

# Journal *of the* American College *of* Dentists

## Why I Teach My Colleagues

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# Journal of the American College of Dentists

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

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- 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.



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Comments concerning any material appearing in this journal are welcome at dchambers@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.

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Cover image Teaching colleagues is rewarding.

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## From the Editor

# Behind the Regulatory Curtain

Some years ago I obtained a small device that is activated when vague generalities about helping others are rolled out to mask self-serving detail. The device has been screaming at me when I point it toward North Dakota.

I do not have perfect pitch: but I can tell when someone is off key. Something was not quite right about an e-mail blast I received a few months back from a think tank called Heartland on behalf of the Texas Public Policy Foundation (TTPF). It made a case for proposed legislation in North Dakota that would create a licensure category for dental therapists. It left some “what,” “who,” and “why” questions unanswered.

The proposed legislation can be read at [www.legis.nd.gov/assembly/65-2017/documents/17-0709-03000.pdf](http://www.legis.nd.gov/assembly/65-2017/documents/17-0709-03000.pdf). The bill was defeated in 2015 and again this year. According to Dr. Brent Holman, executive director of the North Dakota Dental Association, this was achieved by dentists individually taking the case to their neighbors, some of whom sit in the state assembly. But that will not be the curtain at the end of this play.

Engrossed House Bill 1256 before the North Dakota Legislative Assembly would have added five new sections to Chapter 43-20 of the state’s code regulating commerce. The scope of practice for therapists would have included, among other things, (a) preparation and placement of direct restorations; (b) extraction of primary teeth and simple, nonsurgical extraction of permanent ones; (c) pulpotomies; (d) placement of preformed and temporary crowns; (e) direct and

indirect pulp capping; (f) administration of local injections and nitrous oxide; and (g) suturing. There is language in the bill about training, portability of licensure, and ethical violations that would result in revocation of licensure.

Procedures would have been performed under a written management agreement with a dentist providing “direct or indirect supervision.” In Section 14, subsection 3 the proposed bill stated that to the extent the supervising dentist approves, these services could be performed in “a practice setting where the supervising dentist is not onsite and has not previously examined the patient.” Although the conventional red flag of “diagnosis” is avoided, therapists would have specifically been permitted to “formulate [and execute] an individualized treatment plan [for patients].” I understand this to mean that therapists could determine the care patients would receive without there being a diagnosis and then provide some of it without a dentist’s oversight. Therapists would not have been “independent” practitioners, meaning that they could not bill under their own name. The maximum number of therapists a dentist could employ would have been five.

Some years ago I obtained a small device that is activated when vague generalities about helping others are rolled out to mask self-serving detail. The device has been screaming at me when I point it toward North Dakota.

We do not know what is going on behind the curtain.

The noble language at the front of the stage masks what is going on behind the curtain. I contacted the eight legislators who sponsored the bill, but none has been able to tell me who sponsored the proposed change. Heartland claims it was only paid to front for The Texas Public Policy Foundation. TPPF is unable to trace the source of the initiative because “all monetary contributions are placed in a common pool.” The Association of Dental Service Organizations’ website describes individually the legislative initiatives it sponsors in various states. There is a link to North Dakota, but it is password-protected and for members only. The ADA posts policy statements on its site. There is one for MLPs, but as of this writing it has been disabled.

I know the “what” but not “who” or “why.” I can only frame a story that would make the unusual but hushed events in North Dakota plausible to me.

Dental practices, like law firms, real estate agencies, and personal trainers, are in a category of businesses known as professional service firms. These firms provide highly skilled and customized services directly to clients. Unlike supermarkets, airlines, or leaf-blower manufacturers, they cannot use economies of scale or automation. The time and expertise of the professional sets a limit on productivity and type of

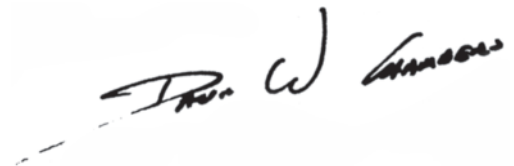
service provided. There are only two ways professional service firms can increase productivity: delegate work to the lowest-paid individual capable of performing the task adequately and segment the market to focus on clients who want and can afford high-end services.

Dentistry has done both. The number of auxiliary staff has increased on average about one per office every 15 years since 1950, and according to ADA figures, 70% of the difference in dentists’ incomes is proportional to the number of auxiliary personnel employed. Part of the access to care issue is attributable to dentists choosing (often by where they set up practice) to focus on that segment of the market demanding care that leads to higher reimbursement. Both strategies were enormously successful until about ten years ago when they reached saturation. The current shift to corporate practice is an attempt to break out of this constraint.

Dental practice acts and other legislative matters regarding commerce are regulations and are contrary to the notion of a free market. They both establish monopolies protecting professionals and impose OSHA, HIPAA, and other burdens intended to promote public safety. The FTC piles on rules intended to keep the commercial playing field level. There are always differences of opinion regarding which of these regulations are net beneficial, the opinion depending greatly on where one stands.

Regulations are disproportionately onerous for small businesses, including dentistry. It makes sense for larger organizations to hire specialists in tax law, compliance, HR, and environmental safety—or lobbying. It is a small percentage of their operation, but a large portion of the profit margin for small businesses. A major reason for the explosion in DSOs is the rising burden of regulation. This has been known for some time, and the strategy has been used successfully by large firms to drive small ones out of business. That is why a large number of proposed regulatory adjustments come from big business. Certainly a law that expands the scope of practice of low-end providers in oral health care would be more advantageous to corporate practices than to those dentists practicing under the traditional model.

I salute the dentists of North Dakota for not letting something scary out of the bag. We can only guess about who brought this to our doorstep and what else is going on behind the curtain.



## Readers Respond

### Letters to the Editor

If we are ever going to capture the attention of those in their dental careers enough to promote “ethical behavior,” it will need to come through the passion for excellence these dental assistants displayed.

#### Getting the Autonomy Thing Right

It is extremely encouraging to read a student’s call to upgrade the ethics of his profession (Z. Smith. “What Did We Just Agree To? Analysis and Rewriting of The Dentist’s Pledge,” 2016, number 1). The ethics of a profession are properly established and maintained by its members, and when a “young” one takes on the task of renovating something as fundamental as an oath, this is a very good sign. Professional ethics is not a static enterprise, and the process of continuous evolution requires newcomers to make their point of view known. So, thank you, Zack, for this thoughtful effort. Keep it up.

There is one thing in the essay that I would like to tweak. Zack is right to include autonomy in the mix of essential components of an ethics oath. But his description was not quite clear. Here is what I teach dental students at the Dugoni School of Dentistry: both parties in the doctor-patient relationship have autonomy that must be respected. There is patient autonomy and there is dentist autonomy, commonly referred to as “professional autonomy.” Neither party can prevail over the other.

Each party can manifest autonomy by saying “no” to the other. Treatment only takes place when both parties say “Yes.” Dentists must provide whatever amount of information is needed to get to yes. Generally, patients determine if and when they have sufficient information. The question of “sufficient education” becomes a judgment call for dentists when patients are disinterested or when they ask their dentist to decide for them.

*Bruce Peltier, PhD, FACD  
San Francisco, California*

#### The Passion of Assistants

Congratulations to our *Journal*. This edition [“The Dental Assistant’s Perspective,” 2016, number 4] was the most readable and worthwhile of all because it speaks to the heart of why dentistry can still be a wonderful career for all involved. I intend to share it with my staff who will find it refreshing to read about those with similar ambitions for career integrity.

As much as I have (occasionally!) enjoyed the more cerebral and esoteric themes about ethics, accreditation standards in schools, and so forth in the *Journal*, the fact is that those topics did not speak to my dental passions like this one did. I would propose that we use the same approach to find out what is in the mind of young (and old)

dentists, hygienists, and patients. Because if we are ever going to capture the attention of those in their dental careers enough to promote “ethical behavior,” it will need to come through the passion for excellence these dental assistants displayed.

The recent transition from caring for the patient’s needs to caring for the dentist’s needs started when dental school debt became the excuse for loss of empathy for the patient. Well, the “millennial mind” may be different from “baby boomers,” but everyone still likes to be treated with respect and kindness. So if we promote what dental assistants describe as “why their office is the best place to work,” then it turns out we will be promoting empathy and ethics. Ask any dentist, hygienist, or patient why they are proud of their office and I suspect that the same song of empathy and ethics will ring out.

Let’s start a movement to celebrate ethics in dentistry in order to build a groundswell of public and professional enthusiasm for what is in the best interest of the patient. The American College of Dentists carries the torch of ethics in dentistry. So let’s lead the way.

*H. John Schutze DDS, FACD  
Queensbury, New York*

Professional ethics is not a static enterprise, and the process of continuous evolution requires newcomers to make their point of view known.

