President's Message

Busyness, the Dental Workforce and Endodontics

William T. Johnson, D.D.S., M.S.

As an educator and a practicing endodontist, I am concerned about the short-term challenges facing individual endodontists during tough economic times and the impact of long-term trends on the profession. As AAE president, I want to make sure we are doing everything we can to help our members.

The 2011 AAE Member Busyness Survey results (www.aae.org/surveys) showed that roughly half of AAE members are still struggling with busyness. Members identified three factors that they believe are responsible for a decline in patients: the state of the economy, increased competition and availability of alternatives to endodontic treatment. A fourth factor, inadequate promotion of endodontic services, was also evident from busyness survey results. In terms of promotion, the AAE is devoting significant resources to providing AAE members with tools to market their practices and improving awareness of endodontics at the national level. The other three factors involve very complex market forces and are difficult to impact. However, the AAE Board is committed to moving the AAE forward based on a solid understanding of these forces.

At its recent Summer Retreat, the AAE Board devoted a half-day to the issue of the endodontic workforce. Dr. Eric Solomon, a dentist and the executive director of Institutional Research at the Texas A&M Health Sciences Center, gave a comprehensive presentation on the market forces that have impacted the dental and endodontic workforces over time and factors that will impact it in the future. He emphasized that evaluating and making predictions about the dental workforce is complex.

Dr. Solomon’s presentation reinforced some of my observations over the past several years. For example, some of the factors impacting the dental workforce are changing demographics and disease rates, maldistribution of providers and consumer demand, which can be dramatically impacted by the economy.

By 2020, the overall population will have increased. But the World War II generation and the baby boomers will together comprise only 29% of the population, changing the profile of dental disease. Since the 1970s, dental disease has been on the decline. In 1958, 42% of all services were for examinations and prophylaxis. Amalgams accounted for 41% of all services provided and extractions were 13%. By 1999, examinations and preventive services accounted for 76% of the services with restorations decreasing to 13%. Extractions were reduced to three percent.

The changing demographics of the dental workforce itself are also important. Women are becoming dentists in far larger numbers than in the 1970s and 1980s. According to the ADA, 44.5% of 2008 dental school graduates were women, and by 2020 it is projected that 30% of the practicing dentists will be women. The workforce is aging and by 2020, 40% of dentists will be 55 years or older. Retiring dentists could outnumber graduating dentists.

Technologic advances such as rotary canal preparation, implants, improved restorative materials and direct computer-designed restorations impact workforce productivity, though it is difficult to measure.

Based on history, I am concerned that any approach to dental workforce could create more problems than it solves. Dr. Solomon highlighted past governmental efforts to address projected shortages of dentists and physicians. In 1965, Congress enacted a law that provided more than $800 million for the construction and renovation of dental schools between 1963 and 1981. Known as Capitation Grants, these funds increased the number of dental schools from 53 to 60 and enrollment of first-year dental students from 3,775 in 1971 to a mean high of 6,302 in 1978.

However, the projections of a workforce shortage did not account for major changes in oral health care, such as fluoridation, prevention, increased production with four-handed sit-down dentistry and technological advances such as the high-speed handpiece. Due to pressure from the dental community about a glut of dentists, student enrollment decreased to 4,554 in 1986 and to 3,979 by 1989. During this time, six dental schools closed.

One of my greatest concerns in the current environment is the impact the new and proposed dental schools will have on the workforce. In the past decade, eight new dental schools have opened, and as many as 10 new schools are under serious consideration. Many of these are “for-profit” schools. By 2020, the number of graduating dentists could increase from the current rate of 4,000 a year to 6,000 or 7,000. This is occurring at the same time that mid-level providers, dental therapists and expanded function assistants are aggressively seeking to expand their scope of practice in some states.

Last year the dean of my dental school, University of Iowa, attended a meeting of 26 research intense universities with dental schools to discuss the impact of new schools on dental education. He reported that some of the issues discussed were: the impact of the new schools on grants and research dollars (dilution of funding and research faculty); the potential of the for-profit/proprietary schools to change the educational model from the traditional scholarship, teaching and service to strictly clinical activities (often at remote sites); the dilution of the applicant pool for predoctoral programs and acceptance of less-qualified students; the changing model of dental educators to part-time and volunteers; the dependence on the generalist to teach predoctoral students versus specialists; the impact of mid-level providers; and, of course access to care.

In a presentation The Opportunities Ahead: Making the Most of Disruptive Change in Oral Health Care, Dr. Karl Hayden introduced the concept of disruptive innovation to dental education1. Disruptive innovation overturns the status quo, increases access to a product or service by enabling more people to acquire skills previously possessed only by specialists. By definition, the change is far reaching. Within the health professions, disruptive innovation can meet with resistance, yet it can be a fundamental driver of economic growth. An example of disruptive innovation in dentistry might be the creation of a new “Oral Health Practitioner” in Minnesota.

Dr. Hayden addressed concerns among dentists that forthcoming changes may compromise care. He emphasized that patients will play a central role in determining the so-called “standard of care” in the health care arena in the future. For example, inaccessible and expensive


continued on p. e86

JOE — Volume 57, Number 9, September 2011 e85
all our stakeholders,” said Dr. Deblinger.

As part of his long career in the field of dentistry, Dr. Deblinger has served in many capacities at both local and national dental associations, including president of the Passaic County Dental Society and the New Jersey Association of Endodontists. He is also a clinical assistant professor at the University of Medicine & Dentistry of New Jersey’s endodontics department. He is a member of both the American and International Colleges of Dentists. In addition, Dr. Deblinger has served on and been chairman of many of the board committees at Delta Dental of New Jersey.

Delta Dental established the Delta Dental of New Jersey Foundation in 1986. Its mission includes promoting and assisting educational projects devoted to the enhancement of dental health, providing research programs designed to increase public awareness of the general benefits of good health and improving dental health through the science of dentistry. Each year, the Delta Dental of New Jersey Foundation provides financial support to various organizations throughout the state.

President’s Message, continued from p. e85

our recent busyness survey highlights several opportunities where each of us can adapt to the significant changes occurring around us by taking personal initiative in managing and marketing our endodontic practices. Offering flexible payment options and financing programs to patients, and providing promotional information about their practice to both patients and referring dentists are activities currently underway with only a small percentage of endodontists. The AAE recently unveiled the Professional Outreach Toolkit, a marketing handbook that provides many valuable resources to assist in growing relationships and referrals. There are numerous other clinical and educational tools that can be used effectively with patients and referring dentists, and these can be found on the AAE website at www.aae.org/practicepromotion. Our Headquarters staff are always available to offer assistance, and so I encourage you to explore these opportunities personally!

Despite challenges, I have never been more optimistic about the future of endodontics. We have great students entering our programs and research that would have been unimaginable 20 years ago, and we continue to save teeth that would have otherwise been extracted. If we also maintain an intense focus on the quality of care we deliver, and demonstrate flexibility and initiative in our approach to current circumstances, we will weather the storm!