Journal *of the* American College *of* Dentists

How the Future of Dentistry Looks from the Outside

Fall 2020
Volume 87
Number 3

Journal *of the* American College *of* Dentists

A publication advancing excellence, ethics, professionalism, and leadership in dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD, and additional mailing offices.

Postmaster–Send address changes to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

The 2020 subscription rate for members of the American College of Dentists is $30 and is included in the annual membership dues. The 2020 subscription rate for nonmembers in the United States, Canada, and Mexico is $40. All other countries are $60. Foreign optional airmail service is an additional $10. Single-copy orders are $10.

All claims for undelivered/not received issues must be made within 90 days. If the claim is made after this time period, it will not be honored.

For bibliographic references, the *Journal* is abbreviated J Am Col Dent and should be followed by the year, volume, number, and page. The reference for this issue is: J Am Col Dent 2020; 87 (3): 1-36.

Member Publication
AADEJ
American Association of Dental Editors & Journalists

Communication Policy

It is the communication policy of the American College of Dentists to identify and place before the fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the college. The college is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in college publications do not necessarily represent those of the American College of Dentists or its fellows.

Objectives of the American College of Dentists

The American College of Dentists, in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
D. To encourage, stimulate, and promote research;
E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

Correspondence
Address correspondence relating to the Journal to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

Letters from Readers
Comments concerning any material appearing in this journal are welcome at dchamber@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. The editor reserves the right to refer submitted letters to the Editorial Board for review.

Business Office
Journal of the American College of Dentists
Tel. (301) 977-3223; Fax. (301) 977-3330

How the Future of Dentistry Looks from the Outside

Ethics Case

Departments

Cover image What you see depends in part on where you are standing. Dentistry often looks different to those with no handpiece in their hands.

From the Editor

It Is the Relationships

I'll bet you are just a little tired of seeing opinion pieces about "How the Covid-19 has changed my world." We have passed the first wave of folks saying, "See, I told you that what I was concerned about before is really important now." The brave mumble slogans like "the new normal." Others are checking to make sure the important stuff is packed in the car in case an evacuation is declared. How we as a profession and a community stabilize in a year or two will not depend on what we try to save, but on how we relate to those around us.

There doesn't seem to be any evidence that patients are being infected in the dental office or that dentists are being infected by patients. Dental practices are plateauing at about 80% capacity. The new normal seems to include patients being afraid of Covid-19 on public transportation while on their way to a dental appointment or struggling with other personal needs. Office staff most heavily impacted are young women, auxiliaries, who have to stay home for their children.

How we respond matters just as the contagion does, and our response is a function of where we are in the huge and complex network of social relations.

The battles here, and they are pretty fierce, are over how to share the cost of reestablishing equilibrium. What is "essential" is not the same for all. Perhaps the government has not taken care of small businesses as it should. The submerged debris that has always been there is now obvious because the tide is out. In times of difficulty our first response is to say, "Oh, no."

The difference between a disease like cancer or diabetes and the Covid-19 infection is that it attacks our relationships with others. All diseases damage those directly affected, but plagues attack communities. Everyone catches a pandemic.

Those who study system dynamics, including spread of communicable diseases, say communities cannot reestablish equilibrium while significant parts of them remain damaged. In other words, fixing the part closest to us may not be a stable solution. It is also known that prolonged disequilibria cause permanent realignments of the parts. The human amygdala, for example, shrinks permanently and loses function under prolonged stress when it is overworked.

I track the infection rate per 100,000 population by state every day. As of November 2020, per capita infection was 40% greater in states that voted for a male president in 2016 than those that voted for a woman. This is not a function of geography or physical susceptibility. It is a function of attitude, and no cause for celebration in a city such as San Francisco, which is less the 50% of the national infection rate. We are all in this together.

Systems theorists have worked out the way communities form, segment, and reintegrate based on relationships. We are affected by what we do and by what those around us do. That goes equally for the bugs whose spread is controlled by these rules and for us. We are controlled by the same relationships as the bugs are. Like the human brain that is remarkably plastic, when a formerly useful connection is disrupted, we either begin decline or build alternative paths.

Covid-19 is an ethical issue because it involves how we relate to others in community. Considering only our own interests is unethical—not because it violates principles, but because that limits the extent to which a community can flourish. If everyone else did that I would not have to worry about ethics. After all, there would be no reason for a particular individual to be vaccinated against smallpox if everyone else were vaccinated. The most ethical person, the one I respect and humbly envy, is the one whose actions are guided by an attempt to

live in the most ethical and prosperous community possible. But we cannot be ethical alone. I need your help.

Now for some reading on the plague while sheltering-in-place.

William McNeill wrote the classic and very readable *Plagues and People* covering the history of pandemics from the scientific, epidemiological, and social perspectives. They are episodic, mostly misunderstood, and they go away after changing communities. One community makes progress while another a few hundred miles away perishes because of differences in how people relate to each other.

The Decameron by Boccaccio was written in mid-fourteenth century Florence, supposedly involving ten young lords and ladies escaping to a country estate to avoid the plague. They tell ten stories each to pass the quarantine period. Generally they are racy; some are really funny.

Daniel Defoe's *A Journal of the Plague Year* recounts the 1665 epidemic in London. In addition to describing the physical and psychological decay, he excoriates the government, and especially the establishment clergy, who escaped to the country and then came back to profit from the reconstruction.

A Distant Mirror by Barbara Tuchman richly details the pivotal 1300s in Europe. The plague killed up to half of the land-bound serfs in France, Germany, and England. The resulting labor shortage gave economic power to the poor who survived. Governments attempted to stabilize the market by passing laws preventing farm workers from moving more than a few miles to take new jobs and imposing fines on land owners who raised wages. It didn't work, and a new class of laborers freed from the land emerged. Tellingly, the plague never reached Eastern Europe, which is why there were serfs there until the beginning of the twentieth century.

> All diseases damage those directly affected, but plagues attack communities. Everyone catches a pandemic.

Albert Camus's fictional tale of a plague in Oran in contemporary Northern Africa, *The Plague*, is a look at how fear of what we cannot control corrodes relationships. We are all in different places in the community. We make individual choices, some of which undermine others and some strengthen community.

Technology Is Not Stuff

It Is New Experiences

Todd Blankenbecler

Abstract

Technology change conceived of as new things sometimes misses the point. Unless technology significantly changes the experience of those involved, its impact is too small to command our attention. It is change in the experiences of patients, dentists, office staff and routine, and manufacturers that matters. The changes are coming very quickly and will sometimes require different kinds of responses from the profession.

Todd Blankenbecler is president and CEO of EasyRx, winner of the 2020 American Association of Orthodontics Innovator Award; todd@easyrxcloud.com.

The user experience defines everything. By users, I mean the participants in dental treatment: The patient's user experience, the office user experience, the dentist's and staff 's user experience, and even the manufacturer's user experience.

The Patient User Experience

Today, the practice controls the patient's user experience. The practice schedules most appointments, shares communication, and handles billing and insurance filing, and the patient comes to the practice for evaluation, diagnosis, and proposed treatment plan. This will change over the next 20 years. Driven in part by today's millennial culture, patients will want and demand more control over the look and feel of dental care. They will expect ease of access like remote exams, scheduling control, more treatment choices and options, greater ease of delivery, and pricing transparency. We see the early stages of this trend today with more and more practices offering online scheduling options and remote monitoring services.

The trend is toward balance in control of transactions. Before patients come to a practice for treatment, they will have completed detailed online research, scheduled their appointment, provided and approved necessary patient information, submitted a preliminary diagnosis, and even selected their preferred treatment options. They will have already taken photos and x-rays using a personal mobile device. Automation and artificial intelligence (AI)-based technology will complete a preliminary analysis, including confirming the diagnosis and detecting underlying issues like caries, periodontal problems, cracked or damaged teeth, and other possible health issues.

Mobile devices that do not use radiation will capture diagnostic images. Dr. Marc Lemchen patented capturing x-rays using algorithms based on "sonic digitizing" back in the '90s. These patents were the foundation of Dolphin Imaging. We will have some form of technology to support this soon. Virtual initial patient exams will be the norm, completed before the patient comes to the practice, perhaps done in the evening or on the weekend. Dental practices must adapt to this new patient-centric user experience and accommodate the patient's schedule. It won't take place once the patient is in the chair and the dentist and staff will not play their customary role.

Patients will research dental practices in new and different ways before engaging. This fact finding will move past the simple "how is the practice rated" to investigate how the practice handles specific procedures and treatments. For example, instead of checking how many stars the practice has, the patient will research Dr. A's

rating when needing a 3-unit bridge with a specific type of printer design.

With the dentist adequately vetted, the proper diagnosis determined, and the treatment plan selected, all before the patient comes to the office, patients will want to be treated by the best. They will expect technical care that meets standards and will be looking for nontechnical enhancements. They will be comfortable with and open to traveling farther to be treated for their needed procedure. Dental visits may become destination visits: "I'm traveling to London to visit Dr. B because he is the best in the world, plus we are doing a few tours!"

Patients will also get closer to the manufacturer. We are already seeing this today in the aligner market, with brands like Invisalign and Smile Direct Club. The direct-to-consumer model will expand to other services. There will be more options available offering dental services. We've seen disruptions in many other industries. Look at what Waby Parker did to eyeglasses. We will see similar disruption in the dental industry. Chris Kabot, Vice President, Technology, Research and Development at Core 3D Centers, says, "Patients will not go to the same dentist for all their needs, instead they will seek alternatives." We are already seeing big-box retailers like Walmart offer in-store dental services. These types of offerings will expand. Much like hair salons and manicurists today, we'll see brands opening, offering specific services, seeking distinction like Invisalign or Smile Direct Club, maybe ABC Crown or Simplified Splint. Let's say the patient accepts a treatment plan requiring a splint. The patient may choose to visit the online store of their preferred or recommended splint manufacturer, share their diagnosis, treatment plan, photos, and x-rays, and then order direct from the splint manufacturer. They may schedule delivery at their primary dentist or perhaps in-home, delivered by a properly licensed assistant if needed. We may get our teeth cleaned in traveling mobile cleaning services. Scan centers may also be common.

The Office User Experience

As will happen for all businesses, the coming fourth industrial revolution of robots and automation will impact dental practices. Robots will be part of our daily life at home, at work, and in the dental office. When patients visit the office for treatment, the office user experience will be much different from today. The "front desk" person may go the way of the elevator operator. A practice's humanoid "customer welcoming system" will greet patients. The robot will recognize the patient using facial recognition or bio-scanning. The system will pre-screen the patient for possible health issues, checking temperature, cough, and other issues, before allowing the patient into the practice. Once admitted, the wait will be short. Patients will expect the practice to run on time as our daily life's pace will only accelerate in the future. The patient will be escorted to the chair by the practice robot. The chair experience will be more automated, and much of the assistant work will be handled via robots and automation. Automated dental chairs will manage seating the patient and positioning the delivery of air, water, and suction. A robot will assist the

> Patients will want and demand more control over their user experience. They will expect ease of access like remote exams, scheduling control, more treatment choices and options, greater ease of delivery, and pricing transparency.

dentist during the procedure, delivering instruments, materials, and supplies. This robot will be available to provide education content if needed. Routine and repetitive tasks like sterilization, clean-up, and vacuuming will also be handled by automation.

Industry experts believe human interaction and variability will be reduced in the fourth industrial revolution. Although robots and automation will impact day-to-day repetitive or routine tasks, there are limits to completely replacing the human element. The dental staff may need to learn new jobs and skills, but there will be opportunities for them. Perhaps there is a new role, "Human Interaction Team," whose function is to personalize the experience while robots and technology handle the routine tasks.

Core software, such as practice management, will be more automated and more customer-facing, giving the patient more control of their experience. Patients will schedule their appointments, pay for services, file insurance, generate correspondence, and communicate with the practice, all from their mobile device. Patients will dismiss themselves at the end of visits, pay any fees, file insurance claims, and schedule follow-up visits, similar to the contactless grocery stores we see today. Patients will only make payments in digital currency. Integrated voice recognition will also be the norm. The patient's medical and dental records will be linked (finally!). The décor of the offices will be open, clear, and accessible.

The Dentist and Staff User Experience

One thing that will not change soon is human anatomy. Even as everything around treatment will change, patients will need crowns, bridges, implants, braces, and other preventative and restorative services as they do today. The techniques, materials, and delivery of treatments will change. The distribution of disease burden may change. Over the next 20 years, the combination of quantum computing and artificial intelligence will move us into a new era of patient-centric, evidence-based "control" of treatment, clearly defining the objectives and benefits of treatment, monitoring the progress of treatment, and maintenance of the result. This will result in shorter treatment times, more consistent results, and a better user experience. Dental technology will tightly intertwine artificial intelligence, machine learning, and deep learning in the dentist and staff user experience.

These terms are in vogue these days. Let's take a moment to clarify what they mean. "Artificial intelligence" is a broad and general term that refers to any computer software that engages in humanlike activities, including learning, planning, and problem-solving. "Machine learning" is primarily used to process large amounts of data quickly. "Deep learning" is an even more specific version of machine learning that relies on neural networks to engage in nonlinear reasoning based on pattern detection. For the most part, when we hear "software built on AI technologies," this is a generalization of all three of these processes and is commonly referred to as "AI" software. "Artificial intelligence is kind of the second coming of software," says Amir Husain, founder and CEO of machine learning company SparkCognition. "It's a form of software that makes decisions on its own, that's able to act even in situations not foreseen by the programmers. Artificial intelligence has a wider latitude of decision-making ability as opposed to traditional software." Companies will develop software on the foundation of these principles. The impact of AI-based technologies is limitless and will allow any dentist to act like an "expert" in any area by merely implementing the right technology.