### Editor’s note

*The rate of increase in dentist’s educational debt has been constant over the period 1970 to 2015. Practicing dentists’ net incomes increased at a parallel rate until 2006, and have been stagnant since. Approximately 15% of practitioners earn less in real dollars than they did a decade ago. We do not have the statistics for dentists, but studies place the average age of physicians who have their licenses disciplined just above 55.*

### The Math Is Working Against Us

In reading Dr. Oettmeier Jr.’s President-elect’s Address in the fall 2016 issue of the *JACD*, he says that the average age of incoming fellows is 55 years old. I then read a little further in the journal how Lifetime Achievement awards were given to a number of members with 50 years of membership in the College. This would mean that the average member

of the ACD would have to be 105 years old before receiving this award!

I forgot the year I was inducted, but I seem to recall maybe eight years ago (I turn 50 this year) which would mean I would have to live until at least 92 to receive this award. I don’t believe the average American lives that long, though I hope I’m around to enjoy the honor. It would be nice for the ACD to consider shortening the term of the award given most members don’t stand a chance to receive it!

*Stuart Segelnick, DDS, MS, FACD  
Brooklyn, NY 11235*

### Editor’s note

*Your little tongue-in-cheek arithmetic calculation carries an important message. It is true that*

I forgot the year I was inducted, but I seem to recall maybe eight years ago (I turn 50 this year) which would mean I would have to live until at least 92 to receive this award.

*combining the average age of current induction with 50 years for the Lifetime Achievement Award does put folks in a superannuated category.*

*The facts of the matter are that there are exceptional fellows inducted at a very young age (though I tend to think of all fellows as exceptional), and it was the original intent of the College, and one we have drifted away from recently, to induct most at a younger age. This would bring us more years of leadership.*

*We can solve the problem two ways. In one approach, if you believe author Yuval Noah Harari (Homo Deus), we are rapidly approaching the point where some rich folks can buy spare parts to keep going. That scares the ethical fiber out of me.*

*A much better alternative would be to go back to the original purpose of the College and induct fellows based on demonstrated leadership activities early in their careers. Of course that does not help those who have already been passed over during the early excellent years of their professional lives under the current scheme. But it might be better for the College.*

*I believe that is the point Dr. Oettmeier was trying to make.*

*In the meantime, I wish us both long life.*

## Errata

*Fellow Marina Sexton of Norris Point, Newfoundland, noted a misstatement in our last issue where we printed a summary of Secretary Norman Mineta's convocation remarks. We reported the population of Halifax, Nova Scotia, where planes were diverted during the 9/11 crisis, as being 4,000. This is our mistake and not the convocation speaker's, and we apologize to the 396,000 citizens of Halifax we forgot to include.*





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"...to advance excellence, ethics, professionalism, and leadership in dentistry"

April 25, 2017

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Dear Sir:

I am writing this open letter on behalf of the Board of Regents of the American College of Dentists to formally register our disagreement with the views expressed in your article, "Suck It Up, Buttercup!" that appeared in the January 2017 issue of *Dentaltown* magazine.

The College stands for a level of ethics and professionalism that does not condone placing the dentist's income above patient health, regardless of debt load or any other personal consideration of the dentist. Misrepresentation associated with performing a procedure beyond one's level of competency instead of referral and then seeking to avoid responsibility is inconsistent with the standards of the College, and we believe with professionalism generally.

The standards of ethical conduct and core values of the College include:

- "Providing competent oral health service with compassion and respect for human dignity";
- "Integrity, honesty, and professionalism"; and
- "Truth telling as the bedrock of a trusting doctor-patient relationship."

These standards can be seen at [www.acd.org/aspirationalcode.htm](http://www.acd.org/aspirationalcode.htm).

Respectfully,

Bert W. Oettmeier, Jr., D.D.S.

President, American College of Dentists

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# Why I Advocate that Continuing Education Can Be a Game Changer

Mark E. Hyman, DDS

## Abstract

Few students graduate from dental school completely equipped to manage a thriving practice; because the context of dental practice is constantly changing, clinicians must be constantly upgrading their skills. My quest for continuous learning started with this realization, and I have endeavored to help others along their path to more successful practices. I have been guided by three experts, each offering a valuable insight. Dale Carnegie said that success leaves clues. Cathy Jameson said there is no such thing as the status quo—one is either advancing or falling behind. Tom Peters said our choice is between being distinct or extinct.

Dr. Hyman practices in Greensboro, North Carolina; [alogan@jamesonmanagement.com](mailto:alogan@jamesonmanagement.com).



Thinking back on my early years of practice, I made so many mistakes it is not even funny. I was angry because I bought a business and then I had no idea what to do. So I started doing anything I could to learn how to be better: reading books, going to courses, you name it. From that moment I learned and embraced the idea that we as dentists and business owners are always going to be studying, learning, and seeking out mentors if we truly want to stay sharp and be successful throughout our dental careers.

It has been an honor and a pleasure to be a part of the dental education world now for well over a decade. I have presented nationwide and beyond at major meetings and study groups, as well as to dental students here in my home state of North Carolina. If I can press anything on to each of you it is this: if you want to be in the top tier of dentistry, you are never finished learning.

I have been asked before, what are the top game changers in my personal dental career? In my opinion, there are three areas that will make all the difference.

## Success Leaves Clues

Put it on the shelf, Doctors. What do I mean by this? One of my favorite business thought leaders, Dale

Carnegie, always said “Success leaves clues.” You want to be the best? Keep pursuing that greatness through the exceptional clinical educational and hands-on training opportunities that are available post-dental school. Your dental degree is only the beginning of your journey.

There are some tremendous programs available today: Pankey, Dawson, Spear, and so on. Do your homework, find the organization that best fits your approach and philosophy to dentistry and get plugged in, now. Not only will this sharpen your clinical skills when it comes to comprehensive, restorative, and cosmetic dentistry, it also leverages you in the eyes of your team, your patients, and your community. The more you know, the more you grow.

## There’s No Such Thing as the Status Quo: You Are Either Going Up or Going Down

This wisdom comes from Cathy Jameson. Invest in coaching and mentors. It took me years to buy into this piece of continuing education. If I could go back and do anything again, it would be that I would have invested in this aspect of my practicing life sooner. It was not about the additional money that came because of it; I sought out help because I wanted to calm the chaos that was occurring in my practice. How could I run my business more smoothly? How could I reduce the amount of turnover I was

experiencing with my team? How could I improve my approach to case presentation so that I was doing the dentistry I wanted to do and do it in a way that did not leave me burned out within a matter of years? This is where a great dental coach can help you.

Do you know where I found my coach? A dental meeting. Twelve years later, and I still work with my management and marketing coaches at Jameson.

I also looked outside of dentistry and found mentors, books, courses that helped me become a better leader, a better businessperson, and a better communicator. Something we all know is true is that little to no focus is placed on the business of dentistry when we are in dental school. We are taught the science and facts. Not how to listen, communicate, lead, make business decisions, and so on. We have to figure that out for ourselves and the sooner we start pursuing that knowledge, the better for our health and well-being and that of our practice.

Build your library. Help your team build a library. If you do not have a library of business and leadership books that you have studied or are studying and implementing into your career, get started now. I would venture to say that the “greats” have such a library because they know there is no end to the pursuit of greatness.

The moment I stopped telling them what they needed and started asking them what they wanted, it was an amazing revelation for me. A game changer.

In the same vein of coaching and mentors, seek out circles of professionals with the same philosophical mindset as you. You may find this in a local study club. You may find this through a favorite annual meeting. You may find this through one of the clinical hands-on organizations that I talked about in my first point. You may have to go outside of dentistry and find a group that fits the mold of the philosophy you are approaching in your business. Whatever it may be, it is important to find like-minded professionals that will push you to grow and stay sharp.

### **Distinct...or Extinct**

This piece of wisdom comes from business self-help guru Tom Peters. Continuously educate yourself and your team with intention. What is your vision for your practice? What do you need to do to get there? Invest in the right courses, the right conventions, the right workshops, the right educators to help you and your team become stronger in the areas that need work.

In my early years, a game-changing book for me was *In Search of Excellence* by Peters. As time went by I realized

I had a decision to make. Do I want to be a provider of a commodity or a doctor in relationship with my patients? I settled on the latter and realized I needed to work and focus on my skills, and my team’s skills, to make this type of practice a reality.

So, not only do I invest in myself and my clinical training, but I invest in both myself and my team and our business, communication, and customer service training. What I realized in the care of my patients was this: the moment I stopped telling them what they needed and started asking them what they wanted, it was an amazing revelation for me. A game changer.

While there is a leap in the popularity of virtual and online CE, I still see a place of importance in attending conferences, lectures, in-office learning, and in experiencing training of any nature face-to-face. My friends at Jameson have taught me the importance of visual learning. We know this as dentists when we have the opportunity to use intraoral cameras to not only tell our patients what is happening in their mouths, but to show them. The same is true for our own learning and continuing education.

Benjamin Franklin and many, many others going back to antiquity, said

this and I think it drives home my point perfectly: “Tell me and I forget, teach me and I may remember, involve me and I learn.”

