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An adapted continuing education program in gerodontics: The actual challenge

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ABSTRACT

The Concept started after WW2 mainly is US, and was divided in 3 directions; Geriatric Dentistry, Gerodontics and Gerodontology. Two important Journals were edits; Special care in Dentistry and Gerodontology. In Europe we were witness to the creation to the International Association in Gerodonotology. In 1991 appeared the European College of Gerodontology actually publishing in the Journal Gerodontology Since this topic is not recognized as a specialty, the Faculties were not enthusiastic to introduce it in the basic formation. Moreover in the large audience meetings/ Congresses the number of Speakers were very small. In the FDI it took time under my leading to fix Gerodontic sessions. Only during the last few years appeared an initiative that was sponsored and under the control of the FDI, a Federation of Dental Associations and the OHAP (Oral Health for an Ageing Population). But despite these progresses, on a Continuing Education level few people attended the lectures and also only a few remained until the end of Lecture. Consequently it is necessary to find out the reasons of this situation

Keywords: Continuing, Education, Gerodontics, Oral health.

INTRODUCTION

The important demographic changes were predictable before about 30 years. The consequences were also described in milestone articles mainly in two journals; Special Care in Dentistry and Gerodontology.[1] In Europe, with the foundation of the European College of Gerodontology, we were witness to the development of a group of highly specialized colleagues in this issue. Then, step by step, gerodontics started to be present in the dental faculty syllabus for dental students.[2] In parallel at the postgraduate level appeared several types of Continuing Education Programs. In fact, Gerodontology was never considered as an independent specialty, but rather as a conglomeration of major disciplines: oral medicine/pathology, prosthodontics, and community dentistry.[3] Despite all these efforts, very few were realized, and mainly gerodontics was not an independent and recognized discipline. The gap is even greater when concerning the Continuing Education Programs.[4] Nevertheless, numerous health organizations launched Oral Health Campaigns underlining the importance of oral health and the relationship with the universal health status. If we are adding the treatment barriers, we are coming to a very bad conclusion concerning the actual gerodontologic situation. Therefore, our mission is to try and clarify this acute problem.

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BARRIERS IN DELIVERING ORAL HEALTH TREATMENT TO ELDERLY OR HANDICAPPED PATIENTS

One of the first steps is to gather the main reasons of the delivery care programs. There are several main restricting causes.

1. The distance and the accessibility of the clinics
2. The time factor
3. The lack of adequate equipment
4. The lack of financial support
5. Insufficient working force
6. Inadequate training and experience of the dental team
7. The loss of planning and collaboration of the authorities
8. The little interest of the professional organizations
9. A variable collaboration with the universities.

THE NEEDS AND THE DEMANDS OF THE HANDICAPPED/ELDERLY POPULATIONS

To establish a correct estimation is a difficult task and not the aim of our article. Nevertheless, a global schema is necessary to evaluate the amount of necessary oral health treatments. The first observation is that the number of total edentate persons is dropping down as is the complete dentures need.[2] Consequently, partially edentate and partial reconstruction will increase. Caries and root caries are frequent as a consequence of sugar intake, poor hygiene and partial prosthodontics. Periodontal diseases are common and totally neglected. Multiple extractions and minor surgery are often the only solution in these tragic circumstances. The bottom lines are that, for these patients, oral pathology masticatory dysfunction, esthetic appearance, poor nutrition, and bad speaking are part of their daily Calvary. From an ethical point of view, the profession has the duty to come up with realistic solutions to reduce the distress of these persons.[4]

A NEW BIO-PHYSIOLOGIC MINIMALISTIC APPROACH

Several attempts to simplify were successfully launched; as the ART Procedure for dental caries and the attempt for minimally invasive dentistry. Concerning removable denture prosthodontics, several evidence-based procedures allowed for more rapid and less invasive treatments.[5] Setting up a treatment plane, the practitioner should proceed to a realistic evaluation of patient resources and dentist skill and capacities. The main guidelines are the prevention of diseases, the maintenance of oral structures, and interventions limited to what is really necessary for patient needs.[6] In this approach after stabilization of the pathologies, the main recommendation is the realization of a transitional intermediary step. As mentioned, the financial burden is one of the major obstacles. Reducing the chair time and the clinical cost will increase the willingness to pay. Comparison of the cost of a conventional complete denture and a mini intervention denture (MID) demonstrates a significant higher cost for the conventional procedure that needs at minimum six visits versus three visits in the MID.[7] A shortened dental arch was recommended to reduce traumatic posterior contacts and avoid sores from biting the internal jaw mucosa.[8]

If the number of total edentulous is decreasing, we are witness to an increase in the number of partial edentate patients. Restorations utilizing RPD usually are responsible for the elimination of the supporting abutment teeth due to occlusal trauma and periodontal diseases. This situation might be managed by an appropriate design and a strict follow-up for periodontal disease prevention.[9]

DEVELOPMENT OF GERODONTICS

Obviously without qualified practitioners and a skilled team, good results cannot be expected. Qualified manpower and a good dental team are a crucial issue.