Virtual exams and consults will be in 3D, allowing the dentist to perform comprehensive evaluations remotely, including photos and x-rays. Much like the physician's assistant model in medical, dental assistants, specifically trained to do so, will handle some or all of these virtual exams, supported by the incredible technology available. We will see automated, evidence-based decisions, and treatment recommendations, driven by AI, communicated to the patient.

All impressions and x-rays will be digital. Intra-oral scanners will be handheld, small, fast, and full color. The files outputted will be smaller in size but higher in quality and resolution. There will be a universal lab prescription platform, and lab prescriptions will also be 100% digital, no PDFs or (egad!) paper. The traditional practice-to-lab communication model will expand to include patients-to-practice and patient-to-manufacturer. Patients will expect to have access to and contribute

to all communication about their treatment, all parts of their experience.

Most office visits will be treatment visits, as consults, exams, and treatment planning will be done virtually by a dental assistant before the patient visits the office. With most of their time spent on treatment visits, production by the dentist will increase.

Dentists and staff can expect "regular office hours" to include nights and weekends, as patients demand more flexible hours and availability. Remember, the patient user experience is critical to success in 20 years.

Remote treatment monitoring will be considered standard of care. The sophistication of the monitoring will only increase, allowing both patient and dentist to be confident and comfortable in remote monitoring. In addition to compliance and monitoring, these services will monitor other areas such as gingival recession, how the teeth impact bone, and who knows what else. These remote monitoring services will provide treatment recommendations, again based on AI integrated software. An expected advantage of remote, digitally mediated oral health monitoring will be earlier and more targeted seeking of care.

The Manufacturers' User Experience

The manufacturer user experience will also change significantly in the next 20 years. We will see more and more vertically integrated companies offering services and products for the entire experience. These companies will not be distributors, but companies owning and controlling their whole product suite. Many will work directly with patients. These companies will be "major influencers" in the market. Materials, processes, and equipment will change, impacting commercial manufacturers and in-house manufacturing. 3D printing will see expanded capabilities, lower costs, and greater simplicity. Materials and designs will be open source. Chris Kabot, for example, predicts that "we will see 3D printed natural-like teeth, certainly within the next ten years."

Responding to competitive pressures and patients' demand for more control, we will see a marked increase in in-office manufacturing. The practice's in-house lab will be critical to the patient user experience. The in-house lab will include advanced 3D printers, robots and automation, CAD/CAM, and related software, and of course, be built on AI technology. The in-house lab tech will be technically savvy, experienced in complex manufacturing processes, and higher paid than today. In-house labs will manufacture all sorts of dental appliances using many different materials, crowns, bridges, prosthetics, veneers, implants, and even brackets for orthodontic treatment in-office manufacturer to determine the patient's best prescription. With these increased capabilities and cost justifications, practices will offer more treatments in shorter time frames and increasing capacity and production, making the practice more profitable.

There will be consolidation in the commercial lab industry. The number of commercial labs will shrink significantly due to pressures from these powerful vertically integrated companies and the advancements in the in-house lab. It will be common to hear someone comment, "I ran my own lab for the last ten years, but took over Dr. C's in-house lab recently."

> Perhaps there is a new role, "Human Interaction Team," whose function is to interact with patients while the robots and technology handle the routine tasks.

In conclusion, oral health and dentistry will be radically different in 20 years. The fourth industrial revolution of robots and automation and AI technologies will change all participants' user experiences. The patient user experience will be paramount and be the focus of the other user experiences. The success or failure of all users will be driven by adapting to these new user experiences.

The future of dentistry will not be like the recent past. I can't wait, but it is coming so fast I need not wait long. ■

A Betrayal of Trust

Neil Fulton

Abstract

Overtreatment has been identified in the American College of Dentists Ethics Report as a frequent and increasing feature of dentistry. The work may be of acceptable quality, but the patient would not choose to have it done if full informed consent had been given. It is an unfair economic transaction. The impact of overtreatment extends beyond the single event. Patients lose trust in the profession as a whole. A patient relates his experience with gross and continuous overtreatment.

Mr. Fulton is an engineer living in San Jose, California; nwfulton21@outlook.com.

In 2017, a dentist in San Jose, California, voluntarily surrendered his license and retired from the profession under documented accusations of extreme overtreatment. He eventually settled suits brought by patients in excess of three million dollars, paid by the state's dentist-owned insurance fund. Before the pattern of excessive work came to light, the practice was sold to another dentist in the community who eventually reported the matter to the appropriate agencies, as required by the American Dental Association's Code of Professional Conduct, 4.C. The retiring dentist was also charged with insurance fraud. The case was reported in the local media and in an article in *The Atlantic* magazine.[1]

The comments below are a transcription of an interview with one of the patients involved in this case, recorded in July 2019. The full interview includes comments by the dentist who purchased the practice.[2] Both references are also found on the ACD website.

I came to California in 1964, so sometime in my junior year of high school I connected with this dentist and so did my sister as well as my mother. So it was the three of us who were being treated by the doctor. Through the years we spent most of our time hearing from the doctor, "You need to have a root canal, you need to have a root canal, you need to have a root canal, crown, crown, crown." It got to the point where it was expected. Every single visit it was expected. In fact, it got to the point where we would call each other after a visit and say, "Need a crown?"

The net effect of that over the years was pretty impactful because I was with that doctor until he retired. You can image that meant a lot of work was done in our three mouths. On a family impact, my sister is very emotional every single time she talks about it because, and not to be too dramatic about it, but she feels like she's been maimed. There's been work done on her that was not necessary to be done. My mom, the same thing. Each one of us probably has between seven and nine crowns. And the majority of those probably have root canals. So it was a pretty traumatic event.

As patients we had no way of knowing whether what was happening to us was legitimate. The reason why is that when we sought second opinions, each time we went to other dentists they praised the technical quality of his work. Now they did not know whether this was necessary because they were looking at what happened afterwards. But what we knew and what we found was that the number of times this was happening was above what we considered to be normal.

There's just no way with the way we keep our teeth—we're flossers, we brush two, three times a day—there's just no way we could come up with this kind of work being necessary for the three of us.

What the long-term effect has been is an erosion in trust in dentistry. In fact, as late as this morning, I received a text from my sister saying that her son is being prepped for braces and they want to remove four teeth. And I just don't trust them.

So what am I to do? In my own case there is an ongoing situation in my mouth where I had to have a root canal because I had an infection. I also had a rotator cuff surgery so I had to worry about the infection in my tooth spreading. So they went in and they fixed the infection. But I was reluctant about that. And then I was approached by my current dentists who said, "I think we need to do a crown." So in my head, the first thing that came up was, "Here's another dentist telling me I need to have another crown."
Is that the only solution we have here? I'm at a point now where I have endured so much pain in my mouth that I am looking for options for ways for people to stay out of my mouth.
So my new dentist said one approach would be to do a filling. It would be a large filling, and we could try it. But the dentist highly recommended going with the crown. And I ultimately decided to go with the crown because I trusted this dentist.

It isn't a matter of how intelligent or motivated we patients are. We just don't know, we have to trust the dentist.

I left the dentist who was overtreating us, basically because he retired. I might have stayed a little longer, but how much longer, I don't know. Because I was at a point where I was either going to run out of teeth or I was going to run out of money—one of the two. We just couldn't keep up with the pace. It also manifested itself by my deliberately not going for cleanings and checkups because I knew what the outcome was going to be. I would walk in with no pain and what I perceived to be no problems in my mouth—no bleeding, no anything—and walk out of there having to reschedule to start working on a crown.

When this issue started to come out in the local papers and in discussions with the American College of Dentists, I was absolutely relieved. Hopefully what I suspected was the issue was now going to come out. My reaction to making this public was one of relief. And also sort of a renewed hope that there were people out there who did have an ethic. I was surprised to find that there were people who would question someone else in the same profession. I called my sister and said you can't believe the conversation I just had. And then she said, "Well, we'll see what happens." So we've started to look at news articles and in papers to see what's going on.

It isn't a matter of how intelligent or motivated we patients are. We just don't know, we have to trust the dentist. It's discouraging when you find out that your trust has been betrayed. ■

Online Sources

1 www.theatlantic.com/magazine/archive/2019/05/the-trouble-with-dentistry/586039

2 https://lectures.pacific.edu/Mediasite/Play/6d5b57abd41c4ec0ad98a69197865b301d

Fighting for Quality, Affordable Health Care for Older Adults

AARP Still Going Strong after Six Decades

Lina Walker, PhD
Andrew Scholnick, MPS

Abstract

AARP's mission is to improve the quality of life for those over 50 years of age. This includes advocating for improvements in oral health as part of total health. Research informs policy creating, which in turn informs advocacy, primarily by working with organizations that share similar goals. AARP's attention to oral health is on clarifying the details and implications of adding oral coverage to Medicare.

Dr. Walker is Vice President, Health Security in the Public Policy Institute and **Mr. Scholnick** is Senior Legislative Representative, Government Affairs: Federal Health & Family Team, both at AARP; LWalker@aarp.org.

AARP has a long tradition of advocating for affordable health care for older adults, with roots in the activism of founder Ethel Percy Andrus, who fought tirelessly for elder rights. Ethel was a former school principal at a time when retired educators had limited pensions and no health insurance. One popular story is that Ethel was galvanized into action when she found a former colleague, a retired teacher, living in a chicken coop. That spurred Ethel to help retirees get affordable health insurance, eventually creating AARP in 1958.

Certainly, the situation for older adults has improved tremendously over the years, most significantly due to the creation of original Medicare in 1965. Medicare is a federal program that provides comprehensive medical coverage for people age 65 and older and people with disabilities. As of 2019, more than 62 million people were enrolled in Medicare.

More recently, the passage of the Affordable Care Act (ACA) significantly improved access to health care for millions of people without employer-sponsored health insurance coverage. This is especially important for older Americans not yet eligible for Medicare and those with preexisting health conditions.

Health Care Issues Always at the Forefront

Despite these gains, affordable health care is still out of reach for millions of older adults. Five and a half million people ages 50 to 64 are uninsured. Among adults with Medicare, half spend 16% or more of their income on healthcare expenses. Amounts above 10% are considered unaffordable.

Medicare is popular but not always well understood. Because Medicare guarantees coverage for critical medical services, many people assume it will cover all their healthcare needs. In fact, Medicare does not cover many services important to the well-being of older adults, such as dental, vision, hearing, and long-term care. For people who need those services, the financial burden of paying for these expenses can be exceedingly high and can impose significant strain on families. Forgoing that care can lead to higher healthcare costs in the future. Moreover, some services covered by Medicare, such as prescription drugs and long stays in hospitals or skilled nursing facilities, require high out-of-pocket expenses—even higher for people who are older, sicker, and more frail. These costs sometimes force families to make difficult choices about how to afford the prescription drugs or health care they need.

Our social mission is to fight for and equip every person to live their best life. Access to affordable health care is critical to this goal. Developing and advancing public policy solutions to address barriers to affordable, high-quality health care for older adults is a core activity for AARP.

Working to Improve Oral Health

Surveys of older adults have shown that oral health care is important to overall general health and dental visits are as important as doctor visits. Research funded by AARP shows that nearly two-thirds of Medicare beneficiaries do not have dental insurance and about half have not been to a dentist in the past year. The statistics are even more concerning for Black and Hispanic beneficiaries, of whom more than 65% (71% for Blacks and 65% for Hispanics) have not been to a dentist in the past year. Statistics such as these motivate AARP. But it is not just numbers that fuel AARP's actions.

Medicare beneficiaries surprised by the lack of dental coverage in Medicare and confronted with high out-of-pocket costs may be forced to delay or skip dental treatment because of cost. Often, there are downstream consequences that come with that choice, including avoiding social interactions because of missing teeth or dental pain. In fact, 15% of adults ages 65 and older have no natural teeth, and AARP's survey found over half of respondents wanted oral health coverage to manage their pain.

One key issue among oral health advocates is adding dental coverage to Medicare. But there are many questions tied to achieving that goal. Dental coverage in Medicare could take many different forms. Is it a standalone benefit similar to Part D drug plans? Is it part of the basic Part B benefit design? What is the extent of the coverage? Is it only medically necessary care, or preventative too? How much will it cost seniors? How much will it cost the Medicare program? Finding answers to these questions about policy options is one of the steps to understand how they may affect affordability and coverage for people and the Medicare program. The research that reveals coverage gaps and needs among older adults helps us understand the impact of policies on overall health, access, and equity.

Data-Driven, Evidence-Based Solutions Generation

The role of the policy research group within AARP is to solve for these unknowns and generate possible policy solutions. A curiosity in Washington, D.C. is that the term "policy" is often a euphemism for advocacy, and the words are used interchangeably "inside the beltway" (referring to the interstate highway loop surrounding the greater Washington, D.C. area). In AARP that is not the case.

The policy research and thought leadership work at AARP is separate from, but supports and informs, our advocacy activities. As a consumer-focused organization, understanding and quantifying the impact of any public policy on older adults is a primary consideration. We seek to know how policies may affect the most vulnerable groups, such as people with lower income and poorer health status, who are older and more frail, and how those policies may differentially affect people from different racial and ethnic groups. It is an important part of the policy research agenda to ensure policies help all and reduce disparities.

One key issue among oral health advocates is adding dental coverage to Medicare. But there are many questions tied to achieving that goal.