In a nutshell, intentional seeking of and investment in the appropriate CE for your practice and your vision is key. A balance of both clinical skill sharpening and business acumen will take you to great places, if you are open to investing in it, listening to and embracing it with an open mind, and implementation.

Implementation is the key point here. We can go to course after course but if we do not incorporate something from the information we have learned, we are either going to the wrong courses for our practice philosophy or level of skill or we are stubborn and haven't moved past the idea that we already know it all. If there is no implementation, you are wasting your time and your money.

As you seek out the appropriate courses, coaches, mentors, and books, for you, your team, and your practice, no educational experience—no matter how earth-shattering—is going to make a difference in your practice and your life unless you take what you learned and put it into play when you return to work. How are you implementing the tools you are learning? How are you leading your team to implementation?

We as dentists and business owners are always going to be studying, learning, and seeking out mentors if we truly want to stay sharp and be successful throughout our dental careers.

In today's world, instant gratification is the expectation. It is as if we believe that by sitting through that one course, magic will occur and the tools taught will instantly transfer over into our day-to-day skills and abilities. The true result comes from hard work, consistency, and persistence. Make the time to practice and perfect new skills. I always say in my new patient experience and case presentation lectures that the time I block for communication with my patients is sacred time. I believe that is also true for training and practice time for my team. We have regular lunch meetings to learn and to practice. We regularly shut down the practice for our coaches to come in and work with us on our skills.

Invest in that sacred time—make it a priority—and the tools you learn in your continuing education will become the habits you create to lead you to your ideal practicing life.

When you see me speaking from the podium, my passion is on three areas for you:

- Implementation and maximization of the right technology to build up your practice.
- Understanding the power of listening and communication in the building of relationships and the ultimate growth of your practice. My personal mentors have taught me this and now I continue to spread that message. I always like to say if you want to be the best of the best: out-listen the competition.
- The important role your team plays in the execution of your practice vision and how important it is to not only invest in yourself and your continuing education, but in your team and helping them grow.

The idea of game changers for your dental practice sounds like it would be something cataclysmic, something amazing that you have never thought of before. It is actually understanding fundamental human relationship principles that most men and women in dentistry do make use of. This is where we need to seek help, expertise, CE, and training so that we can be better at building the relationships and the value of the work we as clinicians do. It will bring a lifetime in dentistry that is rewarding and fulfilling. ■

# Why I Advocate for Building Practices by Offering Services for Obstructive Sleep Apnea

Steve Carstensen, DDS, FACD

## Abstract

No dental practice can be outstanding in every way at the same time. Focus is necessary to achieve a high level of excellence. My early curiosity about becoming a better dentist was channeled by contact with outstanding mentors and with patients who had a particular need that was not well understood by the profession. I transitioned gradually from being a student to being a provider of care for, and eventually a mentor to, others in the area of obstructive sleep apnea. This article describes my professional growth and offers a few suggestions for dentists intent on becoming masters in a particular area of professional service.

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“Donna,” said the dentist, “you’ve cancelled or missed three appointments now, and I’m afraid that violates the agreement we made when we started your treatment. Your teeth are healthy now—nothing is temporary—so you have time to find a dentist that is more able to work with your schedule.” I sat, wide-eyed and open-eared as Dr. David Hildebrand put into action his values and commitment to his practice philosophy. I was there at his invitation so he could share with this new (four-years-out) practice owner how he taught his patients to value their dental health. At lunch, as we shared our feelings about the events of the morning’s schedule, he saw in me the need and the potential to grow as a professional, a teacher, a dentist. Twenty-nine years later, that experience helps me encourage dentists to add treating sleep apnea and snoring to their practice.

## Small, Practical Beginnings

Starting up a new practice, solving patients’ problems, hoping for good outcomes and puzzling over bad ones was daily life in those days at the beginning of my practice. Bits and pieces of CE were aimed at new interests—we call them ‘shiny objects’ today. At Dr. Hildebrand’s urging, I started at The Pankey Institute, and slowly practice results not only became more positive but they started to make sense. My second week there, in 1989, I met Dr. Keith Thornton who showed me what passion looks like in

a teacher. I had been one who classmates looked to for help with lessons from fourth grade through dental school. Continuum 2 in Key Biscayne revealed a path forward as safe as any for those who choose to step up and offer to teach. After the invitation to join the faculty, I reveled in how much the lead faculty and participants could teach me about every aspect of dental practice life.

In 1998, a patient asked me if I could fix his sleep appliance and showed me a broken acrylic contraption with connectors I recognized from orthodontics. Gregory went on to tell me how much he struggled to breathe at night and what he had done to overcome this malady. From his full story I understood only one part: how to repair an acrylic device. What was I missing? Curious, I set out to learn more, only to find that my Pankey mentor, Keith, was one of the pioneers of a new field in dentistry treating sleep apnea with such devices. He was organizing a meeting that, as luck would have it, was scheduled to take place right here in Seattle. Physicians, dentists, and “sleep technologists” came together for a common purpose. Reflecting their passion and nurturing the growing excitement in my practice, I started treating sleep apnea and snoring, talking with physicians, and navigating the strange world of medical insurance. Patient after patient rewarded us

with tales of better sleep, more energy, dreaming, and happier spouses. It was not difficult to keep up the enthusiasm for this new quest.

## Focused, Continuous Learning

Sleep education was not easy to find. I joined the Sleep Disorders Dental Society (just before they changed their name to American Academy of Dental Sleep Medicine, AADSM) and went to the small conferences they had. Textbooks for dentists were nonexistent. The Internet was not yet the source of all human knowledge. Payment by insurance companies was spotty, and I was often asked to send in proof of courses I attended in order to justify being paid. Patient rewards kept coming in, however, and my Pankey training of treating the whole

person, not just his or her teeth, drove me to overcome these barriers.

Dentists who want to excel in their field often look for certification by third parties. For me, as Pankey faculty, it was studying to achieve diplomate status of the American Board of Dental Sleep Medicine not long after it was founded. If one is faced with the daunting task of learning a lot about a subject, having a “prize” to go for is a great way of staying with it.

In 2007 I was selected to be program chair of the ADA’s 2009 Annual Session in Honolulu. My office team wanted to go to the meeting (in part to help me celebrate inductance into the ACD), so we created a goal of increasing sleep therapy to fund the trip. Wow, did that idea work out. In six months we had all the money set aside for our trip budget, but, more importantly, we saw that we really liked treating these patients and we were getting good at it. Physicians from our area saw our passion and commitment, and referrals flowed in. Providing ways for a team to reward themselves for their hard work is a leader’s highest calling. Dr. Jim Pride, another mentor, always focused on team achievement. Providing sleep treatment is not something only the dentist, or even the dentist and a key staff person, can do alone. Accepting the responsibility to lead a team means staying ahead of the learning, which drives more study and finding new and better skills.

## Consolidating the Learning in Practice

Sleep problems are sometimes easy to spot. My father, an epic snorer, finally acceded to my pleas for diagnosis when he asked about falling asleep on his evening commute. Patients do not always present with such easy-to-spot signs of sleep apnea. There are others

that dental school training does little to explain. Let’s explore one common example: incisal edge wear without signs of bruxism on posterior teeth.

No one in medicine pays attention to tooth health except dentists. Physicians, trained to look at the soft tissues of the oral cavity and pharynx, skip the teeth altogether. With a disease-alleviation focus, the concept of “smile enhancement” is not mentioned, except perhaps in the plastic surgeon’s office. On the other hand, none of the veneer courses, the restorative dentistry classes I took, nor the “comprehensive dentistry” experiences I led at Pankey addressed much about the why behind incisal edge wear. At Pankey we emphasized a properly set up occlusion per our philosophy of such things. When I did it right, my patients enjoyed beautiful new smiles that have persisted without complications for decades. Except for those where it did not. True to my nature as a dentist, I blamed myself: it was my prep, the lab I chose, the cement or bonding system. Maybe not.

Turns out, sleep-disordered breathing is a problem of obstruction of the oropharynx, which can be reshaped by moving the mandible. Autonomic controls drive whatever-it-takes efforts to maintain ventilation. One of those is protruding the mandible, dragging the occluding body parts out of the airway and keeping us alive. Anatomically, there is no way to stabilize the mandible once it is forward of occlusal contact and the inferior lateral pterygoid muscle fatigues easily. Other muscles are recruited to hold the jaw forward, the front teeth touch and, over time, the incisal edges flatten. Patient and dentist alike want them returned to a youthful look, veneers are placed, and

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the patient is given a nightguard to protect the investment (which potentially can make breathing worse) and the circle spins around the unaddressed etiology.

## Sharing the Philosophy with Others

Expanding dentists' thinking beyond our common areas of expertise became the focus of my teaching in 2010. When I returned to the Pankey faculty after my ADA responsibilities ended, I joined Keith Thornton as part of the Pankey Sleep Course and became director of the course when Keith stepped out a year later. It is testimony to the values held by the Visiting Faculty that many have enrolled in the Sleep Course and taken the learning to the participants in the Essentials and Focus courses they lead. Spear Education gathers its Faculty Club annually for a CE event where my sleep lecture was well-received, leading to their starting a stand-alone sleep course. Every course so far has sold out. Teaching at Spear does not stop at "how-to." The faculty have woven sleep quality awareness into every learning opportunity they offer.

