

# Beyond the Operator: From Patients to Population

JOHN YAMAMOTO, DDS, MPH

## ABSTRACT

There is a shortage of dental public health specialists in the United States, and the number of dentists entering the field is declining. A number of disincentives and barriers to pursuing training and a career in dental public health have been identified. This article gives a personal account of one dentist's transition from private practice to public health dentistry.



**T**he landmark report *Oral Health in America: A Report of the Surgeon General* shed light upon the profound and consequential disparities in oral health that exist within the U.S. population and the need for more information to eliminate these disparities and improve the oral health of all Americans.<sup>1</sup>

Reducing these disparities will require data on health, disease, health practices, and care use for the diverse segments of the population as well as wide-ranging approaches to improve oral health promotion and disease prevention and increase access to care for at-risk populations. The one dental specialty among the nine American Dental Association recognized specialties whose scope of practice is to address these issues is dental public health. Dental public health specialists possess "broad knowledge and skills in program administration, research methods, the prevention and control of oral diseases, and the methods of financing and providing dental care services."<sup>2</sup>

Dental public health is one of the smallest of the dental specialties, with fewer than 200 board-certified specialists nationwide.<sup>3</sup> Evidence from the most current workforce literature indicates there will be a shortage of specialists in dental public health to meet the expanding national need.<sup>4,5</sup> Despite the need for more dentists trained in dental public health, very few recent dental school graduates are entering the field.

According to data from the American Dental Education Association annual survey of senior dental students, public health dentistry postgraduate programs have consistently been the least popular of the nine dental specialties.<sup>6</sup>

Since 1995, less than 1 percent of senior dental students have applied for these programs; and during the last three years of the survey (2000-2003), there has been a declining trend. Because so few recent graduates are entering the field, trends in public health education suggest that a high percentage of the students entering MPH degree programs and dental public health residencies are in the middle of their careers.<sup>5</sup> However, the actual number of individuals entering the field is small, and it is likely that many more are interested in pursuing dental public health training but are unable to leave their practices.

This leads to the question: Why do so few dentists pursue training and careers in public health dentistry?

In February 2002, the Health Resources and Services Administration sponsored a National Dental Public Health Workshop that brought together representatives from dental public health residency programs, government, professional organizations, and dental public health resident trainees

**Author** / John Yamamoto, DDS, MPH, is an adjunct assistant professor and acting director at Wilson, Jennings, Bloomfield, University of California Los Angeles Venice Dental Center, Division of Public Health and Community Dentistry, UCLA School of Dentistry.



to begin to address the dental public health workforce issues.<sup>7</sup> The attendees worked in groups and identified key problems in workforce development such as the lack of understanding of what dental public health specialists do; a training program model that creates financial and logistic barriers by requiring recent graduates and those in mid-career to complete a master's in public health degree followed by a separate dental public health residency; the low compensation compared to other specialties and private practice; the perception that dental public health is a nonclinical specialty; and low visibility and prestige among dental students, faculty, and school administration. The workshop made recommendations to address many of these challenges that have been incorporated into the long-range strategic planning to ensure an adequate dental public health workforce to meet the oral health needs of the United States.

As a recently trained, board-eligible public health dentist who entered the specialty at mid-career, many of the issues listed above are personally relevant. Although I cannot speak for others who have chosen to pursue a career in dental public health, I will try to explain how I made the decision to go from treating patients in private practice to serving the public and community. As with most dental students, when I was in my fourth year, ready to graduate from the University of California San Francisco School of Dentistry and enter the "real world," the field of dental public health was not on my radar screen. I was vaguely aware that the specialty existed, but I really had no concept as to what the field entailed. I wanted to be a general dentist because of the variety of patients I could care for and the range of procedures I could provide. The first seven years in private practice

were rewarding for me both clinically and personally; however, I began to feel professionally unfulfilled and unsettled. I began to question why we (dentists) base so much of our treatment decisions on what the patients' dental benefits cover; why we (dentists) flock to communities and compete for patients with good dental benefits and good oral health while in other communities, people lack any dental benefits and have almost no access to basic dental care; and whether we (the dental profes-

**I began to realize that the incentives and disincentives built into the health care system have a profound effect on the way dentists practice dentistry.**

sion) are providing quality dental care. So I began to contemplate a change in the direction of my career.

As I was reaching this crossroad, I was fortunate to have the unique opportunity of spending an extended period in Japan observing and interacting with Japanese dentists. I began to learn about the structure and financing of the Japanese health system. They have a universal health care system through employers and the government that provides access to dental care for all citizens. I saw that despite having similar clinical skills and techniques, Japanese dentists practiced in a very different manner. I observed that Japanese dentists provide many more patient visits per day than American dentists; however, they do not complete many more procedures. One example of this that I observed was a single root endo that took six visits (15 to 20 minutes in duration) to complete that would have been completed in one visit in the United States. As I gained an understanding of the reimbursement for care in terms of the fees and patient co-payments, I began to think about

how the financial incentives built into the system drive how care is delivered. The experience made me reflect upon the way that dentistry is practiced in the United States, and I began to realize that the incentives and disincentives built into the health care system have a profound effect on the way dentists practice dentistry. With the experiences I had and a new perspective of the dental profession, I had also found an appreciation and understanding of public health dentistry that I did not have as a dental student or recent graduate. I felt a growing need to better understand how dentistry in the United States is structured and financed, how quality of care is determined and assured, and why there is an access-to-care problem.

