VIEWPoint

MyView

Delivering better dental care

Robert G. Donahue, D.D.S.

As a practicing general dentist of nearly 34 years, I frequently think of how to enhance outcomes in all phases of my personal and professional life. I have come to the conclusion that, in my opinion, we as a profession are long overdue in contributing more directly in enhancing the medical care of our patient population. Consider the mindset that we are "a physician of the mouth." No, I am by no means a frustrated physician. I never applied to medical school. I am a dentist through and through and proud of it. I believe that dental offices are in the unique position to be utilizing entry-level diagnostic testing of patients on a regular basis. For example, consider hypertension screening as well as cholesterol, glucose and diabetic testing, smoking cessation and drug abuse counseling, to name a few. Then these patients would be referred to qualified medical professionals for definitive treatment. Some of this may occur currently, albeit on an extremely limited basis. The dentist — the physician of the mouth — should be treating, more fully, the oral manifestations of systemic diseases. This represents more eyes looking at a problem, attempting to find solutions. Why not even consider staffing your office with a registered nurse or nurse practitioner to provide some of this initial care? Reasons abound as to why not.

To my premise, The New England Journal of Medicine Dec. 17, 2018, issue reported on a study launched by the Smidt Heart Institute in 2016. It dealt with the topic of how barbershops could help lower blood pressure and involved 319 African-American men with hypertension and 52 barbershops in Los Angeles County. Men were randomly assigned to a program led by a specially trained pharmacist or to a control group. This study proved community-based medicine closed the gaps in health care disparities. The barbershop was their safe haven. The pharmacists eventually earned the patients' trust. Treatment modalities for hypertension probably saved lives or mitigated associated medical conditions. This type of study and treatment is spreading across the country. Hopefully, this treatment access proves sustainable.

My own barbershop performs a cursory skin cancer exam of my head, neck and face during a haircut; not uncommon in this profession. More than 80 percent of squamous cell carcinomas and basal cell carcinomas occur on these aforementioned areas. Melanomas, the most dangerous form of skin cancer, tend to be disproportionately fatal on the scalp. I know I have advised patients to get a dermatological consult due to something I detected during a dental appointment on their head, neck and face areas.

As a dentist, I conceivably deliver well in excess of a thousand injections of intraoral anesthetic annually. In some states, depending on regulations and training, dentists can perform dermal filler injections. However, it is more than likely that a dentist cannot give a flu shot, legally, without proper vaccine training.

I understand the reasons why. I get it. So why not get trained and do it? Think of all the patients you could be helping directly, indirectly and, perhaps, even unknowingly. Implementation of this one example could make

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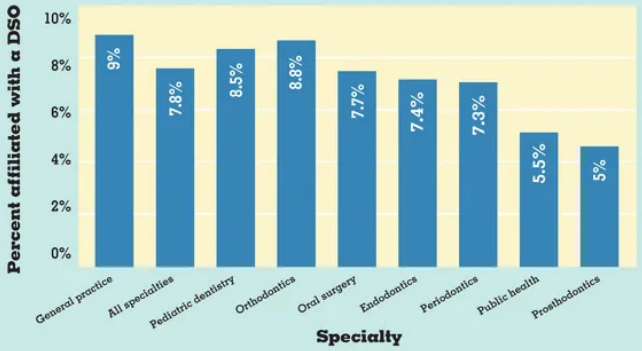
LETTERSPolicy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; email to ADANews@ada.org.

SNAPSHOTS OF AMERICAN DENTISTRY

Dental service organization affiliation by specialty

In 2017, 9% of general practitioner dentists were affiliated with a dental service organization. Among specialist dentists, orthodontists had the highest affiliation with DSOs.



Source: ADA Health Policy Institute Infographic, "How Big are Dental Service Organizations?" Available from ADA.org/en/science-research/health-policy-institute/publications/infographics.

Letters

The Atlantic article response

In the May 2019 issue of the The Atlantic, author Ferris Jabr describes an incident where a dentist purchased a practice from a retiring dentist and discovers examples of extensive overtreatment. Patients have been informed and the retiring dentist is under indictment for insurance fraud and is being investigated by the Dental Board of California. The article also describes activities such as evidence-based dentistry, supported by the American Dental Association, and other policies intended to place a strong scientific base under oral health care. The article mentions that these efforts are ongoing and not necessarily understood or applied by all dentists.

The American College of Dentists supports the growing scientific basis for oral health care, the professional ideal of service to patients and others who need oral health care and the responsibility of dentists to help each other achieve these ideals and protect the public.

We, therefore, regard The Atlantic article as an opportunity for reflection on ways to build an even stronger dental profession, grounded in strong science, service and the mutually shared standards among dentists. We honor those who make patients' oral health paramount.