Outside of AADSM, early teaching in sleep disorders treatment by dentists was mostly led by manufacturers and other industry providers. Industry looked to the emerging leaders to generate enough enthusiasm for treating patients so that the attendees would, in turn, buy more product. Several of us were hired to present basic information about "Dental Sleep Medicine" to audiences across the country, sponsored by industry, and many dentists found a new, interesting, and rewarding field to explore. Attendees also engaged with industry partners willing to sell product. This entire arrangement can work out great for all parties. Once the dentist

Providing ways for a team to reward themselves for their hard work is a leader's highest calling.

learns enough to identify a patient, he or she needs industry support to provide treatment. Leaders in sleep dentistry remain the mainstay educators for most industry-sponsored education today.

As is true for every subset of humans, there are strata of values, ethics, and business goals. Some industry-sponsored events seem focused on selling more than teaching, some emphasize financial return more than patient outcomes, some instructors seem barely more aware of the subject than those who are paying for their "expertise." This is not unique to dentistry and cannot be a surprise for anyone who has attended a class or two. It will never go away. Any speaker can be passionate; ask yourself: "Where is the passion directed?" To you and your patient benefit or the commercial sponsor? The dentist-consumer must ask enough questions prior to signing up for a course, or, if found unexpectedly engaged in a low-value experience, to discover enough pearls to rationalize the investment of resources.

Learning comes from a wide variety of experiences. For the 2011 ADA meeting, a course I offered for sleep bruxism was the second-highest

attended course at the meeting and it had changed rooms several times in the run-up to the meeting to meet demand. I was used to Pankey classes of 24, had done a few lectures to local dental societies, knew my material, and was not afraid of the stage, but those 1,200 people and I were disappointed by my presentation. One reason to look at a prospective lecturer's history is to see if the course you are considering is consistent with that experience. If your speaker has a track record of invitations to major dental meetings and research shows that the topic has evolved over time, that's a good sign. If you are signing up for a small-group session, make sure the speaker has deep practice experience in the subject, as you will expect answers to more detailed questions than the large venue allows. As a meeting planner for the Pacific Northwest Dental Conference, ADA's America's Dental Meeting, Pankey Sleep Course, and Spear Education Sleep Course, choosing faculty for those events is an exercise in matching skills to educational objectives. Be sure to provide feedback to every meeting you attend so the planners learn what worked and what did not!

Once your basic understanding of treating sleep-disordered breathing with mandibular advancement devices is solid, you will find yourself faced with more and more unique clinical puzzles. You are used to this in your dental practice; each patient presents an opportunity to get to know him or her, plan appropriate treatment, and fully apply what you know to achieve the optimum outcome. What I find in sleep breathing treatment is the need to know my patients at a deeper level, not only what is motivating them towards therapy, but what should I pay

attention to in their medical history? The requirement to reach out to medical doctors and other providers, obtain records, and study them to truly know our patients is an expansion of normal dental practice.

One of the challenges of dentists engaging in sleep medicine practice is our relatively poor medical history training, its implementation in our offices, and record-keeping. We are used to providing care that we can see: a new filling, a root canal, or crown margin that can all be evidenced by imaging. We manage chronic diseases such as periodontal inflammation or jaw pain and there are tools we can use to record status over time. Think about your physician encounters. The physician listens to your story, asks questions, touches you only to gather diagnostic data, and then pronounces an assessment and plan. This is termed “medical decision making” and is perhaps the largest difference between the practice of dentistry and that of medicine. One thing I have heard over the years from lawyers who have used dental records in court is a generalized judgement of us as poor recorders of the rationale behind treatment.

Teaching dentists how to make a proper medical encounter note is challenging because most dentists, and nearly all dental assistants, have not had to write down much more than the physical findings on the initial examination and the various procedures performed over time. While the device we provide to treat sleep breathing disorders is a physical thing, all the action leading up to impressions and every encounter after

delivery is a medical encounter. Dentists are not at all aware of the definitions of a medical encounter or the requirements of what is to be recorded. The details are available from the defining government agencies, expected by medical colleagues, and required by insurance companies to show proper documentation. Sitting with a room full of dentists and working through seven data points required for the key component of history of the present illness or the two of three criteria for detailed examination is a challenge for me as teacher. No wonder my cofaculty at courses look to me for that segment of the week! Who wants to teach that?

Sure, encounter note training is no moon shot, but Kennedy’s quote comes to mind: “We do these things not because they are easy, but because they are hard.” It is a challenge to bring learners to the realization that they can make a proper encounter note in less time than making a bad one, look more professional doing it, and proudly hand their records to anyone without fear. I find it much harder to maintain high energy teaching simple, easy stuff than the hard parts. It is the stretch that keep our interest in life, in practice, and in leading others, is it not?

### **Becoming a Good Consumer of CE**

There is no shortage of introductory sleep apnea treatment courses available to the general dentist. Nearly every dental conference sports one or more lectures on the subject, and some have hands-on workshops. There are talks on marketing a new service, fabrication of appliances, how to bill medical insurance, and helping dentists interact with Medicare.

Choosing a course based on the teacher, or title of the presentation, comes a bit late in the decision

process. The Pankey Institute teaches that by knowing ourselves, we can (and must) choose how our pathway through the profession should look. Dr. Pride, and his successor Amy Morgan, say that creating an Annual Plan shapes the financial aspects of the practice by setting goals for various parts of the service mix. Blending solid financial planning with knowing what makes us happy every day is good advice shared by most, if not all, of my mentors over the years. The dental team will not be happy if the practice moves in a direction that violates good business principles. Dr. Gary DeWood, now head of curriculum at Spear Education, always told me “unrewarded altruism goes away.” Spiritual rewards are awesome, but bills must be paid. The dentist who is interested in adding sleep services must make decisions based on several criteria, but if the dentist’s vision is to take on an additional, time consuming and demanding service, there must be a plan that is financially sound and directs what training the dentist needs. Some dentists have time on their hands, and bringing a new book of business to the practice might be just the thing.

Let’s put some learning into categories and perhaps a pattern will point the way for you.

### **Introductory Lectures**

Found in local study clubs, dental societies, local, regional, and national meetings, these two-to-six hours of exposure to sleep medicine, anatomy, treatment, complications, and billing are the most common learning opportunities. Dentists who have heard of sleep medicine and want to explore whether it might be right for them find these excellent starting



Once the dentist learns enough to identify a patient, he or she needs industry support to provide treatment. Leaders in sleep dentistry remain the mainstay educators for most industry-sponsored education today.

places. Dental teams learn terminology and, most importantly, how to screen their patients for risk factors. They can have an immediate impact on community health by facilitating the diagnostic process for their patients. These courses are minimally useful for actually treating patients, but give the curious dentist enough information to seek the next level.

### Focused Coursework

Ranging from one to five days, and from individual coaching within the practice by one expert to highly focused, multiple-teacher comprehensive education, this category allows the serious dentist to go from minimal awareness to ready-to-treat with confidence, for many cases. A superior feature of these courses is helping participants appreciate the depth of understanding of basic medical assessment and physiology, thus giving them tools to recognize cases more complex than they are ready to treat and make plans for additional training.

### Mini-Residencies

These are becoming popular as dentists work through the intro and focused courses and seek more learning. These are generally university-based and thus have access to faculty difficult to attract to dental conferences. Often, committed dentist-participants will enjoy talks by several physicians from various medical specialties and detailed hands-on experience over several weekends of coursework. The growing number of these residencies speaks to the values of dentists willing to commit significant resources to learning.

### Online Resources

Spear Education and others have long incorporated online training in sleep education and mini-residencies are enrolling graduates in social media, blogs, and listserves, while some entrepreneurs offer in-depth lectures with online engagement to support the dentists unable or unwilling to travel for courses. This is the finest way for team members to learn sleep therapy in an affordable way. And the ability to rewatch the material is helpful for new hires and to refresh knowledge for every team member.

### In Print

Most of the didactic learning that is necessary for dentists can also be found in textbooks that might serve as excellent reference resources. There are a few written especially for dentists, but most target medical doctors. The dentist need not be intimidated by the 1,784 pages of *Principles and Practice of Sleep Medicine*, but will find within that resource answers to the science and physiology that explains the conditions to be treated. Membership in various professional sleep societies provides access to journals of research

and clinical medicine, and my publisher would be aghast if I did not mention the magazine we started in 2014, *Dental Sleep Practice*, of which I am editor-in-chief. Each quarter, I try to provide practical education to help the dental team. Writing for the magazine and cajoling other writers to share their clinical wisdom has been a welcome and invigorating challenge these past few years, and I hope to continue to provide valuable learning for subscribers for many to come.

