundation Special Report No. 2, PO Box 2316, Princeton, NJ 08540, 1983.
5. Parkins FM: Future of pedodontics public and professional concerns. Presented to the American Academy of Pediatric Dentistry Future of Dentistry for Children Committee, Chicago, 1982.