Another primary role of the policy research group is to build a foundation of knowledge about an issue, understand the opportunities and challenges, gather the evidence on interventions, identify promising practices, and develop potential solutions. It is ongoing and preparatory work so that when an issue becomes a priority within the advocacy agenda, AARP is operating from a position of knowledge and can quantify impacts and offer evidence-

An important part of any advocacy effort is to work with allied stakeholders and build coalition support. Partners can help multiply resources and amplify the message. The most effective advocacy efforts are able to demonstrate to legislators and policymakers the importance of an issue to a wide swath of Americans.

based solutions. As we seek to address the range of questions on oral health coverage, our surveys, focus groups, and research help us understand the concerns of older adults and ensure that policy solutions address the needs of current and future generations, especially those who are most in need or vulnerable.

One advantage of an objective policy research group within AARP is our ability to bring together diverse stakeholder groups and people with diverse perspectives. For instance, an AARP Innovation Roundtable to discuss oral health and the unique considerations for vulnerable adults brought together disability advocates, mental health advocates, nursing home administrators, community oral health providers, researchers, and oral health advocates. Convenings like this provide participants with a forum to share experiences that shed light on a problem and to discuss new and emerging ideas to solve problems. Bringing together groups that do not usually speak to each other can reveal important insights, as this one did.

A good idea that no one knows about or few support has limited value in the public policy world. To that end, a key activity of the policy research group is to disseminate potential solutions and promising practices through publications or public forums. Awareness and support from key policymakers, their staff, and influencers are essential so that these good ideas and practices are incorporated into public policy, whether at the local, state, or federal level. Depending on the topic's importance with consumers, a complementary approach is also to share these solutions directly with consumers through AARP's many communications channels to create a groundswell of support.

Effective Advocacy

AARP's policy research agenda is separate from but aligned with advocacy. Policy analysis and solutions development inform the advocacy portfolio, but AARP's advocacy priorities are decided separately, based on many factors and in context of other issues on AARP's agenda. AARP is active on a wide range of aging issues, such as Medicare, Social Security, consumer protection, financial security, and family and caregiver support issues. Within each of those areas are multiple sub-issues requiring attention and action.

As noted previously, one key issue among oral health advocates is adding dental coverage to Medicare. That, however, is a significant undertaking. Likeminded stakeholders will have to be brought together to coalesce; opposing stakeholders will have to be countered; and legislators will have to be convinced to vote in favor. Any change to a government program, particularly one affecting so many people and with such a large financial impact, is politically fraught.

AARP is typically the largest organization involved in Medicare-related political battles. Our volunteers and members are our strength, as they are active in writing and calling their legislators. They also vote in high numbers relative to the rest of the electorate. Unlike many other advocacy stakeholders and interest groups, AARP is nonpartisan, and we do not make political donations or endorse candidates. Our role is to educate the public and policymakers, and to advocate on issues important to older Americans.

AARP has a variety of tools at its disposal. Effectively advocating for a law or policy change can involve any number of them, such as:

- letters or statements expressing AARP public policy
- AARP staff meetings with legislators
- AARP volunteer meetings with legislators
- AARP members emailing or calling their elected officials
- letters to the editors of newspapers or websites
- TV or radio advertisements to develop public support
- social media promotion

One path, for instance, can be writing a letter to policymakers stating a position for the record; this serves as notice that AARP is paying attention to an issue and has a preferred outcome. From there, AARP lobbyists meet with those policymakers to discuss the issue and educate them on solutions that benefit older Americans. On many issues, AARP is uniquely positioned to ensure the voice of older Americans is heard during crucial policy debates. Our presence in all 50 states and U.S. territories, as well as 38 million members who are likely voters, gives us many ways to mobilize members and represent their interests.

These advocacy tactics are common across many organizations, large and small, nonprofit and corporate. AARP has an advantage, though, with nearly 38 million members, a large, active, and nationwide volunteer structure, and an age 50+ population that make up the most reliable voters.

Other allied stakeholders often look to AARP to take the lead on specific advocacy issues. Many factors, such as importance to membership, achievability, and competing issues, play into the decision of how and whether to engage. A multi-issue organization cannot make every issue the most-important issue, or else it risks diluting its message and becoming ineffective. No organization —even one as large as AARP—can effectively launch a massive advocacy effort around multiple issues. If everything is the most-important-thing, then nothing is; and policymakers would not know the organization's true priorities.

An important part of any advocacy effort is to work with allied stakeholders and build coalition support. Partners can help multiply resources and amplify the message. The most effective advocacy efforts are able to demonstrate to legislators and policymakers the importance of an issue to a wide swath of Americans. Coalitions, especially diverse partnerships with varied interests, can show that the proposed solution is in the broader public interest.

Even with strong coalitions, adequate resources, and high recognition, implementing policy change is never easy. AARP often faces off against other stakeholders who are either entrenched in the status quo or would benefit from a different proposed solution. They have their own coalitions, resources, and messaging. Because of the constant tug-of-war in public policy, even the seemingly smallest changes can take years to enact. It was, therefore, a significant achievement that the House of Representatives passed legislation in 2019 to include a dental benefit in Medicare Part B. Unfortunately, the legislation was not taken up by the Senate. But to effect change, advocacy organizations such as AARP must commit to seeing their goals through to the end.

Conclusion

AARP's healthcare advocacy engagement is a thoughtful and deliberate process. It is grounded in evidence and supported by data to ensure that the policies we advance help older adults live their best lives. Every day, 10,000 new adults sign up for Medicare. Meanwhile, system shortcomings continue to deny people the care they need, and so issues such as oral health for older adults will continue to be important.

The nation has accomplished much in health care since the day Ethel Percy Andrus discovered her retired former colleague living in a chicken coop, yet much work remains. AARP will continue with that work, pushing to achieve further advances in meeting the healthcare needs of older adults.

Lifting Up the Voices of the Unheard Patient

Lantz Rubin
Margaret Brooks
with Pamela Arbuckle Alston, DDS, MPP, FACD

Abstract

We tend to make assumptions about those with whom we have irregular interactions, especially those who do not fit the behavior patterns of those we see more often. In turn, their behavior is guided by some assumptions about us that could be surprising. The best way to work out these differences is to listen to each other's stories. A dentist interviewed two patients who have irregular dental visit habits. One is a contract professional, the other a retired individual with a disability. Neither attends the dentist regularly. Here are their stories, in their words, transcribed from the interviews. Context has been provided at the beginning and end by the interviewing dentist.

Lantz Rubin works on a contract basis as a surgical technician. **Margaret Brooks** is retired and disabled and on government support. **Pamela Arbuckle Alston** is the National Dental Association President-Elect and a Volunteer Associate Health Sciences Professor at the University of California San Francisco School of Dentistry and past president of the Northern California section of ACD; psarbuckle@aol.com.

Pamela Arbuckle Alston: Introduction

There is a group of patients dentists know little about because their contact with the dental delivery system is spotty. Often they present for a visit with a pronounced need. They look like they do not value their oral health because it seems so neglected. They look like they are only seeking relief from pain. They make it seem as though dentistry is not reaching everyone in need.

It can be liberating for patients to translate their dental journeys and experiences into words. The chief complaint is never the full story about how conditions go to this point or why the visit is taking place now. Often these patients do not feel empowered or know the impact of their stories on others when they tell them. But when they voice their concerns they empower dentists to unpack their preconceived notions if they have teachable spirits. Their stories show how oral health fits into a pattern of personal life values that is different, in so many ways, from the perspective of dentists.

Lantz Rubin

As early as I can remember, I had teeth very sensitive to hot and cold. And I do remember that my sensitive teeth affected my eating patterns. I was told that as a child, I didn't eat very much. A lot of times when I would go to the dentist as a child, it was because I had sustained an injury. I've had teeth knocked out on three or four different occasions. The first time I lost a tooth was when I was 11 years old. During a rock fight, a rock hit my face, busted some teeth. I was 13 years old when I lost my second tooth. I fell off a bike, landing face first in the street. I knocked out one of the teeth I busted two years earlier. The other tooth that was busted is still hanging on today for dear life. My dental memories as a child were all about dental pain and repair.

Living between my mom and my dad early on, I never really had a consistent dentist, so I would just go here and there. My mom and dad always made sure I brushed my teeth. Once I reached adulthood and was on my own, I went to the dentist every couple of years for teeth cleaning. The other reason for visiting a dentist was for extractions when I had toothaches. Gosh, when I say it out loud, it sounds like I don't really care about my dental health. In hindsight, I admit that I could have done better. I am pleased to report that nowadays I am brushing my teeth regularly and drinking more water than sugar-sweetened beverages. I am doing the things I am supposed to do, but I am still having all of these issues with pain and sensitivity.

I just have this recurring feeling every couple of years that another tooth is going to go bad and I will need more root canal treatment. I am

resigned to the reality that by the time I reach my fifties, I won't have any teeth left. Then I'll just get them all replaced. I am not bitter. It is my dental situation, but it does preoccupy my thoughts and my dreams. I've dreamt probably five or six times waking up and spitting out a mouthful of bloody teeth. I don't know if this dream emanates from the experience of having so many broken teeth in my mouth. It is what it is. It does make me a little fearful though because I do have a history of broken teeth and broken temporary crowns. These dreams are disgusting because they feel so real in the moment. I am totally relieved when I come to my senses after waking up and realize that my mouth is not bloody. Ah, the dream is just gross. It is more a feeling of fear than disgust though.

Hey, dentistry is expensive. But the cost of dental care is only an issue when I am between jobs because my regular jobs have provided dental insurance. I make sure my children go to the dentist even when they are not covered under insurance. I just have to do better for myself. I don't necessarily go to the dentist when I have insurance but when I find myself between jobs and I need dental care, I think to myself, "I can't wait to get dental insurance again."

I just have to do better overall. I keep my cleaning appointments when I have dental insurance because the dental offices call me on their own to schedule me. I go because they call me to come in. I don't even know how necessary it is for them to give me a super-flossing or the powerful tooth paste. But when I have insurance, the visit only costs my copayment share and a day off from work. So, I just go because they say, "Go."

Hey, dentistry is expensive. But the cost of dental care is only an issue when I am between jobs because my regular jobs have provided dental insurance.

As far as treatment, I would like some bridgework because I have five missing molars and it just gets hard to eat sometimes. Plus, I get injuries to my gums sometimes when I eat. Replacing those missing teeth is just something I want to upgrade in my life.

I have no complaint about the manner in which dentists have treated me. I feel like all my dentists have treated me with respect. But I feel like there is a slight air of fingers being pointed at me. Maybe it's my own guilt. Maybe it's their style. But I have seen a lot of dentists and all of them convey that they expect me to do better or keep my teeth clean, brush more, and floss more. In general, my dentists have been pretty nice to me. I wouldn't keep going back to a dentist who was not nice or respectful. But it is like a parent-child relationship so to speak. It's not disrespectful in any way. I am cognizant of their authority. They know they have power over me.

I have been going to the same office for a period of time where there are three dentists. I honestly don't know one from the other because I don't see the same dentist each time. Sometimes when I needed something, they referred me outside the practice. The reasons they have given are "I don't do that" or "it's not in my skill set." It is the specialist to whom they refer me who really saves the day. The specialists are always nice and respectful too but it's like, "Now you owe me money. Pay me." I can respect that. But I can't help but think that sometimes the most desperate times are the most expensive times for me.

My aspiration at this point is to get acquainted with a dentist who will be like a coach for dental health care. In my mind, it would be a general dentist who could help me get my missing teeth replaced and avoid any more root canals. I want to go with a new dentist, stick with that dentist and stop

bouncing around. I would not go back to any of the dentists who have treated me before because I don't feel like they have been there for me. At the last group dental office, I was bounced from dentist to dentist and I couldn't understand why. I don't know if it was for their convenience or they just didn't have time for me or if a dentist needed more practice.

Before I go to the dentist again, I am going to need to get some insurance because I currently have a per diem job and dental insurance is not a benefit. I don't know if I qualify for Medi-Cal. The last time I applied, I was denied because I made too much money. I hope to have dental insurance again in the next year because it looks like I will be offered a regular position at work in the next year. If I don't get the regular position, I will investigate enrolling my children and me in a group insurance plan through my personal business.

It should be easier for dentists to provide actual care without all of the runaround and paperwork. There is "coverage this," "document that," "payment here," "copayment there." It just seems that dental care is too much like a business and not about care. They should just call it dental or dentistry and not dental care. It seems like there is so much red tape for dentists and other healthcare workers in general to use their skills to improve lives. I will probably be dead before my mouth is fully restored.

If I were able to pass on a message to the leaders in dentistry, the message would be that the general public is in desperate need of dentists' skills and their hands-on application not only in dental offices but also outside dental offices in the community. The general public needs the dental profession to use its influence on the food and beverage industry. The food and beverages that are rotting our teeth are too accessible. And in low-income communities, healthful food is not accessible enough. Dentists need to be in our faces doing hands-on, grassroots work in communities to promote dental health. I recognize that dentists are doing some of this already but they need to reach more people.

It seems like you have to be seriously underprivileged or financially secure to get dental care. There are so many people like me who are in the middle that have the attitude that they will take care of their dental conditions when they can. Take me, for example. I need thousands of dollars' worth of dental work and it will easily take a full day for a dentist to treat all of my dental problems. It is so frustrating for me to be a healthcare worker myself but one who is paid by the hour and cannot afford full dental care. I think we need more missionary work in the United States.

I have some pretty strong views on health care. My mouth is part of my body. Health plans should treat it just like any other part of my body. For example, if I break an arm or if I need gallstones removed, I can use my health insurance for care. But for dentistry, I need a separate insurance.

The "haves" can pay out-of-pocket or they have good jobs that provide dental insurance for their dental care. There is public dental insurance for the "have nots." But there is a third group. I call them "the half-way there" group, you know, the ones who "fake it 'til we make it," who kind of "look good 'til we get there." That's the group I fit in. I don't have private dental insurance and I don't have the $7,000-$8,000 cash to pay to restore my mouth. And I make too much to qualify for Medicaid.