*“The world was never changed by those who sort of care.”*

—Sally Hogshead

Sleep medicine and treating sleep apnea and snoring with oral appliances is not a single category of learning, no more than oral health is set apart from whole-body physiology. Dentists who see more than teeth and gums demand educators to provide what they seek. Recognizing that trend and nurturing a passion for this blue ocean area of our profession, I have enjoyed a position near the front of that parade for a few years now, not because I am so special, but because I am obligated to and inspired by people like Dr. Thornton, Dr. Pankey, Dr. Hildebrand, and many others I have not the space to name. It takes the wisdom of masters, expressed through the passion of the educator, to provide the student an experience that makes the heart race and the mind spin.

Seek out education provided with passion. You deserve nothing less. ■

# Why I Advocate for Practices Having an Established Relationship with a Dental Consulting Firm

Marsha P. Mullett, DMD

## Abstract

The essential skill for dental practice, and for life, is leadership. It is learnable, and professional consulting organizations such as the Pride Institute can teach this skill in a continuous and supportive relationship through consultants and customized programs. I relate here my story both as a dentist whose practice benefited from this kind of relationship and from the perspective of becoming a consultant myself.

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**M**y journey has come full circle. In 1985, two years after graduating from dental school and practicing as associates in two different cities in Florida, my husband, Dan, and I attended a lecture by Dr. Jim Pride. Thus began an odyssey that has shaped our lives, professionally and personally.

After hearing Dr. Pride's message on practice management, we asked ourselves the question, "Why would we wait, make mistakes for the next five to ten years, and then hire a management consulting company to straighten us out?" So we made the decision to begin our new practice together as Pride Institute management clients.

Good decision. Yes, we learned how and why to set up the scheduling, financial arrangements, collections, and continuing care systems within our practice. We learned how to have morning huddles, staff meetings, and growth conferences. We figured out how to hire and compensate staff and, of course, the influencing cycle. All of which were very important aspects in managing our practice. We became experts at "managing by the numbers" with our monthly trends and operating statements, all guided by our annual plan. All of which were very important aspects of running the business side of our practice. We are most grateful to have been trained and guided by Dr. Pride and our Pride Institute

consultants through all these years. With all that we were taught, Dan and I were able to have successful practices and were able to be fully engaged parents raising three very wonderful young men.

Now comes the best part. As grateful as we are for this and for the security and fun it brought to our practice and home, the best part of Pride Institute was the leadership training. Leadership is like an umbrella over all the other parts. Leadership training taught us how to work together as business partners and as a married couple. It taught us how to be better dentists and better people. As we became better leaders, our staff became better leaders. As we became better leaders at the office, we became better leaders in our community and in our church. And, most important to us, we became better leaders at home. Our children were the ultimate beneficiaries of our Pride Institute training. As proud parents, we can now say that our grownup children are very good leaders in each of their fields.

As dentists, we are trained to be excellent clinicians in our dental schools, and yet lack the skills to be business people and leaders. Dr. Pride would always remind us that we were not dentists who happened to be business people, but that we were business people who happened to be dentists. I find that most dentists are in some degree of chaos related to a void in leadership. As dentists, we wear three equal hats: leader, manager,

and clinician. Most of us migrate to the clinician role as that is the one we know the most about and are most comfortable with. Secondly, we might be more naturally gifted in leading or managing. Rarely are we competent in all three. Dr. Pride saw this void and developed his leadership training program.

Hundreds of thousands of dentists have attended Pride Institute courses in the past 40 years. I am humbled by the opportunity to give back to my profession by providing training, coaching, and consulting to dentists and their teams, and by training the dental community at large in our seminars and courses.

In my training and consulting I am thrilled to have a multitude of stories. These are ways to relate the material I am teaching to the real world in which the dentists and their teams live in their dental offices. Because I was first a dental assistant, then a dental hygienist, and then a practicing dentist who was a Pride Institute client for over 20 years, I have literally lived in the shoes of every team member. My stories of real-life examples bring relatability and laughter to our time together and bring application to the material.

Underlying all we teach is the value of strong relationships. Strong relationships between the team members, between dentist and team, and certainly between the office team and the patients. When a strong relationship is built with a patient,

that person will make appointments (accept treatment), keep appointments (not cancel late or no-show), pay their bills, and refer others like themselves. Increases in productivity and profitability naturally follow. There will never be a time in dentistry when business skills, management, and leadership will not be necessary.

My obvious role model and mentor was Dr. Jim Pride. Following in his footsteps there are many who have had tremendous influence on me. My husband is number one. He has been an excellent student of Dr. Pride and exemplifies the principals of business, leadership, and management that he was taught. The result is a dedicated, self-directed team and loyal patients who are ambassadors for the practice.

Pride Institute is an institute first and foremost. I contribute to the dental profession by educating my peers to manage their practices effectively, to increase their practice productivity and profitability, and to confidently lead their team of dental professionals.

I began this article by saying that my journey has come full circle. I am very happy to say that I am a Pride Institute consultant and trainer. My private practice is sold and now I have the opportunity to use my years of education and experience to give back. I cannot think of a better full circle than that. ■

Dr. Pride would always remind us that we were not dentists who happened to be business people, but that we were business people who happened to be dentists. I find that most dentists are in some degree of chaos related to a void in leadership.

# Why I Advocate for the Role of Physiology in Dentistry

William G. Dickerson, DDS

## Abstract

There is a place in dentistry for focused training in a specific treatment philosophy, especially if the evidence showing the critical role played by that factor across oral health can be marshalled. The Las Vegas Institute is built on identifying issues with physiological imbalance and correcting them.

It has been my belief for decades that a dental degree is just a license to learn more about dentistry. I have spent almost three decades expanding my knowledge and fulfilling my passion-filled purpose to share that with the profession. I consider myself to be a perpetual student and am committed to never stop learning. Las Vegas Institute (LVI) is celebrating our twenty-first year and we cover almost all aspects of dentistry, from hygiene to implants, from aesthetic dentistry to orthodontics. But the most important thing I have learned post-dental school is the effect that a pathologic bite has on the overall health of patients and the importance of a physiologic treatment to help these people who have suffered with a lifetime of pain. Almost all aspects of our courses are based on making sure we treat patients in the best physiologic manner possible.

## The Case for the Role of Physiology

Why does this matter to other dentists who are learning it? What is the value proposition?

Several surveys taken on this subject indicate that perhaps as much as 80% of the population is not in the physiologically correct biting position. Although this does not mean that all of them have symptoms that require treatment, as many as half of them

may have chronic problems associated with their pathologic position. Many conventional treatment procedures done by dentists are unknowingly contributing to creating a pathologic condition with the patients. We work from not only a pain elimination aspect, where a dentist can help people that no other health professional can, but also from a prevention aspect, where we do not accidentally create a situation in which we introduce chronic pain without the dentist or patient even understanding that it was due to their dental treatment.

More than 10,000 dentists and their teams from 48 different countries and from general dentists to orthodontists have been to LVI in its 21 years. One of the things I am most proud of about LVI is that in an independent survey by SDM, over 99% of LVI alumni love being a dentist and 92% of them said it was because of LVI. The type of dentistry they learn is not only more rewarding, but their patients say they respect what they do more. They are happy with the way they practice without the interference of insurance to the advanced techniques they learn that put them in the top 1% of dentists in the world.

Everything we present is not only logical and makes sense, but is backed up with complete scientific explanations. Ninety-nine point nine percent of those that come to LVI completely grasp the concepts presented. For example, it is often asked why so many people have bites in a pathologic position? Why would such a large part

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of the population be potentially pathologic? Truth is, it is only the Western population. Malocclusion is not common in non-Western cultures. Those of you familiar with Dr. Weston Price's work are aware of that.

However, modern society has created the situation that causes so many people to have a biting position that is not in the physiologically comfortable position. The big question is why? What is it that caused so many developmental problems? This has been thoroughly explained in the lifetime of work by the late Dr. Jim Garry, who was one of my heroes and role models along with Omer Reed and Ron Jackson. Jim helped so many people in his life, either directly or indirectly, by teaching dentists to recognize the signs and symptoms of airway obstruction. All I know in this area came from this great man and one of greatest honors was when Jim willed me his lifetime of work and presentations.

Yes, the causative factor in most occlusal disharmony cases is airway obstruction during the developmental stages of a child. If we, as physicians of the mouth, can determine those signs and symptoms and then correct the problems, we can prevent these children from growing up to be occlusally-compromised adults. This could prevent many people from a lifetime of suffering from cranio-mandibular disorders (CMD) and

obstructive sleep apnea (OSA). There is a direct relationship between CMD and OSA.

So many children in Western society have snotty, runny noses due to allergies and nothing can change that. The most common food allergen is cow's milk, followed by chocolate and cola. Wheat is not far behind. But there are so many causes of allergies. The point is the environmental situation causes many western children to have allergies. This causes the mucous buildup to prevent the cilia in the nose from doing their job. The cilia beat at ten to 20 times a second, and their job is to transfer the bacteria down into the throat to be swallowed and then eliminated out of the body as waste. If the cilia cannot do their job, the bacteria sit in the back of the throat and culture, causing the tonsils and adenoids to work overtime to fight the bacterial buildup. This causes hypertrophy of the tonsils and adenoids, which leads to the patient's difficulty to breath through their nose. The patient then becomes a mouth breather.