Like many dentists, who, after a number of years in practice, find themselves attracted to a specific niche of dentistry like lasers or TMJ therapy, I found myself being drawn toward health services. To find the answers to my questions and to get some career guidance, I found myself at the UCLA School of Dentistry seeking advice from the dental public health faculty. The advice I was given was, that if I really wanted to work on these issues, I would need to "go back to school and get educated" by enrolling in an MPH program. The decision of going back to school and starting a new career track was difficult as I was faced with many uncertainties. Was I ready to commit to a new career track in dentistry? Could I afford to stop practicing and accept the change in lifestyle and drop in income? Would I miss treating patients? Would I be comfortable being a student again, sitting in lectures and writing papers?

After reflecting on all of the issues, I came to the decision that I would pursue training in public health by enrolling in a full-time, one-year MPH program at the UCLA School of Public Health. I

thought that if I did not like it, I could always go back to private practice. The one year of study in the MPH program exceeded my expectations. I was learning new skills in epidemiology, economics, ethics, health policy, statistics, and community health in addition to acquiring a broad base of knowledge about the U.S. health care system, and interacting with classmates and faculty from diverse health care backgrounds. The concerns I had imagined never materialized. Although I did miss treating patients, the interesting and diverse curriculum and learning environment was more than enough to make up for any drawbacks.

The education I received in the MPH program was just the tip of the iceberg in terms of the breadth of knowledge in the field of public health. I knew that I needed more training and focus on the area that I was interested in, dental public health. I applied for, and was accepted into, the dental public health residency at UCSF. The program is ideally suited for those in mid-career pursuing training in dental public health. The program was flexible and could be completed through a distance learning program. For many people pursuing professional training and advancement, one must be prepared to relocate to attend the institution where the programs are offered. I was fortunate in that I did not have to relocate for a year and I could continue working on the projects I started at UCLA. The training I received combined and built upon my dental training and practice experience with the newly acquired knowledge and skills from the MPH program.

Upon completion of the dental public health residency, I was fortunate to be able to find a position at the UCLA School of Dentistry as an adjunct assistant professor in the Division of Public Health and Community Dentistry. The wide range of activities and projects I

## **The transformation from a private practice general dentist to a trained and practicing public health dentist has opened doors I could not have imagined when I began this journey.**

have become involved with has been incredibly rewarding and has allowed me to utilize much of the knowledge and skill I acquired during my public health training. I have been able to utilize research skills through my involvement in projects studying the out-of-pocket costs for dental care in patients with HIV/AIDS; the perceived need, access and oral health status of a Hispanic immigrant community in Los Angeles; and the self-reported oral health status of enrollees in capitated and fee-for-service dental benefit plans. I have been able to serve the community through UCLA's prevention and oral health promotion programs, such as the dental screening and sealant health fairs, a school-based sealant program, and early childhood caries risk assessment, prevention and promotion program for Head Start children. I have been able to serve as a dental consultant to the firm contracted to conduct quality assurance audits for the California Department of Managed Health Care. This activity has provided me with an opportunity to help ensure the quality of dental care for a large percentage of Californians.

One of the more rewarding activities has been the opportunity to pass on the knowledge I have gained to dental students through teaching courses on the regulation of dental practice, culture and health, and ethics and health policy. Although I believed a career in dental public health meant an end to my clinical career, I have returned to clinical care as the acting director of UCLA's Venice Dental Center, a 20-chair community dental clinic, which provides dental care to an ethnically

diverse, lower-income population whose needs are great but resources are sorely limited.

The transformation from a private practice general dentist to a trained and practicing public health dentist has

opened doors I could not have imagined when I began this journey. The diverse and interesting projects and activities coupled with the satisfaction that one is helping to improve the oral health of the population has made the barriers and disincentives for a career in dental public health trivial. Although a career in dental public health is not for everyone, for those who desire a broader approach than through private practice to improve and protect the oral health of the population, this may be your calling.

CDA

**References** / 1. U.S. Dept. of Health and Human Services, Oral Health in America: A report of the surgeon general. Rockville, Md., U.S. Dept. of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

2. Burt BA, Eklund SA, The practice of dental public health. In: Burt BA, Eklund SA. Dentistry, Dental Practice and the Community, fifth ed., Philadelphia, Penn., WB Saunders Co, 29-37, 1999.

3. American Association of Public Health Dentistry, diplomates of the American Board of Dental Public Health [www.aaphd.org](http://www.aaphd.org) (accessed May 3, 2005).

4. Wotman S, Pyle M, Duffy R, Residency training in dental public health: assessment of status, needs and issues. *J Public Health Dent* 58:68-74, 1998.

5. Shulman JD, Niessen LC, et al, Dental public health for the 21st century. *J Public Health Dent* 58:75-83, 1998.

6. Weaver RG, Haden NK, Valachovic RW, Annual ADEA survey of dental school seniors: 2003 graduating class. *J Dent Educ* 68(9):1004-27, 2003.

7. Weyant RJ, Report of recommendations from the National Dental Public Health Workshop, February 10-12, 2002, Bethesda, Md., *J Public Health Dent* 63(4):258-62, Fall 2003.

**To request a printed copy of this article, please contact /** John Yamamoto, DDS, MPH, Wilson, Jennings, Bloomfield, University of California Los Angeles Venice Dental Center, 323 S. Lincoln Blvd., Venice, Calif., 90291.