People say "the struggle is real." I say, "The fluctuation is real." Sometimes I am doing just fine. I had one month in 2018 when I earned almost $15,000 on the clock. And I had dental insurance provided by that job. But I was working about 80 hours per week and I didn't have time to go to the dentist. And now that I don't have that job, I have time to go to the dentist, but I don't have dental insurance and I don't have the cash to pay.

Margaret Brooks

It is my determination to go to the dentist every year, but it has not always been easy. Of course, when I was a child my parents took me to the dentist. I didn't have a choice. I didn't like going to the dentist. I had quite a few cavities as a child so I knew about the drill. I could hear the drill while I sat in the waiting room and by the time I sat in the dental chair, I was all worked up and scared. By the time I grew up I was really apprehensive about going to the dentist. And fortunately, I had options.

As an adult, if the dentist used instruments roughly in my mouth, I didn't go back to that dentist. If the dentist hurt me, I didn't go back to that dentist. When I was not treated respectfully, I didn't return to that office. Don't get me wrong. I knew I needed to see the dentist. As an adult I have suffered with major health conditions that are affected by good dental health. So I would research dentists and read their reviews before selecting a new dentist. There has never been a shortage of dental offices in my neighborhood community.

So, I have had a choice always. When I look for a dentist, I look for one who will communicate findings from the evaluation and will tell me what he or she is going to do before treating me. I like to have the chance to ask questions.

I have mostly encountered problems when it comes to finances. As far as finances, I haven't always had them. I am disabled now but when I worked, I usually had dental insurance as a job benefit. There was a gap at times between having private insurance and having public insurance due to my employment situation. When I have not had insurance, I have not had money either due to unemployment. I went to the dentist anyway, however. I asked to be placed on a payment plan. Dentists who wouldn't give me payment plans at least gave me the courtesy of telling me how to take care of my teeth on my own by telling me to do things such as flossing, brushing twice a day, changing my tooth brush every two to three months, and having good nutrition.

I admit I am not the best patient when it comes to keeping dental appointments. I have a tendency to be late for appointments or to miss them outright. Dental offices don't necessarily reschedule me soon due to a backlog on their schedules. I think two or three months is a long time to wait even when I have had an emergency like an abscess. When I have an abscess, I think I should be rescheduled right away.

For me, it takes a lot out of me emotionally to go to the dentist. You see, I suffer from anxiety. My primary care physician prescribes medication for my anxiety and I take it before I visit my dentist. It helps keep me calm.

For patients like me, I think dentists need to step outside the box. Let us watch videos and read hand-outs on maintaining dental health while we are waiting to see the dentist. Take every opportunity to educate us. The motivation for some patients like me to go to the dentist is because we have underlying medical conditions that are helped by having good oral health. Talk one-on-one to us. Explain what is going to be done before starting the procedure. Take extra steps to make patients like me feel comfortable. Dentists should do everything they can to satisfy me because you see, if I don't feel comfortable I don't go back. And I go onto social media and write bad reviews.

> As an adult, if the dentist used instruments roughly in my mouth, I didn't go back to that dentist. If the dentist hurt me, I didn't go back to that dentist. When I was not treated respectfully, I didn't return to that office.

Pamela Arbuckle Alston: Reflections

Neither patient is dissatisfied with the quality of treatment he or she receives. They are dissatisfied that they fail to advocate for themselves. The reason could be a lack of confidence, or it could be that they don't believe they would be understood. Subsequently, they exercise their autonomy to leave dental practices and seek other dentists or extend the time without an appointment. Margaret Brooks leaves when she does not feel empowered to discuss the quality of her interaction with the dentist or practice staff when she feels disrespected. Lantz Rubin does not have an issue with the level of respect shown to him. However, he is not empowered to discuss with the dentist what the interaction is lacking. He leaves to see if the next dentist will be a coach of sorts who will motivate him.

The storytellers in this article do not blame the dentists for their oral health conditions. They assume responsibility for their oral health status. They may, however, pick up verbal and nonverbal cues about identity, privilege, and power that inhibit disclosures to their dentists.

We must build a culture of health that encourages patients to disclose what is most important to them. Dentists are accustomed to thinking they know what is best for patients. Dentists can help patients build better rapport if they take the time to find out what is important to the patient. Regardless of the oral health conditions with which patients present, they seek a listening ear without judgment and the opportunity to tell their stories. Their stories may be more important than their chief complaints. ■

The Future of Dental Insurance

Terry Norris, DMD, FACD

Abstract

Prepaid group dental benefits (insurance) has been part of oral health care for just a little more than half a century. It is a four-way partnership involving patients, employers, dentistry, and the insurance industry itself. The interests of these groups are in constant adjustment and not under the complete control of any of those involved. This report reflects some of the major decisions surrounding introduction of the system and its current features. Although it is difficult to say what the future holds, this is important enough to justify studying the matter and trying to find the path that will optimize oral health.

Dr. Norris is a certified consultant with American Association of Dental Consultants, past president of the Kentucky Dental Association, and regent for Regency 4 of the American College of Dentists; doc@drterrynorris.com.

At a glance the future of dental insurance is clear: Yes, it will be here for years to come. Determining what form it will take is a totally different and more difficult matter. Given the difficulty of this topic I am reminded of the words of my father: "If I had only bought Wal*Mart." The information provided here is from my years of experience in the dental insurance industry and is based on what we knew at the time. We do not describe the future: we predict it. The views expressed here are mine and do not necessarily reflect those of the American College of Dentists. I would like to look at where we have been and where we are today before projecting into the future.

The Past

To begin, let us look at the history of dental insurance and the state of dental health prior to dental insurance; this will put the discussion in its proper perspective. Ravi Zacharias has said, "The only thing worse than nostalgia is amnesia." Most of the retired dentists and some of the older dentists know quite a bit about the inception of dental insurance, while our younger colleagues know little, if anything, about its history.

Statistics from the National Institutes of Health show since 1955 edentulism has decreased by 78% with the greatest impact on males and in the African-American community. This is verified by the Centers for Disease Control and Prevention (CDC), which shows edentulism declined from 18.9% in 1956 to 4.9% in 2012. In another CDC study 30% of adults in the age range 34-39 had no tooth loss for the period 1988-1994. That statistic improved to 39% for the period of 1999-2004. To claim this is solely the result of dental insurance would be absurd. In the last 65 years we know that fluoridation of municipal waters has reduced dental decay. We know there is greater access to dental care, especially to low-income individuals with government assistance. We know that two-income households produce spendable income, which promotes regular dental treatment. We know that dental insurance encourages patients to seek regular dental exams, which have slowed the decay rate and allowed diseased teeth to be treated early, minimizing major dental treatment. Practice Booster, an organization that works to inform dentists about the insurance industry, in its October 2019 newsletter stated that studies have shown patients with a dental insurance plan are twice as likely to go to a dentist as patients without a dental plan.

In 1954 a labor union, the International Longshoremen's and Warehousemen's Union and the Pacific Maritime Association (ILWU-PMA), sought to provide its members and dependents with dental benefits. The group representing these workers, presented the idea of dental coverage along with $750,000, to the dental associations in California, Oregon,

and Washington. Soon after, the first three dental benefits organizations were formed. The Washington Dental Service was founded in 1954, and the Oregon Dental Service and the California Dental Association Service followed in 1955. By 1957, nearly 2,000 children were covered by the California Dental Association Service, which later developed into Delta Dental of California, and by 1963 nearly 7,000 dentists joined the California Dental Service network, which had almost 235,000 people covered. As the demand for dental coverage grew, the American Dental Association recommended having a national agency to coordinate coverage across different states. In 1966, Delta Dental Plans Association was formed under the name National Association of Dental Service Plans. The following year, Delta Dental of Washington partnered with the International Association of Machinists to provide the first dental benefits plan across state lines.

The architects and participants of prepaid dental care learned a great deal from their experiences over the next 20 years as they pioneered this new niche in health care. "Part of the problem was that any who knew, or thought they knew, the medical business assumed they were automatically experts in the dental business; not so, they are significantly different in many fundamental ways," Eric Bishop noted in his 1983 book *Dental Insurance*.

Now let us advance to 1966 with the implementation of Medicare. Ironically, one-half of today's dentists were not even born then. The American Dental Association lobbied to keep dentistry out of Medicare, which led to the final separation between medicine and dentistry. Whether this separation was good or bad is still an open question. One firm conclusion is that it protected the business side of dentistry, which made the profession more profitable and kept government intrusion in check, unlike in medicine. Take time to speak to medical doctors and you will hear that given the choice, they would encourage their children to go into dentistry as opposed to medicine. Why? Dentistry is more profitable and dentists are not handcuffed with insurance or government oversight like medicine. You may ask what this has to do with the future of dental insurance; stay tuned.

My mentor, who graduated from dental school in the mid '50s, bemoaned dental insurance. In the '60s and '70s dental treatment was very affordable and cash was king. Why would you want to change that? As for me starting practice in 1978, insurance proved to be a practice saver. It was a needed adjunct in assisting in payment for my patients' treatment.

How did dental insurance progress from 1954, and especially 1966, until now? The most obvious feature is that the annual maximum, for the most part, has remained at $1,000 per yearly benefit period, although some plans have increased their annual maximum to $1,500 or $2,000 per yearly benefit period. When I began my practice in 1978 the typical fee for a crown was $160. With crowns covered at 50% and a $1,000 benefit period maximum, one could easily do 12 crowns in a benefit year and not max out the patient's benefits. Today two crowns will drain the benefits for a typical plan. I have encountered only one plan that has an unlimited benefit period maximum. This has had a great impact on dental practices in that patients are leery about paying for more dental services in a year after their benefits are exhausted.

> Practice Booster in its October 2019 newsletter stated that studies have shown patients with a dental insurance plan are twice as likely to go to a dentist as patients without a dental plan.

Employers are always looking for

With the advent of value-based, or outcomes rather than service-provided, dentistry, these data contribute to standards for patient care-seeking behavior and quality of care provided per reimbursement costs.

ways to curb the ever-increasing costs associated with dental and health insurance, and one way that insurance carriers have accommodated them is with the creation of Preferred Provider Organizations (PPOs) and Dental Health Maintenance Organizations. These two entities have had a negative impact on the business of dentistry in capping and managing fees that its providers are permitted to bill their patients. Some carriers that offer a "premier plan" and a PPO plan are no longer allowing new providers to opt out of the PPO plan. In other words, to become a provider you must accept both plans. This is advantageous for the insurance companies in that they can market and sell more PPO plans because providers are being coerced into signing up for both plans and employers are saving money by choosing a PPO plan. Due to the expansion of PPOs in particular, P & R Dental Strategies stated in 2018 at the annual meeting of the American Association of Dental Consultants (AADC) that insurance reimbursement fees decreased 17%. Practice Booster in the same newsletter cited above echoed the fee decrease by a much smaller amount but went on to add that with new restrictions, limitations, and waiting periods reimbursements had decreased. How can a profession, especially a dental practice, remain viable when fees are being reduced amidst the fact that the cost of dental equipment and supplies is increasing faster than inflation?

I would like to say one important thing in defense of insurance companies. There is one thing that most dentists or insurance clerks in the dental office do not understand. The level of coverage, which includes the annual maximum, the annual deductible if present, and the coinsurance, is determined by how much the employer is willing to pay and how much the employee is willing to contribute towards the monthly premium. If the annual maximum is raised from $1,000 to $1,500 there is a liability the insurance company will incur that has to be offset by the monthly premium. The same scenario occurs, for example, if coverage for "quad scales" for three or fewer teeth is added. The premium must be adjusted to cover the increase in liability to the insurance company. With medical insurance rising at a pace much greater than inflation, an employer is apt to reduce the dental and vision coverage in order to make up for the increase in medical insurance premiums. The PPO plans have fit right into this situation to save the employer and employee money by decreasing the premiums, which in turn reduces the allowable fees for the dentist, thus reducing the amount of the copayment the patient owes. This is totally at the dentist's expense and impacts the dentist more than the insurance carrier. Dentists must learn to be proactive and approach their patients' employers to lobby for adequate dental coverage that is equitable to both the subscriber and the dentist.

The Present

A relatively new twist in the discussion gaining momentum in the last five to ten years is the fate of the McCarran-Ferguson Act. It was thought in the beginning days of health insurance that nationwide control was needed when states did not provide adequate regulations to prevent antitrust violations. Hence, the McCarran-Ferguson Act was initiated in 1945 to provide oversight. This provision was originally instituted to ensure the viability of an infant product, health insurance, and allowed insurance carriers to communicate across state lines, which no other entity had. A partial repeal of this act would amend the section of McCarran-Ferguson that exempts the insurance industry from important provisions of the Sherman Act and the Clayton Act—acts that have the purpose of ensuring fair competition. If passed, this legislation will help level the playing field between health insurers, providers, and consumers. It may also help to make dental insurance more affordable for all Americans. Have you ever wondered how certain insurance companies with

the same parent name have the same fee for your area even though that specific carrier may be in California or Tennessee? Because of this provision, communication is allowed that permits fees to be set across the subsidiaries of parent carriers. Not only that, there is also no wiggle room for providers to negotiate contracts with any success unless one is a specialist. In 2010 a bill for partial repeal of McCarran-Ferguson was passed by the House of Representatives and from there it stalled. In 2017 a bipartisan bill for the repeal of McCarran-Ferguson was passed by the House with a vote of 416-7 and again it stalled. Once again in February 2019 Sen. Steve Daines (R-Montana) and Sen. Patrick Leahy (D-Vermont) introduced S. 350, the Competitive Health Insurance Reform Act in the Senate, which would also provide a partial repeal. We are still waiting for the Senate to bring it up for a vote. As of September this year, H.R. 1418, the Competitive Health Insurance Reform Act, passed again. The good news is that this time it was on a voice vote as opposed to a roll call vote, which indicates overwhelming support without dissension. The saga continues; perhaps the 117th Congress will finally pass H.R. 1418 next year.