You are thinking, so what? Why would being a mouth breather cause malocclusion? This is really quite simple. There is a constant battle in arch development between the sphincter action of the buccinator muscles and the outward forces of the tongue. When a patient breathes through the mouth, the tongue is placed in an abnormal position and does not support the maxillary arch form. Because the tongue has

Going against the status quo has always been hard for anyone in any industry. There are many wrong beliefs, myths, and dogmatic ideas in dentistry and have been in any business.

been taken out of the picture, the buccinator muscles win the war and the buccinator constricts the arch. The constriction of the arch creates less room for the teeth, thus causing malocclusion. Also, in a mouth breather, the tongue may rest on the posterior teeth and prevent them from erupting, causing a bicuspid drop off. This requires them to retrude their mandible in order to get the back teeth together, causing the deep overbite.

With the bite now overclosed and the mandible retruded, there is even less room for the tongue when the mouth is closed. It forces the tongue back, shutting off the airway. So in order to breathe, individuals have to open their mouths so the tongue can move forward. These people become chronic mouth breathers for the rest

of their lives. There is also at least a 75% overlap of CMD and OSA patients. There are common origins in the etiology of both of these conditions which is why treating these patients is so important. OSA is a killer and nothing could be more important for dentists than saving someone's life.

Of course there are many other symptoms that can be created by airway obstruction, anterior open bite, cross bite, Class III, Class II, and too many others to talk about in this article, but I hope the reader understands the stomatognathic imbalance that can occur when there is a disharmony between the forces acting upon the dental arch. It is when the arch reaches a neutral position between the forces of the buccinator muscles and tongue that the arch stabilizes.

I was a typical example of a child suffering from allergies and the malocclusion affect it had. I was a "four bi extraction, headgear case" which today I consider to be malpractice. So how has that affected my adult life? With the constriction of the arch comes a high palate. The high palate creates a reduction in turbinate space. With the reduction in the turbinate space, any inflammation of the sinus will cause enough swelling of the tissue to restrict or block the airway and the ability of the patient to breathe through their nose. Children with airway obstruction problems that

results in malocclusion and high palates become adults with chronic airway problems due to the reduction in turbinate space, many times requiring turbinate reduction surgery. Several years ago I had turbinate reduction surgery and it changed my life. Today I am in orthodontic treatment to expand my arch and bring my maxilla forward and will follow up with reconstructive restorations.

Most of these children grow up to be adults with TMD problems. When the arch is not formed properly, the mandible is not positioned properly either. If the mandible is not in its comfortable position, then the muscles are forced into a chronic contraction state (hypertonicity). That chronic contraction causes muscle pain. Dr. Janet Travell (John F. Kennedy's and Lyndon Johnson's physician) stated years ago that 90% of pain comes from muscles. For every muscle that is in chronic contraction, there are antagonist muscles that are forced to contract as well. This is why neck and shoulder pain are often associated with a bad bite.

### Addressing the Problem

The key for the modern practicing dentist is to be able to recognize the signs and symptoms in children that cause them to become chronic pain patients as adults and require complex restorative or orthodontic treatment to help them. The signs and symptoms in children will still be there as adults. Then it is up to the dentist to learn the fundamentals on how to diagnose the problems and treat them accordingly in a proper physiologic manner.

*Step one.* Realize that as dentists, we can have a dramatic affect on the

patient's health and happiness and even their lifespan.

*Step two.* Learn the early signs in children to prevent a lifetime of problems and the signs and symptoms of adults.

*Step three.* Learn the techniques to treat children and adults with pain causing occlusal disharmony problems. Learn how to properly find that physiologic position. Learn how to create an orthotic to determine if the patient's pain is being caused by the pathologic bite. Learn how to measure muscles to confirm that. And lastly, learn how to properly associate a pathologic case with its physiologic position.

Going against the status quo has always been hard for anyone in any industry. There are many wrong beliefs, myths, and dogmatic ideas in dentistry as in any business. Jefferson said there are three stages of change: (a) ridicule, (b) violent opposition, and (c) acceptance.

There are many people in our profession that have vested interests and want us to be wrong. A wise man once said, the less you know the more everything seems normal. Another wise man said that you cannot diagnose what you cannot see. Unfortunately, many uneducated dentists cannot see the signs and symptoms that dentists educated in this area can see. Their reaction is to accuse the educated dentists of overtreatment when in actuality they are undertreating and misdiagnosing. Commit to becoming the best you can be by incorporating physiologic-based and sleep dentistry into your practice and change your life and the lives of your patients. ■

# Why I Advocate for Learning to Be Technically Expert

Gary DeWood, DDS, MS

## Abstract

There is something in the nature of those who become dentists that drives them to want to be as technically expert as they can be. There is not time to bring dentists to this level while in school. Skill-based continuing education is the answer. Teaching in this environment requires more than having personally achieved a high level of skill: one must love the experience of being with colleagues as they grow professionally.

I knew that teaching would play an important part in my life the very first time I had the experience of sharing something I loved doing with others. That experience occurred well before I was a dentist. In fact it occurred well before I had any idea about dentistry.

I have been active in scouting (Boy Scouts of America) since the age of eleven, earned the rank of Eagle, and served as a Scoutmaster before I had children. One of the tenants of the Boy Scout organization is that no adult does anything a boy can do, and in that environment young men are expected to share the skills they have learned with others for whom those skills are new. Everyone in the troop is given opportunity to lead and to teach, and most do. My experiences in scouting taught me that learning is a process rather than an event. It also taught me that the real learning of anything is in the doing of it, and that the teacher learns as much as the student in that process.

My earliest opportunities to share things with other dentists revolved around my training and interest in using articulators. When I graduated from dental school in 1980 many, if not most, of my classmates could not relieve themselves of those articulators fast enough. I completed a residency in which we mounted models and planned most things on the articulated casts. The process seemed natural to

me and was something I was more than comfortable with. In fact I really enjoyed doing it.

At about this time implants were beginning to become an important part of dentistry and one of my classmates, an oral surgeon, being newly trained in this discipline, was actively soliciting dentists to refer their patients so that he could place implants. In those days implants had to go where there was bone. The techniques available today to provide bone for an implant where the implant needs to be had not been thought of. My friend often found himself lost with respect to where the teeth needed to be when patients were referred for implant placement. It was rare that the referring doctor had articulated casts to look at in planning where the implants should be placed to support the restorative dentistry. He observed that my patients arrived with pretty specific guidelines regarding where the implants had to be because casts were mounted and an outcome planned. If he could not place them where they would support what I planned to do restoratively, he would not place them. For those of us old enough to remember those days, there were a lot of disappointed dentists and patients due to implants being in places that made them useless or

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The things that I most enjoy teaching are the things I most enjoy doing in practice. Understandably, those are also the things that I teach best. They are personal and interesting to me. I have energy and enthusiasm around them.

worse than useless. He asked me if I would be willing to teach others to approach things the way I had been trained and I found myself teaching other dentists.

### **Demonstrating the Best Way**

The things that I most enjoy teaching are the things I most enjoy doing in practice. Understandably, those are also the things that I teach best. They are personal and interesting to me. I have energy and enthusiasm around them. Since teaching became my primary vocation, I have continued to share those things that I love doing even as my practice became a secondary vocation and more limited. Today that sharing is done in organized courses taught at Spear Education or in the outside lectures I am invited to present. The audiences self-select for an interest in the topic of the program, so I always assume they have fixed a value to what they hope to hear and experience. I try diligently to understand that value to each of them and give them what they seek as much as is possible.

Because I have had the opportunity to be a full-time faculty member at The Pankey Institute, The University of Tennessee Dental School, The Seattle Institute, and Spear Education, I have experienced the difference between an audience that “wants” to be present and one that must pay ahead and is told to be there. Dental residents and dental students do not routinely get to pick with whom they will invest their time and energy. The same information can be experienced as having a very different value.

To be effective with a group of people who has taken time out of their

life and selected to learn specific things for which they are pleased to pay me means they already value what is being offered. Dental students present a very different and variable audience. The first thing they will want to know is how much of this material will be tested so that they can achieve their primary goal at this point in their life—successfully getting out of dental school and passing the boards. If there is no such test for which this will provide a correct answer, they see the lecture as provided for their future benefit. I have always tried to create value by placing them at a point in their future when this stuff might actually matter to them as I talk about or demonstrate something. In my experience that is a difficult task and not one that will be universally applicable to everyone in any dental student audience I have had the privilege to be with.

Since I now focus my time on postdoctoral continuing education I have fewer experiences with dental students, so the groups that I encounter are essentially “consumers” whom I am required to please if I hope to have them return. I need to make them feel as if their investment in time and money provided the value they wanted. I do this in conjunction with a group of faculty who share the responsibilities and together we develop a place where the participants feel at home. The participants and the faculty get to know each other, the participants have specific expectations for each seminar or workshop they attend. They come to know and feel our “brand” and feel comfortable with it. We may not be the only source for their learning and continued growth, but the role we play is usually very clearly defined by them.