It is understood that there are multiple, legitimate perspectives on the material presented in the article. There is an opportunity here to learn by listening to these multiple points of view. It is urged that the article be shared and discussed for what can be learned. In order to facilitate this kind of discussion, the college

has developed a set of suggestions for hosting small-group discussions among professionals and for interacting with patients who may have read the article. These listening tools are posted below this response. These are not prescriptive statements; they are suggestions for building stronger relationships among dentists and with patients. The entire contents of the proposed engagement strategy are available and downloadable at the college's website at acd.org.

Thomas J. Connolly, D.D.S.
President, American College of Dentists

Dr. Cole letter to the editor

Here is a quote from the June 18 ADA News: "The American Dental Association and dentists across the country are dedicated to the health and safety of the patients they serve." That was the message ADA President Jeffrey M. Cole emphasized in a June 16 letter to the editor of The Atlantic, in response to the magazine's May article, "The Trouble With Dentistry." Dr. Cole also strongly disagreed with the author's implication that dentists are motivated by profit to pay down their student loans. "[This implication] is not borne out by the facts," Dr. Cole said. "For instance, dentists have for decades advocated for fluoridation of community water supplies to prevent tooth decay. Why does the profession advocate for something that results in less need for treatment? Because dentists are doctors

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a huge difference. One does not have to look any further than our daily news feeds to be made aware of the rampant, widespread medical and public health life-threatening effects of the failure to implement vaccines. Accessibility, fear, cost and not fully comprehending the medical facts of the circumstances of the spread of diseases no doubt play a huge role. Education is key. The preliminary infrastructure of practitioner, patient and facility are already in place. Dentists could be far more encompassing in their treatment armamentarium for the enhanced health of our patients or record, as opposed to the current dental care model of "just fix the main problem." Perhaps we could teach our medical colleagues how to perform a dental exam.

Medical clinics abound in such places as drug store chains and big box retailers. Why not utilize existing dental offices for entry-level medical diagnostic testing and very likely enhance overall patient health? Or employ a nurse or nurse practitioner to implement initial care, as stated previously? This would be a major paradigm shift on many levels, with huge hurdles to overcome: stepping on the toes of other practitioners, retraining of dentists, political, economic, insurance and legal overtones.

I am by no means advocating dentist-centric medical care delivery. I am advocating gatekeeper diagnostic testing and evaluations and, perhaps, flu vaccinations to enhance overall patient health. Patients would be otherwise referred to the medical community for proper treatment. Currently in the United States, many medical staffing studies delineate a shortage of primary care practitioners, now and in the future.

This acute shortage could be mitigated by dental offices, as shown in the barbershop hypertension study, that is a nontraditional health care delivery location.

Philosophically, perhaps we could turn our treatment from a "firefighters" mentality to a "smoke detector" mentality. Not allowing the medical/dental condition to turn from something smoldering into a full-blown blazing inferno.

This mindset shift could also be, admittedly, mutually beneficial for all parties concerned.

I believe this time is long overdue to de-emphasize the current mindset of some dental care: online orthodontic treatment; suspect overseas medical/dental tourism; cheap non-Food and Drug Administration-approved offshore dental labs of questionable quality and materials; upselling questionable restorative treatments or excessive esthetic treatments "because that's what the patient wants;" having our patients like us on Facebook or Instagram for marketing reasons and misleading the public into thinking they are superior to a colleague, based on the sheer number of likes.

I have always considered that patient care is a privilege with many responsibilities and potential adverse consequences. I feel that our obligations and professional abilities fit perfectly into this scope of practice paradigm shift of medical/dental care with benefits for all.

This will not be easily transformative or without its many detractors. But it will be for the betterment of mankind. That alone, should be enough.

Dr. Donahue practices in Washington, D.C. and is a fellow of the American College of Dentists and the International College of Dentists.

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of oral health, and tooth decay is a disease that we want to prevent for the good of the public," he concluded. I am recently retired from 39 years as a clinical dentist. My experience is that there is truth to The Atlantic article. I too often had patients come see me for second opinions because of their doubts about the unexpectedly large amount of problems diagnosed by another dentist, and more often than not, the diagnosed problems were exaggerated beyond what was actually there. No one can say for sure that the previous doctor's motivation was to pay off burdensome student loans. Actual motivation aside, the fact remains that there is actually overdiagnosing and unnecessary treatment occurring. How widespread is it? I could not say, but I do know that it has been increasing in the past five to 10 years, and any level of that is unacceptable. I always wondered when someone would realize that there was an actual problem here, and it is obvious that the author of The Atlantic article has discovered this problem and has started pointing it out. For the ADA president to flatly deny it is disingenuous. Obviously, the problem is not caused by a majority of dentists, and is not an epidemic, but the problem must be admitted and dealt with. People are finally starting to notice.

John P. Walker, D.M.D.
Clearwater, Florida

Editor's note: The Atlantic shortened Dr. Cole's original letter he submitted to the publication. His original letter also stated, "Dentists hold a special position of trust and as such are obligated to adhere to the highest ethical standards with the primary goal being the benefit of patients and the public. A dentist's ethical obligation is to meet the needs, desires and

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