Unlike medical insurance, there is no, or very little, portability of dental claims history between insurance companies. This is changing in that carriers now have the option of subscribing to services provided by P & R Dental Strategies. What does this mean? A dental carrier can run its claims through P & R and have the services recorded not only by the provider but also the patient across different insurance carriers. The following figures were provided at AADC in 2019. In the DentaBase there are 65 dental payers contributing data from 67 million members totaling three billion procedures at the rate of 90 million procedures per quarter, and it includes at least one claim from 93% of the dentists within the last 60 days. This means there can be a claims history on Patient A across different carriers showing a crown completed that was paid by Carrier A in 2018, which would be denied by Carrier B if redone in 2020 due to frequency limitations. Also, providers can be profiled as to filling/crown ratios and prophy/quad scale ratios, to name a few procedures. Other data that are maintained track remake frequency pertaining to fillings, crowns, bridges, etc. With the advent of value-based, or outcomes rather than service-provided, dentistry, these data contribute to standards for patient care-seeking behavior and quality of care provided per reimbursement costs.

Many states have passed legislation calling for prompt payment of clean claims within 30 days. Most providers assume this applies to every dental claim. The exception however is a new entity, ERISA. This stands for Employee Retirement Income Security Act of 1974, which is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry with a goal of providing protection for individuals in these plans. These plans are not subject to the 30-day rule and, in fact, these plans are becoming more prominent. Growing numbers of employers are self-insured and are asking for insurance companies to be Administrative Services Only. In this scenario the insurance company will pay the received claim to the provider and then bill the employer for the claim amount paid plus a negotiated fee for processing the claim. These fall under ERISA and now account for 50% of plans, and they are growing faster than traditional plans.

The National Association of Dental Plans had a paper presented by West Monroe Partners, a consulting firm, at its September 2020 meeting dealing with "The Fate of Standalone Dental: Revisited." The data are showing that more medical plans are now offering dental as a separate policy or imbedding the dental coverage within the medical policy. Practice Booster states that the number of medical insurers with adult dental coverage has doubled in the last year. With dental plans being offered as part of medical plans it may be difficult to chart what is collected for dental premiums and how much is being spent on dental. I am reminded of the movie *Forrest Gump,* which had a production budget of $54 million, grossed $700 million at the box office, but showed a $62 million loss on paper. As we have seen, dental insurance is much simpler than medical insurance. Our ADA CDT Code Book pales when compared to the ICD 10 Code Book. There is a trend by some dental insurers, in order to cut costs, to have surgical procedures filed with the patient's medical insurance before it will be considered for payment by the dental insurer. In a typical dental office, you may have one or possibly two individuals who are adept in their knowledge of the CDT Codes and filing dental insurance. Ask them about CMTs and ICDs and they will think you are speaking a different language. This would be a nightmare for the majority of dental practices,

with the exception being an oral surgery practice.

The Future

I am reminded by my friends at American Dental Political Action Committee (ADPAC) that they are neither Republican nor Democrat. They are members of the Tooth Party. ADPAC does advocate on the legislative side for dentistry and does a great job. It is ironic that the PAC chair in my state, who is a good friend of mine and in the same city, happens to be a member of a different political party than I. However we are both members of the Tooth Party and work together for the betterment of our profession.

What does this mean for the future of dental insurance? ADPAC has been at the forefront in pushing for the repeal of McCarran-Ferguson, and I predict its role will increase in future elections. The old adage, elections have consequences, is becoming more true with each election. Who would have believed that the Affordable Care Act would have ever passed in 2010? Even in the 2008 election it was not a major campaign item. Now let us jump to 2020. "Medicare for All" is the number-one campaign promise for one of the parties. If there is a change in administration every effort will be made to make this campaign promise a reality. Whether some version of this concept is good or bad is up for debate.

The future of dental insurance involves the tracking of procedures by patients and providers across carriers. The future may involve the repeal of McCarran-Ferguson to give dentistry more bargaining power and help reimbursement rates.

Dr. David Lustbader, who is an oral surgeon from Massachusetts and is an advocate for dentistry within his state, echoed the message at the 2018 meeting of the AADC. One scenario he gave involved the reimbursement rate regarding an extraction. I will add to what he said to put it in perspective. Consider that an office charges $175 for a simple extraction and Insurance Carrier A covers it at $110 and Insurance Carrier B covers it at $96, both of which are sizeable write offs. Dr. Lustbader postulated that under socialized dentistry that fee would be $59, which is close to a Medicaid fee level. After having spoken to several others who have knowledge about the fees, I was told that the fee would probably be more like Medicaid plus 10% or Medicaid plus 20%. The fee for the extraction would now be $65 to $70 which is unsustainable unless patients paid for dental care with cash as they did previously. How can a dental practice, as we know it today, survive these write-offs and still deliver not only our high standard of care but also retain that close patient relationship while dealing with an overwhelming federal bureaucracy? It will become a numbers game that involves treating an exorbitant number of patients in order to pay for dental materials, to maintain the latest technology and equipment, and to retain staff—not to mention student loans. The key phrase is "as we know it today." The future of paying the costs of providing oral health care will probably not be like it is today any more than the future in 1950 looked like the past then.

We have seen the inception of dental insurance which broadened the access to dental care and the current state of diminished reimbursements, restrictions, and regulations. The future of dental insurance involves the tracking of procedures by patients and providers across carriers. The future may involve the repeal of McCarran-Ferguson to give dentistry more bargaining power and help reimbursement rates. The worst-case scenario for the future of dental insurance will likely be its inclusion into a single payer system, which sounds like Medicare for All. No one, to my knowledge, is seriously considering the option of doing away with dental insurance.

In closing I would like to update my father's words from the beginning of this paper and make them mine: "If I had only bought Amazon." Predicting the future with any certainty is both risky and essential, however we now have food for thought. My father did make a prediction when he decided to pass on investing in that upstart retailer from Arkansas. He predicted that it was not worth looking into, and his prediction was wrong. ■

Regulation and Lobbying for Dentistry

An Anonymous Professional Lobbyist

Abstract

Regulations serve to protect the public generally from the unequal distribution of information, and sometimes power and misinformation, that would imbalance or hold back the common good. Only representatives of the public, usually elected officials, have the authority to put regulations in place, to inform the public about them, and to monitor and enforce regulations. Lobbying is the attempt by groups to assist public representatives in crafting wise regulation. In its broadest sense, lobbying includes interest groups representing citizens, commercial interests, and ideologies. It may include firms hired by legislators to fact find or fact check. The presumption is that the effect of a rich adversarial mix of lobbying interests will result in fully informed policy making. The process of crafting and using regulation has well-known shortcomings, such as cost inefficiency and misdistribution, unintended consequences, and even the perpetuation of privileges and the further imbalance of the playing field. Society without regulations would be the Hobbesian "war of all against all."

This article was prepared by a professional lobbyist. He has several decades of experience working for a firm that does primarily contract lobby work for legislators at the state level. Most often his clients are elected representatives who feel they need additional, independent information about the effects of proposed legislation.

Regulations come in two types: those others benefit from but we complain about and those we like and could not imagine doing without. Professions are highly regulated in their commercial interactions, always for the safety and benefit of the public. The very license to practice dentistry is a regulation. Regulations flow from the democratic process beginning with legislature and issuing in administrative implementation. The key bridge between the legislatures and everybody who seeks various forms of regulation is the groups of professionals who provide information to the legislature: lobbyists.

The Structure of Regulations

Regulations are a secondary market: they are rules about what can be done and what cannot be done in "free" markets. The notion that everything works best when all parties maximize their self-interests, while allowing others to do the same, exists only as a slogan embraced by a few academics and those who are doing well. Economists insist that one of the requirements for a free market is that all participants have timely access to full information. Dentistry is certainly not a free market. As with virtually *all* trade and interest groups, there is much to be gained by preserving privileged information and by promoting mechanisms that control the free flow of some vital facts (so-called proprietary information) and thus shaping the nature of the decisions to work in one's favor. Of course there are differences regarding how much "adjustment" is appropriate, and interest groups might be thought of as clubs seeking to advance patterns of regulations that most benefit their constituents. Generally those who are doing well by the current play book resist changing the rules, and there is grumbling about regulations that favor others. It is commonly felt that a market is free when it has been properly adjusted by regulations that promote some ideal of the public good. The second most desirable situation is where competing interests have been legislated to the point where no party has an opportunity for further gain by straightforward or by questionable means.

Some examples of regulation include rules that only dentists can practice dentistry, that various procedures such as sedation be limited to those with certifications, that drugs and devices used in dentistry present scientific evidence that they are safe and efficacious, that various categories of practitioners not be allowed to perform procedures other than those allowed in their jurisdiction regardless of competence, that noncompetitive clauses are enforceable, and that insurance companies meet standards for fair practice in the states where they are allowed to operate. The health professions began to be regulated from the very beginning of this country, and were only briefly interrupted in the

populist presidency of Andrew Jackson, before being continually strengthened since. This Wild West of Painless Parker would be acceptable to just a few today. At the turn of last century, drugs were not regulated and "patent medicines" were sold to the unsuspecting public based on who was willing or desperate enough to believe the claims. The term "patent" referred to the fact that the active ingredients of the drugs were protected by patent from being revealed to the public. Generally there is sporadic interest in new regulation or calls for stricter enforcement following breakdown in common sense, such as Dr. Acer in Florida transmitting AIDS to his patients or Dr. Harrington in Oklahoma whose practice was shut down because of gross unsanitary conditions.

Because regulation is about how the "fair" playing field should be laid out, democracies have delegated the ultimate authority for creating, modifying, or putting down regulation to elected officials, with review by the judiciary for consistency with the entire body of law and enforceability. Responsibility for implementation is left to various administrative bodies. Implementation includes operational clarification, public notice, registration and record keeping, investigation, mediation, enforcement, and reporting.

Regulation is an expense the public accepts in expectation of protection from abuse. The argument by those who favor any particular form of regulation is that the cost can be spread across many and the expected benefit to the many will be greater than the cost. Legislatures and other governing bodies have to decide whether they think that is the case. This determination is frequently second-guessed by those who feel they are contributing more than their fair share to the public good.

Regulation is both national and state (and even local). Because regulation is essentially about fair commerce, the determination of jurisdiction turns on the definition of the relevant market. Interstate commerce, per definition, is a national matter. Whether a dental office can be opened in a residential neighborhood is a local issue. The provision of health care has historically been considered a state matter. The U.S. Constitution specifically notes that matters that are not national are reserved to the states. This explains why dental practice acts and their implementation differ from state to state. Further, the same reasoning applies to other matters subject to regulation such as the practice of law, building contractors, real estate agents, banking and accountancy, and so forth. Dentists interact with all of these regulated and thus licensed groups. This means that two dentists in different states who are identically qualified may nevertheless have to adjust parts of their professional lives to accommodate differences in the context of dental practice.

There are some factors that cause strain on the dominant pattern of state regulation of dentistry. Increasingly dentists are moving from state to state and are calling for reciprocity and portability of licenses. Telemedicine and "medical tourism" are blurring the lines of locus of treatment and at least raising the question of states needing to ensure the safety and efficacy of their citizens' health regardless of where care is provided. As corporate ownership of dental practices advances, new questions will spill over state boundaries.

The regulation of health practice at the state level typically involves the creation of statutes by legislatures. These are broad laws establishing a structure for required or prohibited practices or circumstances of practice. For example, a state may enact a statute that no patient can participate in telemedicine until after he or she has been examined in person by a licensed practitioner physically residing in the state who has written a prescription for remote treatment. Or a legislature may enact statutes stating that a hygienist cannot bill for services, except in the case of patients in a nursing home.

Implementation of statutes is accomplished through rules, or what is more commonly known as "regulation." Regulations are crafted to carry out statutes and are more specific. They cannot be contrary in intent or effect to the statutes, but some latitude emerges, especially in enforcement. For the most part, regulations are an administrative responsibility of a bureaucracy in the state, housed under an authority with a title such as the Department of Consumer Affairs. The entities that oversee the fairness of commercial transactions typically include both career bureaucrats and appointed boards, such as State Boards of Dentistry. In several states, individual boards of medicine, nursing, dentistry, and so forth are being consolidated into State Boards of Health. Although it is typical that some members of state dental boards are also members of organized dentistry, all those on state regulatory boards serve as representative of citizens of the states, with ultimate allegiance to the public. They are created by, answerable to, and serve the government in its capacity to enhance the public interest as articulated by the legislature. The recent U.S. Supreme Court decision

concerning North Carolina turned on whether the board, in issuing cease and desist orders under its own name, went beyond its role as a state agency. It was determined that the board could not act independently of the state's regulatory structure.

Boards do propose adjustments in regulations that they believe are in the public's interest, interpret statutes to some extent, and mediate and promote good behavior on the part of professionals consistent with the intent of statutes. It has been found to be good public policy as well as cost saving for boards to be proactive with members of the profession. Thus boards play a role in the licensure process which states use to grant commercial privileges to those who serve the public. When they become aware of practices that are recalcitrantly outside of statute, they turn such matters over to other branches of the state, such as the attorneys general, for civil enforcement.