## It Has to Be Personal

My personal experiences were like that. I met Pete Dawson and Jim Pride while I was in dental school and pursued opportunities to learn with them immediately. I also attended other learning opportunities and had different expectations for each and every one of those because they filled in different parts of the puzzle for me. Learning is always extremely personal, and I have tried to carry that into my teaching. If I can understand what it is the participant hopes for from this interaction, I can attempt to find a way to deliver on it. In a structured class setting I have my agenda to be sure, but one of my responsibilities is to find a way to flex that agenda to address the concerns and hopes each participant arrived with. If those concerns and hopes do not fit the structure of this particular course, I consider it my duty to point the participant in the right direction to discover the things they seek. That is why I try to find a way to talk with people before they plan their next step with us.

One of the most important things I've learned as I have engaged more in teaching is that the actual transmission of information occurs very differently for different people. As I think about helping dentists better understand occlusion, there are some for whom the information that helps them develop an understanding, a reference if you will, is a vital first step in taking that to the mouth. These participants feel better about their learning when they attend seminar presentations before hands-on workshops, so that they have had time to think through

the concepts and ideas. For others, hands-on exercises of a practical nature provide the reference for them to consider how this fits into their current understanding, so they benefit from initial workshop experiences followed by concepts and ideas in a lecture presentation. Helping participants understand how they learn has played a large role in my ability to best impact the “take-home” for each participant by appropriately directing their path in learning experiences.

My undergraduate degree is a BS in education. I learned that teaching children is easy, just put it out there and they are eager to absorb it, generally without prejudice. Adults are very different in their capacity for learning. Adults must identify that they want to learn something before they will commit time and energy to it. Most need to find a way to fit whatever they seek into their current understanding, or see that it represents an addition to their understanding that is valuable to them at this time, or they will not spend time or energy learning it. Without that fit, adults can come away feeling as if the information or the experience was not “worth it.” Trying to understand why a participant comes to or wants to come to a seminar or a workshop is, for me, the first step in presenting the data or designing the experience so that they can invest energy in learning. We work hard to understand that for our participants.

I have had many teachers and mentors who impacted me profoundly, and it would be impossible to mention them all here. Of those, a few are especially present for me every time I interact with a group or with an individual participant. Drs. Richard Green, Irwin Becker, Steve Ratcliff,

Cheryl DeWood, and Frank Spear each have had and continue to have influence on my ability to connect with a wide range of people from diverse backgrounds and with varied interests, in what I am hopeful is an impactful way.

Frank Spear has talked many times to many audiences about his teaching and his belief that teaching is not just passing on information or techniques so that others may take the data for themselves. Teaching is sharing of yourself freely with others and letting them take what they hear or experience to a place you might never have imagined. Teaching is an act of love. ■

A colleague asked me if I would be willing to teach others to approach things the way I had been trained and I found myself teaching other dentists.

## The Dilemma of the Undocumented

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#### Abstract

A scenario is presented where a Hispanic child in need of care fails to show up for an appointment for treatment. This case involves conflicting values, norms, and laws, including duty to promote health, inability of children to give consent, potential neglect by parents for not bringing child for needed care, confidentiality, and linguistic and cultural barriers, both real and perceived. The issues involved are discussed and it is suggested that dentists in such situations may find it helpful to avail themselves of community resources.

There is great potential for ethical dilemmas to arise in caring for the child patient. The dentist's primary obligation is to serve the needs of the patient. However, parents and guardians are ultimately responsible for consent, and acceptance of dental treatment is contingent on the family's values and resources (Seale 2004;

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American Academy of Pediatric Dentistry, 2015b). Ethical dilemmas exist when the dentist's recommendations are not compatible with the family's situation, viewpoint, and paradigm. The question of child abuse (neglect) arises when parents do not avail themselves of care for their children.

Dentists face further challenges when they care for children with fragile social situations including patients in poverty, wards of the state, patients with special healthcare needs, and those with status as recent immigrants (Guendelman, 2005). This paper will address a scenario involving care for an undocumented minor and provide an ethical framework to help the practitioner address this situation.

#### Scenario

A four year-old Hispanic male presented as an emergency with facial swelling and a history of dental pain. He was accompanied by his mother and they were both exclusively Spanish-speaking. A family friend served as their interpreter while the medical and dental histories were completed, followed by a clinical exam. The examination revealed a severely decayed primary molar as the probable source of infection, although multiple carious lesions were noted throughout the mouth. The patient was placed on antibiotics due to concerns about the ability

to obtain adequate local anesthesia and limited opening, and the patient was scheduled to return for the extraction in one week.

The dentist determined through the help of the interpreter that the patient had no dental plan or coverage, either public or private, and very limited financial resources. The dentist encouraged the family to pursue public insurance coverage so the patient could receive comprehensive care. The mother revealed that they were not citizens and did not have documentation to live in the United States. They reported they fled their home country in Central America due to violence that they believed was life threatening.

The dentist referred the patient to a respected and confidential charitable organization that provides care for low-income, uninsured children regardless of immigration status, hoping that it would be able to pay for comprehensive dental treatment either in the clinic or under general anesthesia. The patient was appointed for an extraction within one week and the dentist assured the family that the treatment would be performed regardless of ability to pay. With the help of the interpreter, she discussed the possible sequella of failure to treat infection, including facial swelling, pain, and possible spread of infection that could result in death.

The patient did not appear for the follow-up appointment. When the dentist contacted the patient, the

mother reported they did not have money to pay and were afraid to apply for the support of the charitable organization for fear of deportation. The dentist again assured the parent that the extraction would be provided at no charge and that the charitable organization would not reveal their records to authorities. The patient did not show up for a second appointment, and the family did not answer the dentist's subsequent phone calls or return messages.

### Discussion

The four primary principles that are in conflict in this scenario are beneficence, nonmaleficence, veracity, and autonomy<sup>1</sup>. Each will be considered in turn. The dentist clearly has a duty to promote the child's health and wellness under the principal of beneficence. The child would benefit from removal of the tooth, and failure to do this could result in pain, infection, and even death as a remote but real possibility. Minor patients cannot consent to dental treatment for themselves. When parents fail to meet the needs of a child after being informed of significant needs (and financial barriers have been removed) such a situation may constitute neglect. Dentists should consider cultural

The mother revealed that they were not citizens and did not have documentation to live in the United States. They reported they fled their home country in Central America due to violence that they believed was life threatening.

norms and barriers when determining how to proceed with regard to a formal report. Child neglect is specifically addressed in the ADA description of beneficence and where it is stated that dentists are obliged to be familiar with signs of neglect and to report suspected neglect consistent with state laws<sup>1</sup>.

The normative principle of nonmaleficence requires dentists to “do no harm.” One may argue that if the family is reported to a governmental agency and enters the legal system, this may result in deportation or some other such government action<sup>2-3</sup> (Berk, 2001). The family reported that they are fleeing their home country due to fear of violence that they perceive as life threatening. Given the current political climate in the United States, many undocumented immigrants are extremely fearful of the risk of deportation. A dentist may argue that putting the patient into this circumstance would be more harmful to the patient than the dental infection.

The principle of veracity might guide the dentist in reporting neglect compared to remaining silent to prevent deportation. Dentists who choose to remain silent with regard to neglect are not fulfilling their legal duty as a mandatory reporter. Does that imply that the dentist is not being truthful?

Some ethicists view confidentiality as a normative principle. If the dentist does contact a government agency to report suspected neglect, is the doctor-patient confidentiality expected of the medical professional being

betrayed? Could reporting constitute a violation of the Health Insurance Portability and Accountability Act? HIPAA regulations permit disclosure of information without legal guardian authorization in matters that affect investigation of matters that relate to abuse or neglect (Committee on Child Abuse and Neglect, 2010). The dentist is not obligated to disclose the family’s immigrant status upon reporting suspected neglect, although such revelation most likely would be made upon investigation.

The principle of autonomy concerns the parent’s right to consent or not consent for treatment. It has been suggested that, in certain situations such as these, the principle of nonmaleficence “trumps” the principle of autonomy where a patient’s well-being is threatened (Campbell, 2003). The purpose of the principle of autonomy is to prevent a paternalistic approach to care where the clinician does not provide options for treatment, but rather dictates what is best (Ho, 2008). In the case of caring for a minor, a clinician’s primary concern is for the patient; respecting the parent’s autonomy is secondary.