Several studies have been undertaken to take care of this education challenge.

Dental Faculties and Dental Schools

In a majority of European dental schools, gerodontology is taught at the undergraduate level. European College of Gerodontology published in 2009 undergraduate curriculum guidelines in Gerodontology. However, unfortunately, each country decided on their own syllabus and only a very few formed specific gerodontology departments. A majority of the teaching was prosthodontic in nature.

In most schools, clinical training was delivered within the dental faculty linked with others disciplines.

In the USA

The American Dental Education Association published guidelines for a pre-doctoral curriculum in geriatric dentistry.[3] This document is rather a recommendation for the development of a future curriculum.

Nigeria

Actually, there is some research published about the impact of elder's oral health. This lower level of attention may be a result of a lack of focus for the elderly as there are more important health problems. Since patients are expected to pay for dental care, the aim should be for an absence of pathologies and pain. An increase in life expectancy will increase the size of the geriatric population and hopefully also the health-care services for this population.

Japan

There is a great effort concerning geriatric dentistry. The Japanese Journal of Gerodontology published 307 original articles and several statements. There is a challenge to reach a consensus to

maintain the oral health for the elders within the limited budget and the inadequate number of trained caregivers. A new network to establish a new approach is now required.

South Africa

Although most dental treatment is gratis in most South African public hospitals, the lack of education among the elderly has resulted in them not seeking regular consultations with dental professionals, thus leading to a situation of requiring more complicated dental care. Geriatric dentistry issues are generally part of the prosthodontics, periodontics, and general dentistry topics.

In conclusion, there is lower levels of teaching, lesser knowledge about gerodontics as a specialty and insufficient clinical experience.[10] Concerning the specialty of geriatric dentistry, it was noted that few dental faculties presented a project for the development of a gerodontic course at the dental faculty. In the same way, research into the motivation and attitudes of dental medicine students towards elderly patients was extremely poor.[11]

Postgraduate Studies

Since geriatric dentistry is not accepted as an independent discipline, there are no rules and defined universal programs. The panorama is surprisingly large and varies from symposiums, courses, and postgraduate programs. A number of universities are offering a one or two year program and then delivering an Attestation or a Certificate. Since these programs are running on a voluntary basis, the number of graduating professionals is not sufficient to fulfill the manpower needs.

Continuing Education

Continuing education is a lifelong obligation. The last FDI statement recommends a compulsory program for all practitioners. In Europe, about a year ago, only about 50% of the countries had an obligatory program; but now nearly all European countries have adoped an obligatory continuing education system.

International Congresses

Unfortunately, in main major events, gerodontology is not really present. It is only in the past few years that even the FDI has begun an effort to address this issue. Lectures in Geriatic Dentistry are now a common highlight at FDI Global Continuing Education Programs. However, no viable feedback or evaluation has been collected on how these programs are appreciated by those who have attended them. Nonetheless, general practitioners are keen on picking up clinical tips from these programs, which would offer solutions to problems faced in their daily practice. It was[12] noted that, with exclusive scientific statistics, the public was poorly served.

THE DILEMMA: MINIMUM ETHICAL STANDARDS OR A MINIMAL INTERVENTION CARE

Looking on a scale of global oral health responsibilities toward our special care populations, we are presented with a dichotomy. On one hand, there is a tremendous breakthrough in technological and digital treatments. On the other hand, a huge majority of the patients are not able to afford even the most basic treatment. In fact, this underlines a real barrier because of perhaps high ethical standards.[13] Add to this several old dogmas and non evidence based procedures and we come to the conclusion that another approach is necessary. Taking advantage of transitional treatments the minimalistic dentistry intervention, we can offer a wide arsenal of solutions. In a book entitled "Rehabilitation for compromised and Elderly Patients" edited by Springer is presented removable and fixed prosthodontics, periodontics, endodontics, conservative dentistry, TMJ diseases and implantology. The fundamental strategy is defined as a minimal care program that is better than no treatment and is able to contribute towards betterment of oral health and improved quality of life.

RECOMMENDATIONS AND CONCLUSION

There are serious difficulties to change conservative syllabus as well as traditional behaviors. This challenge needs a consensus from the main leaders of our profession. A realistic dialogue should be initiated with the public health authorities.[14] May be also that leading industrial sectors could be motivated to support our aims.

However, the most important step should be the introduction of gerodontics as a full partner in Continuing Education Programs. To coordinate such a crucial project, the creation of a provisional organization could be necessary.

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Conflicts of interest

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