Influencing the Rules by Lobbying

There are significant differences of opinion regarding whether the regulatory playing field is fair, and even if it were once brought into complete harmony, changing circumstances would necessitate continual tweaking. Who would have given deep thought to HIPAA before the computer? With the exception of states where there are initiatives and referenda, and then only rarely, the public expects legislators to decide which statutes, and thus which regulations, are in the public's best interests. It would be messy beyond practicality for the public to do this kind of work itself and dangerous to leave it undone. And more to the point, the public cannot be expected to have the interest or expertise to know all the relevant facts and understand the competing interests. In fact, legislators are only better at this job than the public because they devote more of their time to the practice, have some experience, and appreciate their answerability to the public. To help them in this responsibility, they depend on lobbyists.

A lobbyist is an individual, often a team of individuals, whose job it is to dig out the facts regarding potential adjustments in regulation, organize them, trace out potential consequences, and package meaningful positions into actionable policies that legislators can modify and choose among. Their training and skill is not in making decisions for the public (that is the job of the legislators), but to clarify issues and their practical consequences better than legislators can. It may not be in any individual lobbyist's job description to present a comprehensive and balanced picture of any issue. They are often advocates for special interests. It is, however, one of the legislator's duties to consult and consider all relevant sides of issues presented by lobbyists (at least to the extent that these interests matter to the legislator's constituencies). The lobbying system is, like the American legal system, adversarial. Justice and fairness are not assumed to be the personal insights of brilliant statesmen or judges, but the best choice among relevant and necessarily conflicting positions, fully presented. Lobbyists who present information to legislators favoring stricter regulation of guns are not expected to make a case for Second Amendment rights. But they expect that others will make these arguments.

Although it is often said that lobbyists advocate on behalf of special interests, that is not the full description of what happens. They provide information, and we presume nothing else. They advocate, in the sense of representing the interests of various parties. But it is bad form to present false information. No legislator wants to advance in public a position provided by a lobbyist and later discover that this is without basis in facts or has been distorted. Such lobbyists generally lose their credibility. Nor can lobbyists attempt to influence legislators other than by providing facts and plausible interpretations of them. Bribes, favors, and services are technical fouls and may carry civil penalties.

The public expects legislators to decide which statutes, and thus which regulations, are in the public's best interests. It would be messy beyond practicality for the public to do this kind of work itself and dangerous to leave it undone.

Lobbyists made their debut on the Gallup poll of public trust in the professions in the fall of 2016. It was an inauspicious beginning as they are starting at the very bottom in terms of public trust. (Ironically, lobbyists do score more trustworthy than the legislators they serve.) It is easier to generate disagreement than agreement on any issue. There are more ways to dislike federal support for health care than there are ways to agree on the perfect system, so there will always be many citizens who can find some fault with any legislation. With the recent rise of social media, this privilege is now being screamed. It is a fantasy to believe that the market will function without regulation. It is equally inconceivable that we can craft regulations that work without the services of lobbyists. But dislike for the outcomes of the system are almost baked in.

Everybody lobbies, and both the groups that do and the resources they use are diverse. We think naturally of trade associations such as Big Pharma investing heavily in promoting rules that benefit Big Pharma. In fact, there are more Big Pharma lobbyists in Washington than there are representatives or senators combined. We expect that the insurance industry is looking for competitive advantage against medicine while at the same time saying they are acting in the public interest. This class of lobbyists is supported by taxes on organizational members in the form of dues or subscriptions from the firms in the industry. These are the major leagues and the issue is obviously competitive. It is truly a blue-chip secondary market.

> The lobbying system is, like the American legal system, adversarial. Justice and fairness are not assumed to be the product of brilliant statesmen or judges, but the best choice among relevant and necessarily conflicting positions, fully presented.

But there are also large lobbying organizations that do not participate directly in the market and represent "the public," such as AARP and "watch dog" groups like ACLU. Although the lobbying arms of these groups may employ large staffs of professionally trained personnel they are not obviously associated with commercial interests. They may represent only a segment of society, such as the interests of the elderly or veterans, in competition with other lobbying groups that vie for public resources for their segment of the public, such as Native Americans or the handicapped. Generally, these "public" lobbying organizations are supported by donations. An interesting example is the Citizen Advocacy Center in Washington, which lobbies on behalf of members of state boards of dentistry and other health professions.

Commercial and public lobbying organizations come in all sizes, ranging from those that most of us would recognize by name to small concerns, often local in interest and even temporary as an issue flares up or dies down. They have smaller staffs, may have multiple clients and more limited resources, and may even be amateur and voluntary.

Although strictly not lobbyists, legislators may have their own staff dedicated to performing lobby-like information gathering and position testing. A senator, for example, who sits on a health policy committee may have a full-time or part-time paid or volunteer staff member who focuses on health issues.

There are even contract general purpose lobbying firms. They can be hired by legislators or by special interest groups for specific projects. If they are large enough, such lobbying firms have depth and expertise in special areas. In general, they understand the overall role of lobbying better than do those individuals who work within the world view of a particular large, special-interest group.

Lobbyists are experts at finding relevant facts and packaging these in terms of practicality and enforceability, public perception, legal constraint, and conflicting views. Many have relevant career history and access to relevant information that significantly exceeds what legislators can find given their immense workloads. If they intend to stay in business, lobbyists must be credible to both those who pay their salaries and to legislators. Wise legislators can be expected to pick their lobbyists carefully and to listen to them critically.

Good Regulation and Bad

There has been much debate recently over the proper amount of regulation. That is a clumsy way of framing the question. It would be more useful to consider which types of regulation serve the public interest, which regulations are cost-effective to enforce, how regulation can have unintended consequences, and what the alternatives might be. Because the public interest and the market are self-correcting systems, every mistake will sooner or later have to be explained or corrected. Most people would agree that regulation is better than lawsuits. It is less expensive, fairer, and prevents much damage before it occurs.

Cost

Regulation is like dental care: the benefits are most conspicuous when nothing happens, and only become urgent when things go seriously wrong. Almost 80% of dental visits are preventative and result in no corrective action being taken. For regulation the proportion of true negatives must certainly be higher. That means we are all paying for a benefit we may never directly experience. Every regulation should stand the reasonable cost test of preventing an aggregate damage that exceeds the cost of implementation, monitoring, and enforcement. And as a group we are notoriously poor at thinking through this sort of thing. There is a body of literature showing that people are consistently willing to pay more for flight insurance to protect against terrorist attacks on a plane than they will pay for insurance against all kinds of flight problems.

Being a legislator under such circumstances is certainly a challenge. Most of the time regulations draw our attention when there is a small personal cost but we see no personal benefit at the moment or when regulations were not in place or not enforced and there is a catastrophe. We do not weigh costs and benefits on the same scales. Mercury recapture prevents damage to a tiny fraction of patients and office staff but is paid for by all patients. Most patients are unaware or could care less—until they are the rare individual who suffers huge damage. Cass Sunstein's *After the Rights Revolution: Reconceiving the Regulatory State* contains a table showing the cost per death prevented for various regulations. These range from $132 million per individual for banning certain additives to cattle feed to $400,000 for asbestos removal to $136,000 for banning saccharine to $59,000 for the 55 MPH speed limit and finally to compulsory seatbelt usage, roadside hazard removal, and clothing flammability that costs less than $10 per life saved. Clearly, cost is not the only factor that drives regulation.

Complicating the calculation of cost for regulation is its uneven distribution. First, there is the problem of moral hazard: folks are unlikely or reluctant to pay into a pool for the common good if they think others stand a better chance than they do of drawing from the common fund. And psychologists have repeatedly shown that humans are absolutely awful at making these calculations. Second, those most likely to bear the cost of compliance are apt to be the ones who previously were not offenders anyway. Bad actors will be most motivated to get around regulations, leaving the moral majority to pick up the tab. This shifts even more burden onto those who follow regulations.

The human inability to rationally compare the other guy's benefit to our own cost (forgetting often that we have a chance of being the other guy and that others might buy dinner) means that even the best regulations, the most civic minded of legislators, and the most sagacious lobbyists will get less credit and more blame than they deserve. The deck is stacked against anyone liking regulations.

Unintended Consequences

When lobbying has been incomplete or legislators have made a biased decision, the regulation will have unintended consequences. These include failing to ensure compliance under reasonable implementation, regulations costing more to monitor or enforce than anticipated or generating backlash, or shifting costs to those who were supposed to experience relief, producing other effects whose negative impact is worse than the problem the regulation was intended to correct. Helmet and speed laws, permitting for certain gatherings, labor requirements, and even delegation of duties in dental office staff are selectively enforced because it is just not worth it to go all out. There are dentists who practice on the edge of regulations who make enough money from bending the rules to retain more lawyers than could be hired on the budget allocated to some dental boards. Sometimes the regulation makes sense in an ideal world, but just does not work in some realities. Sometimes politicians who cannot stop a regulation from becoming statute block it by making it onerous to enforce or by reducing funding required to implement the statute as passed.

Unintended consequences of regulation also flow directly from complying with regulations. Why, for example, will we find in many cities modern, safe buildings up to the latest code for plumbing, fire regulations, and handicapped access right next to dilapidated and patently unhealthy structures? The reason is often regulation. Because most building codes are grandfather regulated, it is sometimes less expensive to retain the old and dangerous conditions the regulations were intended to correct. Some health measures that require only the very top level of care or none at all force patients to do without because they cannot afford the best.

Whose Benefit and Whose Cost?

Dentistry is a highly regulated profession. Despite dentists complaining about it, most of the regulations have been created by dentistry itself. According to some legislators who have been involved with health regulations, they have never seen a suggested bill that was not offered on the grounds of patient safety. Lower cost to the consumer and greater access are not so common. This is a matter of perspective and mixed motives. Most of the recent actions by the Federal Trade Commission involving the professions are played out on this issue. The Bates-Osteen case that forbade the American Bar Association from disbarring members who advertised their services to the public is a case in point. The U.S. Supreme Court decided that the benefit to the public from having information (at least not false or misleading information) outweighs the freedom of the profession to determine what information should be provided to the public. The profession argued, unsuccessful in this case, that only an individual professional could advise an individual client what would be in the client's best interests.

The problem comes down to the fact that there are usually more than one set of benefits attached to a policy, and that means more than one benefit for each of the parties. A professional can legitimately claim to favor a policy because it is safer or otherwise benefits the client and at the same time that policy enriches the sponsoring professional. Legislators, with the help of lobbyists who will point out the benefits for both their clients and those who stand in the way of their clients, must make the determination about what is best for all considered. So-called "Robin Hood" cases involve professionals winking at regulations while gaining personally. "What is wrong," regulation scofflaws say, "with waiving copays or upcoding? The insurance companies are getting rich and this does not hurt patients."

Generally, regulation favors larger organizations. The marginal cost of compliance is less for a huge organization than for a small one. That is why we hear so much about regulation hurting small businesses. Less often mentioned is the further point that regulations are introduced by big organizations to drive out competition from the little guy. That was certainly the case with the railroads at the end of the nineteenth century. It may be the case today with Big Pharma and insurance. Certainly, corporate dental organizations are in a better position to manage regulations than are solo practitioners and would differentially benefit as regulation increases.

Alternatives

Is it wiser to fight about the rules than to fight without rules? The answer to this question too often comes down to those who win the contests over rules favoring somebody paying to have them enforced while those who lose the contests over rules keeping an eye out for ways to get around them. It would probably be easy enough to get agreement in principle that regulation should always be kept to a minimum. But agreement in fact is another matter entirely. The rub comes in getting everyone involved to agree when the free market is working better than would any conceivable adjustment. It is human nature to imagine that one's golf lie can be "honestly" improved. Most of us could think of regulations on others, paid for by others, and rigorously enforced by others against the violators that would make our lives better. The problem is that others have the same right and they may be thinking that we should pay the costs of restricting our own natural rights. We have a free opportunity to make our case, and we would be well advised to use the help of those who are especially good at this, professional lobbyists. We certainly could not deny the same privilege to others. And in the end we have to leave the ultimate decisions to elected representatives and those they hire to implement, monitor, and enforce the regulations. Complaining about it is free; doing something to bring about the fair playing field is not. ■

Who Has the Influence?

Sreenivas Koka, DDS, MS, FACD

Abstract

Incisal Edge magazine, which purports to "serve the dental profession," listed "The 32 Most Influential People in Dentistry" from 2017 through 2020. A categorization of the influencers by sex and position included a predominance of males who held top positions in corporate organizations. The implications of influence on the values of the profession coming from this direction are discussed.

Dr. Koka is in private practice in San Diego, California; skoka66@gmail.com.

Ideally, healthcare systems serve patients in a manner that provides a caring and kind experience, yielding desired patient-centered outcomes using care models that are affordable to patients and to society at large. As much as organizations heavily influence who health care is offered to, and received or not received by, the leaders of organizations exert significant influence. In dentistry, as in medicine, there is a tension between those whose primary mission is for profit and those whose primary mission is nonprofit. Furthermore, the interplay of stakeholders of society, patient, patient's family, clinician, employer, policymaker, academic, dental organization, equipment manufacturer, supplier, state government, and insurance company provides another level of complexity to the challenge of determining exactly what "influence" is and, consequently, who has said influence.

In 2017, *Incisal Edge* magazine published the first in a series of annual rankings of the "32 Most Influential People in Dentistry."[1] The magazine is published by Benco Dental (Pittston, PA) and claims "*Incisal Edge* reaches more than 130,000 Benco customers and their staffs. This number continues to grow due to media partnerships and a subscription option."[2] Therefore, the list is widely distributed across the United States. However, who is responsible for generating the list is unclear as is the precise manner by which people are considered, vetted, or excluded and, if included, how it is determined where each person ranks.