### Possible Courses of Action

What is the recommended course of action for the dentist according to these ethical principles? First, it must be recognized that barriers other than finances may be impacting this family. The use of a family friend to interpret what the dentist is saying may result in misleading information being transmitted to the mother. It is possible that the family interpreter gave information that was imprecise or inadequate. Also this friend’s personal feelings regarding dentistry may have influenced how information was communicated and it could have come across as threatening or

frightening. A trained medical interpreter should be sought rather than relying on an untrained individual to explain such serious issues. The Affordable Care Act Section 1557 mandates nondiscrimination against persons with limited English proficiency (LEP) enrolled in federally funded healthcare programs, including Medicare, Medicaid, and CHIP<sup>4</sup>. Providers are required to “provide meaningful access to individuals with limited English proficiency” for the 15 most common non-English languages in their state. Although it may seem this family would not fall under this rule as they are not enrolled in a federal funded healthcare program, the dentist is still obligated to provide language services under this rule. However, the rule may be interpreted to apply to all entities that receive federally-financial assistance from discriminating on the basis of race, color, national origin, age, disability, and sex. Dentists are becoming more adept at communication with families with LEP. In this scenario, use of an interpreter would certainly be in the child’s best interest.

Despite the use of an interpreter, cultural barriers may exist that prevent the family from understanding the true urgency of needed care and potential sequella (Horton, 2008; Hoelt, 2011). Due to cultural beliefs, the family may view primary teeth as unimportant or an infection as a benign situation. They may also view their diet as healthy when they cook homemade treats rather than candies, even if such treats are made of fermentable carbohydrates (Rosas, 2009). In their native country, the water supply may be compromised and unhealthy, resulting in the consumption of fruit juices instead

When the dentist contacted the patient the mother reported they did not have money to pay and were afraid to apply for the support of the charitable organization for fear of deportation.

(Muñoz-Antoli, 2014). As a result of this historical occurrence parents may continue the tradition once they are relocated to the United States despite the safety of a public water supply.

The American Academy of Pediatric Dentistry (AAPD) defines neglect as the “willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection” (American Academy of Pediatric Dentistry, 2015). However, if this failure to seek care is due to a misunderstanding of care or barriers to care, then it would not constitute willful failure. Is the lack of parental follow-through (as a result of cultural, financial, or transportation barriers) the same as refusing care?

If the distinction cannot be made, then the practical presence of neglect (at least according to AAPD guidelines) may not be met. There are no guidelines or defined number of missed appointments that constitute neglect. This is up to the provider’s judgment. If the dentist feels he or she has done an adequate job explaining

the risks and benefits of treatment versus declining treatment and a parent does not follow through with recommended care, then the criteria for reasonable suspicion is likely met.

The dentist may choose to seek the assistance of community partners, particularly organizations that support the Hispanic community, including physicians, teachers, or social workers, to overcome cultural barriers to care. In a case such as this one, organizations such as Amnesty International may be of assistance to ensure the family is not deported, since they fled their home for fear of their safety. It may be possible that the family is so fearful their status will be discovered and lead to deportation that they have elected to seek care elsewhere. In such an example, the original dentist described in this scenario would have no indication that care was sought and could understandably report neglect even though that is no longer warranted. The dentist may choose to contact the patient through an intermediary such as a community organization or a certified interpreter. However, if the dentist cannot confirm treatment was provided, there is a legal and moral imperative to report suspected neglect. If the child develops a life-threatening infection and dies, the dentist is responsible for failing to act in the child’s best interest to prevent such a negative outcome. The dentist’s intentions may be honorable in trying to prevent deportation, but the potential serious consequences may outweigh the risks of not reporting suspected neglect.

If efforts to overcome barriers to care are unsuccessful, reasonable

suspicion of neglect is present and the dentist is ethically and legally obligated to report. This decision is wrenching, but the dentist cannot let theoretical harms that could befall the patient prevent them from addressing real and present oral health harms.

## Conclusion

Care for patients who are in fragile social situations is complex and multifaceted. Care for recent immigrants, particularly undocumented immigrants, is especially complex due to lack of financial resources, legal obstacles, language barrier, cultural barriers, transportation barriers, and high risk for dental decay (American Academy of Pediatric Dentistry, 2015a; Nunn, 2009; Stevens, 2010). In 2012 the Department of Homeland Security estimated that 11.4 million unauthorized immigrants were living in the United States<sup>5</sup>. They estimate 1,120,000 or 10% of this group are under eighteen. When caring for these patients it would behoove the dentist to make efforts to have culturally appropriate resources in their office, including translators and interpreters.

It would also be prudent to build a network of community partners and gather resources to help address cultural and financial barriers to care. Most communities have nonprofit organizations that help undocumented immigrants both understand the cultural norms expected of them while living in the U.S. and access resources to comply with such norms. Many of these nonprofit organizations are trusted by undocumented immigrants and can help serve as the impetus for seeking necessary care. Dentists wishing to establish these relationships may choose to visit health fairs or activities that target specific ethnic

groups. They can help communicate the likelihood that legal status will not be disclosed as well as the importance of seeking care.

In conclusion, dentists who care for patients in fragile social situations face challenges in cultural competency. They need to evaluate circumstances by considering the cultural, language, transportation, and financial challenges these families face. Caring for these children requires special communication including the use of interpreters. Building a strong network of community partners including social workers, medical colleagues, and community organizations can help assist with difficult situations such as this one. ■

## References

- American Academy of Pediatric Dentistry (2015a). Guideline on caries-risk assessment and management for infants, children and adolescents. *Journal of Pediatric Dentistry*, 37, 132-139.
- American Academy of Pediatric Dentistry (2015b). Guideline on informed consent. *Journal of Pediatric Dentistry*, 37, 315-317.
- Berk, M. L., & Schur, C. L. (2001). The effect of fear on access to care among undocumented Latino immigrants. *Journal of Immigrant Health*, 3 (3), 151-156.
- Campbell, A. V. (2003). The virtues (and vices) of the four principles. *Journal of Medical Ethics*, 29 (5), 292-296.
- Committee on Child Abuse and Neglect (2010). Policy statement—Child abuse, confidentiality, and the Health Insurance Portability and Accountability Act. *Journal of Pediatrics*, 125 (1), 197-201.
- Guendelman, S., Angulo, V., Wier, M., & Oman, D. (2005). Overcoming the odds: Access to care for immigrant children in working poor families in California. *Maternal Child Health Journal*, 9 (4), 351-362.
- Ho, A. (2008). Relational autonomy or undue pressure? Family's role in medical decision-making. *Scandinavian Journal of Caring Sciences*, 22 (1), 128-135.
- Hoefl, K. S., Barker, J. C., & Masterson, E. E. (2011). Maternal beliefs and motivations for first dental visit by low-income Mexican-American children in California. *Journal of Pediatric Dentistry*, 33 (5), 392-398.
- Horton, S., & Barker, J. (2008). Rural Latino immigrant caregivers' conceptions of their children's oral disease. *Journal of Public Health Dentistry*, 68 (1), 22-29.
- Muñoz-Antoli, C., Pavón, A., Marcilla, A., Toledo, R., & Esteban, J. G. (2014). Prevalence and risk factors related to intestinal parasites among children in Department of Rio San Juan, Nicaragua. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 108 (12), 774-782.
- Nunn, M., Dietrich, T., Singh, H., Henshaw, M., & Kressin, N. (2009). Prevalence of early childhood caries among very young urban Boston children compared with U.S. children. *Journal of Public Health Dentistry*, 69 (3), 156-162.
- Rosas, L. G., Harley, K., Fernald, L. C., Guendelman, S., Mejia, F., Neufeld, L. M., & Eskenazi, B. (2009). Dietary associations of household food insecurity among children of Mexican descent: Results of a binational study. *Journal of the American Dietetic Association*, 109 (12), 2001-2009.
- Seale, N. S. (2004). Behavior Management Conference Panel III Report—Legal issues associated with managing children's behavior in the dental office. *Journal of Pediatric Dentistry*, 26 (2), 175-179.
- Stevens, G. D., West-Wright, C. N., & Tsai, K. Y. (2010). Health insurance and access to care for families with young children in California, 2001-2005: Differences by immigration status. *Journal of Immigrant Minority Health*, 12 (3), 273-281.

The dentist is not obligated to disclose the family's immigrant status upon reporting suspected neglect, although such revelation most likely would be made upon investigation.

## Online Sources

- 1 [www.ada.org/~media/ADA/About%20the%20ADA/Files/code\\_of\\_ethics\\_2012.ashx](http://www.ada.org/~media/ADA/About%20the%20ADA/Files/code_of_ethics_2012.ashx)
- 2 <http://humanservices.arkansas.gov/dcfsc/DCFSexeDirectives/Procedure%20XII-A1clean.pdf>
- 3 [www.cga.ct.gov/2012/rpt/2012-R-0007.htm](http://www.cga.ct.gov/2012/rpt/2012-R-0007.htm)
- 4 [www.ada.org/en/publications/ada-news/2016-archive/august/office-for-civil-rights-will-not-delay-sec1557-final-rule](http://www.ada.org/en/publications/ada-news/2016-archive/august/office-for-civil-rights-will-not-delay-sec1557-final-rule)
- 5 [www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20PopulatiPo%20Estimates%20in%20the%20US%20January%202012.pdf](http://www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20PopulatiPo%20Estimates%20in%20the%20US%20January%202012.pdf)





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