The words "influence" and "influential" bring nuance. Merriam-Webster defines "influence" as the power or capacity of causing an effect in indirect or intangible ways; the act or power of producing an effect without apparent exertion of force or direct exercise of command; corrupt interference with authority for personal gain; and, an emanation of spiritual or moral force. "Influential" is defined as exerting power or influence. Clearly, influence implies power; specifically, the power to exert an effect, and the effect may be positive or negative. Of course what constitutes positive and negative lies in the eye of the beholder. In the case of the *Incisal Edge* magazine rankings, the following factors were considered when determining who had sufficient influence on dentistry to be included on the list: "Trying to determine what exactly constitutes influence, we ultimately nailed down a few key metrics. We counted dollars—company size, or size of budget controlled—as most important. Next, we looked at the weight an organization can throw around: If a group is influential, by definition its leader is too, even if he or she operates behind the scenes. Finally, we tried to calculate size of voice: how much influence an individual has through his or her speaking, writing or

research activities." The purpose of this report was to review, compare, and contrast the yearly lists of the "32 Most Influential People in Dentistry" in order to determine the relative ranking of executives, administrators, academics, clinicians, government officials, and patients over the time period of 2017-2020. Additionally I sought to determine the percentage of men and women deemed to influence dentistry, the degree to which the rankings were made up of individuals whose inclusion was due to for-profit or nonprofit activities, and to compare to published rankings of influencers in health care.

Materials and Methods

To extract relevant data from the articles, I noted each individual's primary role and gender, along with the organization they were associated with and its designation as for-profit or nonprofit. Then, using this information, individuals were categorized into one of three sectors based on the following definitions:

- Government: Listed in article as: (a) an elected public official (e.g. senator, governor) or (b) holding a position in government or at a government organization (nonprofit).
- Industry: Listed in article as: holding an executive, founding, or administrative position at a for-profit organization or LLC.
- Academia/Advocacy: Listed in article as: (a) holding a position at a nongovernment, nonprofit organization or (b) a writer or content-creator regardless of organization.

After categorizing individuals, distributions for gender and for individuals working in each sector were calculated in order to plot trends across the sampled time period. Percentages were chosen for analysis rather than frequency in this study because of the potential for ties on each list from *Incisal Edge*. Although each article purported to list the "32 most influential people in dentistry," in 2018, 2019, and 2020 there were 33, 42, and 42 individuals listed, respectively, as a result of ties.

Furthermore, in each of the four years, there was one instance of a group making the list in place of an individual. These cases were excluded from the gender analysis but were categorized into appropriate sectors based on their descriptions in each article.

Results

From 2017-2020, *Incisal Edge* magazine named 80 unique individuals to its annual "The 32 Most Influential People in Dentistry" articles. The dominance of industry influencers in dentistry was apparent, with their prevalence ranging from 53.1% to 69.7% (mean = 63.8%) of individuals named in each year (Figure 1). Many of these individuals were associated with for-profit organizations and held senior administrative or executive-level positions, e.g., chief executive officer, director, president, founder, owner, etc. By comparison, academia/advocacy influencers comprised 16.7% to 31.3% (mean = 22.1%) of the lists, and government influencers comprised 9.1% to 16.7% (mean = 14.1%) of the lists.

For gender distribution, yearly percentages of women in the lists ranged from 12.2% to 19.4% (mean = 14.8%) indicating that women held, on average, less than one in six positions perceived to influence dentistry (Figure 2).

Discussion

Logeman et al (2019) reviewed trends in all of health care across a 17-year window ending in 2018. Results indicated an obvious upward trend in the influence of "industry" leaders, reaching an apex of 72% in the final year. Additionally, a minority of those listed were female, with yearly percentages ranging from 17% to 28%. The present study indicates the dental industry's conformity to general healthcare trends described by Logeman and colleagues, with industry executives from for-profit organizations dominating the lists. Additionally, the present study showed a consistent disparity between genders over the four studied years, with the average yearly percentage of female influencers at only 14.8%. This percentage is less than half of the percentage of the dentist workforce composed of women (33.4%)[3] and demonstrates an opportunity for improvement.

Revisiting the definition of "influence" used by *Incisal Edge* magazine, the most important criteria listed are "dollars," "company size," "size of budget," and "weight an organization can throw around." These criteria are in opposition to the fact that dentistry is a healing profession. The lists do indicate that individuals from nonprofit organizations like the American Dental Association, American Dental Hygienists Association, American Dental Educators Association, and the National Institute of Dental and Craniofacial Research have influence, which is encouraging inasmuch as these individuals represent dentists. However, their influence is ranked lower than that of individuals from

FIGURE 1. **Percentage of individuals constituting list of Most Influential People in Dentistry (U.S., 2017-2020) by designation of primary organizational affiliation (industry, government, or academia/advocacy).**

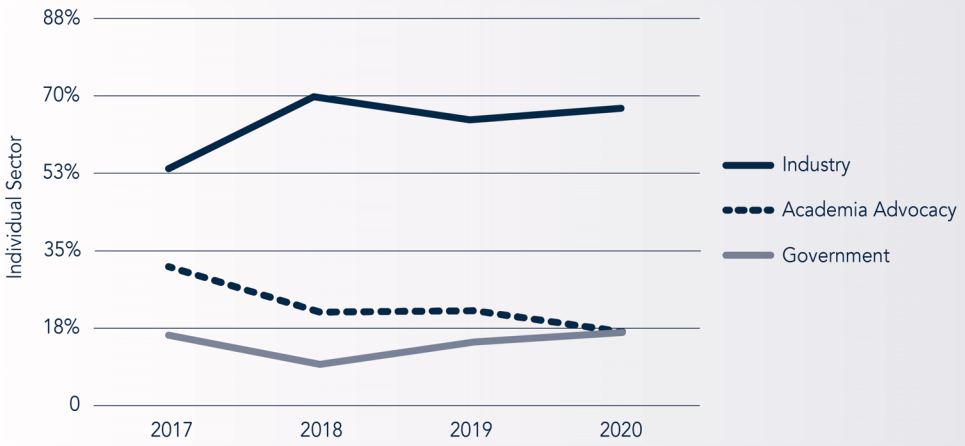
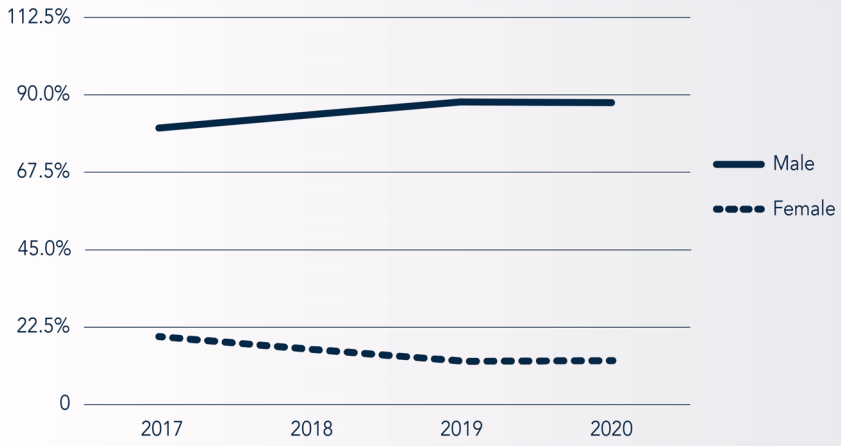


FIGURE 2. **Percentage of men and women constituting list of Most Influential People in Dentistry (U.S., 2017-2020).**



for-profit organizations implying there is a disconnect, and resultant tension, between the ethical human imperative of our profession of dentistry and those individuals for whom the industry of dentistry prioritizes profit. For context, among healthcare professionals, dentists are considered less honest than nurses, veterinarians, medical doctors and pharmacists, while business executives, who apparently are dominant influencers in dentistry, rank lower than lawyers.[4]

Ultimately, any entity that influences dentistry modulates the influence of dentistry on the various stakeholders in dentistry. For example, patients, clinicians, industry representatives from supply companies and manufacturers, laboratories, researchers, employers of dentists such as dental service organizations (DSOs), educators, insurance companies, lobbying groups, legislatures and government entities, charities, and advocates all seek a positive outcome through dentistry. The results of this study are disturbing to those who believe that the patient-clinician relationship is the key relationship in the provision of ethical patient-centered care as patients are conspicuously ignored while almost 60% of the most influential leaders in dentistry are associated with for-profit organizations. Of course, dentists have partnered with "industry" for many years in purchasing materials and equipment and conducting research studies. Nevertheless, it appears that dentists are losing control of the patient-clinician relationship due to the influence of factors that compromise their ability to do so. Whether it be insurance plan policies, the continuing commoditization of dentists through DSOs, or the use of "key opinion leaders" by large dental for-profit corporations to promote their products to name a few, there are more threats to putting the patients' best interest first than ever before. The looming shadows of dental school debt and daily financial production sheet mandates by DSOs further tempt or force dentists to take a path that realizes financial benefit instead of what is best for the patient.

Dentistry is, unfortunately, following a path similar to that taken

The intrusion of commercialism in dentistry under the flag of "recognized influence" is a challenge to the values of professionalism in dentistry.

by physicians, who delegated more and more nonclinical work to administrators and executives and then found themselves often unable to control their own patient-clinician relationship. As a result, physicians in hospitals and clinics became commodities, and dentists appear to be headed in the same direction. In the final reckoning, dentistry is a noble profession. Dentists are the final guardian and protector of the patient and the patient trusts the dentist not only to do no harm to them but to always do what is best for them. One cannot, at the core, balance a patient-centered mission with a profit-centered mission. One is a social mission (to help fellow humans) and one is a market mission (to realize a material/financial gain for oneself). One is about serving the world and one is about savoring the world. When conducted with authenticity, putting the patient first is all-encompassing and requires a ruthlessness to eliminate everything else, especially profit, from consideration.

As previously mentioned, the criteria for selecting the "most influential" individuals have not been reported. It is possible that Benco Dental, which published the study, selected individuals representing interests of particular interest to itself rather than to the practicing profession. To the extent that this is the case, the intrusion of commercialism in dentistry under the flag of "recognized influence" is a challenge to the values of professionalism in dentistry.

In conclusion, although I was not able to study influence directly, the present data indicate that, like health care in general, public opinion and policy in dentistry are chiefly influenced by male executives who are motivated by commercial and financial goals and incentives. Without patients, advocates, and clinicians in this list of influencers, commercial goals rather than care-centered goals control dental policy in the United States. As a result, many patients find themselves priced out of care, and in a system that does not prioritize their well-being. The profession must review its own role in shaping the practice of dentistry and make a concerted effort to advance diverse voices within it. Furthermore, it must explore ways to ensure the promotion of patients and their advocates as the ultimate stakeholders in dentistry. ■

References

Logeman, A. L., Ponce, O., Alvarez-Villalobos, N., & Montori, V. M. (2019). Who influences health care in the United States? A study of trends from 2002 to 2018. *Mayo Clinic Proceedings. 94* (11), 2360-2361.

Online Sources

1 E. Dilts. 2017's 32 Most Influential People in Dentistry. Incisal Edge Magazine. www.incisaledgemagazine.com/mag/article/winter-2017-the-32-most-influential-people-in-dentistry/; 2018, ww.incisaledgemagazine.com/mag/article/reinventing-dentistry/, 2019, www.incisaledge magazine.com/mag/article/32-most-influential-people-in-dentistry/, 2020, www.incisaledge magazine.com/mag/article/4th-annual-32-most-influential-people-in-dentistry

2 www.incisaledgemagazine.com/readership

3 American Dental Association Healthy Policy Institute. https://www.ada.org/en/science-research/health-policy-institute/dental-statistics/workforce#:~:text=How%20many%20dentists%20are%20female,2019%2C%2033.4%25%20are%20female

4 https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx

Ethics of Dental Care for Medically Complex Patients during the COVID-19 Pandemic

Tatyana Alimova Straus, DMD, MBE

Abstract

COVID-19 disproportionately affects older and medically complex individuals. As dental care operations resume and ramp up, concerns have been raised about providing dental treatment to populations who are at a higher risk of complications from COVID-19. Comparing the risk/reward ratio to scenarios encountered previously and providing analysis in the context of the ethical principles of justice, autonomy, nonmaleficence, and beneficence can help guide dentists seeking to provide dental care to medically complex patients during the COVID-19 pandemic.

Dr. Straus is a clinical Assistant Professor in community Oral Health at the University of Pennsylvania Dental Medicine; talimova@dental.upenn.edu

COVID-19 can affect anyone, regardless of health status, but it disproportionately and more severely affects people with comorbidities and pre-existing conditions, such as diabetes, hypertension, and immunocompromise (Jordan et al, 2020). Dental care throughout the United States had been limited to emergency and urgent procedures for many weeks since a state of emergency was declared by governors in multiple states. As the states have resumed regular dental care operations and expanded the types of allowed procedures to include elective treatment, additional concerns have been raised regarding treating populations who are at a higher risk from COVID-19. General guidance on reopening dental practices has been produced by the CDC as well as multiple dental associations,[1, 2] but little direction has been presented on addressing specific concerns for individuals at the highest risks of complications from COVID-19. As the number of COVID-19 cases continues to increase throughout the country and several states are reversing their re-opening plans, many dentists are concerned about ensuring the safety of their patients as well as about mitigating potential liability so that dental offices can remain open.

Dentists have been discussing options for safe dental treatment of medically complex patients, including the possibility of delaying treatment for these individuals until the current rate of COVID-19 community spread has slowed down, which could be several months or longer. This possibility raises several ethical concerns, such as autonomy, nonmaleficence, beneficence, and justice. The purpose of this commentary is to elucidate these concerns and to provide possible solutions.

Current CDC Guidelines for Dental Settings

The CDC guidelines for dental settings are frequently updated, indicating that our knowledge of the virus is rapidly evolving.[3] For example, the update released on August 4, 2020 strengthened recommendations for protective eye wear and lowered the threshold for the definition of "fever" as used for the purposes of justifying delay of dental care for patients or staying home for employees. Current guidelines for dental settings recommend that dental health care providers (DHCPs) "consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances." Additionally, the CDC recommends that dentists "provide dental treatment only after you have assessed the patient and considered both the risk to the patient of deferring care and the risk to DHCPs and patients of healthcare-associated SARS-CoV-2 transmission …. If PPE and supplies are limited, prioritize dental care for the highest need, most vulnerable patients first—those at most risk if care is delayed." While this recommendation was made in good faith, it essentially asks individual dentists to ration care, putting an additional moral burden on providers. This recommendation leaves room for

Our goal should be to reduce risk to medically complex patients seeking dental care rather than to simply deny or delay their treatment.

potential misinter-pretation and confusion on how to weigh the risks and benefits for the patients and how to balance these with the professional ethical obligations.

Ethical Principles at Stake

An ethical dilemma arises when two or more ethical principles are in conflict. Considerations to delay dental treatment for medically complex patients in the context of the COVID-19 pandemic may put autonomy, beneficence, nonmaleficence, and justice at odds with one another. One widely referenced set of bioethical principles is discussed in detail in *Principles of Biomedical Ethics* (Beauchamp & Childress, 1983). Autonomy is the right to self-governance and the patient's and other's right to make decisions in the healthcare context for themselves. Nonmaleficence is the obligation to avoid or mitigate unavoidable harms. It is unethical to perform treatment when risk is judged to exceed benefit based on information that conscientious practitioners should have. Beneficence refers to the obligation of medical professionals to do good for their patients, such as by performing necessary treatment to address disease. Justice means distributing benefits and burdens fairly across classes of individuals, such as ensuring equal access to dental care.

In society, autonomy is not absolute because our actions and behaviors can affect others. We give up certain freedoms and choices to live peacefully with one another and to benefit humanity as a whole. In the medical setting, patients do not have the absolute power to demand that healthcare providers perform specific treatments. During public health crises, some autonomy must be sacrificed for the sake of public safety. As part of the implied societal contract, healthcare providers have an obligation to treat patients fairly, and denying treatment to some while allowing it for others cannot be done without sufficient ethically sound justification.

Here, I compare the inability to fully honor this set of four principles, because of their inconsistency, in providing care to high-risk individuals during the COVID-19 pandemic to certain scenarios we have encountered previously.

Hypertensive Crisis

Dentists regularly refuse to perform extractions on patients whose blood pressure exceeds a certain limit, for example 180/120 (Muzyka & Glick, 1997). If the dentist performs the treatment and the patient suffers a negative effect, such as a heart attack, the dentist is morally responsible and may be legally liable as well. The risks of performing an extraction in these circumstances and the risks of delaying treatment are known and roughly quantifiable. In most cases, the risk of delaying the extraction is less than the risk of a cardiovascular event if the extraction is performed during a hypertensive crisis. A patient may protest the delay, but it will be the responsibility of the dentist to refuse to perform such treatment. In this case, the ethical principle of nonmaleficence (avoid increasing risk of cardiovascular complications) trumps the principle of beneficence (treat disease, extract the tooth). This is not because one principle supersedes the other in general, but because professionals as a group endorse the probable health outcome of one course of action to be superior to the other, all things considered.

In the COVID-19 case, medically complex patients are at higher risk of complications if they contract COVID-19. However, because asymptomatic carriers exist and we lack widespread testing that reports timely results, we do not have the evidence to conclude that the risk of contracting COVID-19 is greater for those who are medically complex, though it is likely. Additionally, the risks of contracting COVID-19 and of possible complications are less well known, poorly quantifiable, and not imminent. That is, medically complex dental patients may contract COVID-19 during dental treatment, and they may have complications from it, but the risks are vaguely described due to the novel nature of the disease. In contrast, a patient's blood pressure can be readily measured, and the risk of a cardiovascular event during a hypertensive crisis is described by the American Heart Association. Although the same ethical principles are in play here and in the hypertension example, the professional judgment of dentists may lead to a different calculation of risk/reward ratios. Patients may have their own and even competing calculations of this ratio.

Implants in Persons Who Smoke

We know that smoking greatly increases risk of implant failure (Strietzel et al, 2007), and dentists work hard to avoid implant failure. However, we also know that there are

many people who smoke who have implants. The risks of implant failure in smokers can be roughly quantified and many studies have been done on this topic (Gorman et al, 1994; Klokkevold & Han, 2007; Wallace, 2000). The informed consent process involves establishing the expectations of treatment with the patient, including the risks, benefits, and alternatives, and ultimately allows patients to exercise their autonomy by making a decision about their course of care. The responsibility of the dentist is to outline the risks, benefits, and alternatives, and to help the patient make the best decision. For the most part, implants are elective procedures, though they have significant benefits for the patient in improving masticatory function and esthetics. Denial of implants to people who smoke may be rooted in other concerns, such as cost or complexity of treatment. In general, a patient who understands and accepts the risks of implant placement given their smoking status is a suitable candidate for implants from an ethical point of view. Many would believe that patient's autonomy takes precedence over nonmaleficence in this case, because the risks of failure are known, quantifiable, and manageable.

Similarly we can apply the informed consent process to the COVID-19 decision. A reasonable level of disclosure of risks, benefits, and alternatives may include informing medically complex patients that they are at a higher risk of danger if they contract COVID-19 and that current CDC recommendations are to stay home as much as possible, to practice social distancing, and to delay non-essential activities to lower the risk of infection. However, we do not currently have evidence to indicate that the risk of contracting COVID-19 is higher for the patient during dental treatment than it is during essential activities such as grocery shopping. If such evidence emerges, this information must also be disclosed. The patient can then weigh the risks of delaying dental treatment with increased risk of COVID-19 complications.

HIV and Discrimination

We also must be mindful not to discriminate against certain groups of people, remembering to uphold the principle of justice. Denying care to subsets of the population under the guise of caution has a long history, rooted in social bias. We must not forget that during the HIV epidemic in the late 1980s and early 1990s people living with HIV were regularly denied dental care (Scheutz, 1990). At-risk groups have had to fight fear and hatred to ensure that their right to treatment would not be abridged. Even today, there are people living with HIV and other medical conditions who are denied care, supposedly out of caution, but in reality out of prejudice. Additionally, not all patients are aware of their medical conditions. People walk around every day with hypertension, diabetes, HIV, and cancer and do not know it. Other people may actively hide this information from their healthcare providers, including dentists, out of fear of discrimination or because they desperately want or need treatment. Delaying care or denying treatment to patients due to certain conditions can make patients feel that they are being punished for their honesty and is likely to result in patients being less truthful about their health.

In the COVID-19 case, singling out patients with medical conditions, such as HIV, and denying them dental care because of their increased risk of complications from contracting COVID-19 would be unjust and discriminatory. This is not a dilemma, pitting two ethical principles against each other: it is just plain unethical. It is likely to promote filtered reports from patients about their health status and therefore increase risk of complications. It would be ideal if all medical professionals always were just. Unfortunately, as the AIDS epidemic demonstrated, medical professionals are not immune to fear, confusion, and discriminatory behavior. Often doctors are blinded by the idealistic belief that they and their colleagues will always do the right thing, even though history has provided evidence to the contrary. We would be remiss to not apply the lessons of the AIDS epidemic to today's COVID-19 pandemic. It is critical to be proactive in outlining and addressing the ethical concerns that arise so that we do not repeat the ethical violations of the past.

Recommendations

Eliminating all risk of dental care is not possible. There is also no guarantee that delaying dental treatment will necessarily lower the risks associated with COVID-19, and certain patients may jeopardize their systemic health by delaying urgent dental care. Therefore our goal should be to reduce risk to medically complex patients seeking dental care rather than to simply deny or delay their treatment. The difficulty of providing accommodation is not a sufficient reason to refuse an individual seeking access to care.

Consider the difficult work and advocacy done by people with disabilities to ensure accessibility of public buildings. Making a public building wheelchair accessible may be more expensive or require additional space, but those reasons do not justify denying people who use wheelchairs access to the building. Similarly in a dental setting, before shielding of cavitrons and defibrillators was common practice, patients who had implanted defibrillators would receive hand scaling rather than ultrasonic dental cleanings (Miller et al, 1998; Pisano et al, 2016). We did not deny

patients dental treatment just because their prophylaxis required more time and effort, and we should not deny accommodations to our medically complex patients either.

I recommend that rather than delaying care for the medically complex population, or conversely, treating them exactly the same as low-risk individuals, we focus instead on harm reduction strategies and on informing our patients of potential risks, especially as more knowledge of the risks is discovered. As part of nonmaleficence and justice, we are obligated to consider harm reduction strategies for this vulnerable subset of patients. Based on the CDC and other organizations' guidelines, these strategies may include: (a) dedicating the first appointment of the day for patients with comorbidities so that no potentially infectious aerosols are present in the operatory (similar to certain grocery stores having special hours for seniors); (b) allowing additional time between patients; (c) additional dedicated staff to help disinfect treatment space and speed up procedures; (d) using a negative pressure room; and (e) eliminating in-office waiting to minimize potential exposure to other people. I am confident that the dental community will come up with many harm reduction strategies for this novel scenario.

The unfortunate reality of the situation is that inadequate resources will likely limit the number of such appointments and accommodations, and thus inevitably delay care for some. In addition patients, especially those who are more risk averse, may choose to wait several weeks or months before they resume dental care. However, both from a public health and a public relations perspective, it is better to have the ability and willingness to provide care safely to those who seek it than to delay or deny care to all medically complex patients under the guise of nonmaleficence or due to fear of litigation. Currently I do not see an ethically sound justification for delaying or denying care to patients with comorbidities.

As of December 2020 there has not been a confirmed case of COVID-19 transmission in a dental office. While this lack of confirmed transmission is hopefully due to the extensive precautions many dentists have taken, it could also be due to the lack of testing and contact tracing. The definitive reasons are beyond the scope of this article. Whether a confirmed transmission has already occurred is less relevant than dentists' fears of liability and of contributing to patients' harm. There has not been a single confirmed transmission of HIV to a dentist in a clinical setting either, but this fact has not stopped discrimination against HIV positive patients.[4] Some dentists worry that the first confirmed case of transmission of COVID-19 in a dental office could lead to sudden, drastic regulations as well as negative publicity. A proactive approach to dealing with this possibility is recommended. ■

References

Beauchamp, T. L., & Childress, J. F. (1983). *Principles of biomedical ethics.* New York: Oxford University Press.

Gorman, L. M., Lambert, P. M., Morris, H. F., Ochi, S., & Winkler, S. (1994). The effect of smoking on implant failure at second-stage surgery. *Implant Dentistry, 3*, 165–168.

Jordan, R. E., Adab, P., & Cheng, K. K. (2020). Covid-19: Risk factors for severe disease and death. *BMJ*, doi:10.1136/bmj.m1198.

Klokkevold, P. R., & Han, T. J. (2007). How do smoking, diabetes, and periodontitis affect outcomes of implant treatment? *International Journal of Oral and Maxillofacial Implants, 22*, S173–202.

Miller, C. S., Leonelli, F. M., & Latham, E. (1998). Selective interference with pacemaker activity by electrical dental devices. *Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontics, 85* (1), 33-36.

Muzyka, B. C., & Glick, M. (1997). The hypertensive dental patient. *Journal of the American Dental Association, 128* (8), 1109-1120.

Pisano, P., Jr., Mazzola, J. G., Tassiopoulos, A., & Romanos, G. E. (2016). Electrosurgery and ultrasonics on patients with implantable cardiac devices: Evidence of side effects in the dental practice. *Quintessence International, 47* (2), 151-160.

Scheutz, F. (1990). HIV infection and dental care: Views and experiences among HIV-seropositive patients. *AIDS Care, 2* (1), 37-42.

Strietzel, F. P., Reichart, P. A., Kale, A., Kulkarni, M., Wegner, B., & Küchler, I. (2007). Smoking interferes with the prognosis of dental implant treatment: A systematic review and meta-analysis. *Journal of Clinical Periodontology, 34* (6), 523-544.

Wallace, R. H. (2000). The relationship between cigarette smoking and dental implant failure. *European Journal of Prosthodontic and Restorative Dentistry, 8*, 103–106.

Online Sources

1 American Dental Association. (2020). ADA: Guidance on Continuing to Practice Ethically during COVID-19. https://success.ada.org/~/media/CPS/Files/COVID/ADA_COVID_How_Do_I_Ethically_See_Patients_During_Pandemic.pdf?_ga=2.118664521.1549986915.1584969723-495610539.1570458475

2 American Dental Association. (2020). Return to Work Toolkit: American Dental Association. https://pages.ada.org/return-to-work-toolkit-american-dental-association

3 Interim Infection Prevention and Control Guidance for Dental Settings During the Coronavirus Disease 2019 (COVID-19) Pandemic (2020). www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

4 Hardie, J. Good News: Dentists Not at Risk of Acquiring HIV/AIDS from Infected Patients and the Illusion of Infection Control. www.oralhealthgroup.com/features/good-news-dentists-not-risk-acquiring-hiv-aids-infected-patients-illusion-infection-control/

American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

Periodicals Postage
PAID
at Gaithersburg, MD
and additional
mailing offices