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

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Communication Policy

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

Objectives of the American College of Dentists

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

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
D. To encourage, stimulate, and promote research;
E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.
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Letters to the Editor
I recently spent almost two hours in a general dentist’s waiting room with some colleagues and six very talkative patients. Call him Dr. R. It was at the end of the practice day, and this was a focus group gathering information about how patients make decisions regarding orthodontic care for themselves or their children. Despite the fact that our panel came from diverse backgrounds there was a common theme. It showed largely through nonverbals. People were glad to be squashed together in a small space during their dinner hour, overstaying the allotted time, to talk about dentistry. Because this is not typical, it would be useful to find out why.

It was a mixed lot. There was a woman on welfare who almost cried as she explained that her teenaged daughter had high school friends who were “getting their Invisalign now,” knowing that she would never be able afford that. There was a fellow who looked for all the world like a professor and denied any interest in or knowledge of dentistry but immediately diagnosed that access to orthodontics is controlled by the GP. One older woman, who appeared to me to be overdressed for the occasion, danced around concerns she had carried since childhood about unnecessary extractions and other questionable treatment by an unknown dentist. The fellow sitting next to me told the story twice of how Dr. R had made a “mouth thing” for his daughter after her ortho so she could play the clarinet without pushing her upper front teeth out.

Dr. R had selected these six individuals from his practice as representative patients. His recruiting speech, he said, went something like this: “Would you be willing to come to my office for a half an hour at five o’clock on such-and-such a date to participate in a small discussion group about dentistry?” No other enticement; all agreed. At the end of the session, I gave each person a quart of apple sauce I had made. One of my colleagues, whom I will call Dr. T, apologized that the Starbucks gift cards that were meant as compensation had not yet been approved by the department chair, but would be sent soon. Dr. R’s staff agreed to follow up on that. Dr. T thought this was very convenient for him.

This is a story about the difference between relationships and transactions. Why were we crowded into a dentist’s reception area talking to strangers about something that almost never comes up in daily conversation? I certainly would not have driven 100 miles and missed dinner for a Starbuck’s gift card, which I and several others did. The answer was the relationship these individuals had with Dr. R. He had asked them to participate in something he thought was important, and because of their
relationship with him, they said yes. It was completely obvious in the body language of both Dr. R and the patients when he joined the conversations episodically. They mutually cared what each other thought about the topic, even if it was a bit abstract.

A transaction is the mutually beneficial exchange of things valued, but which are superfluous enough to part with. They are governed by market considerations—could I get a better deal elsewhere?—and by market efficiencies—what is the minimum I must sacrifice to get what I want? They are one-off affairs. Each transaction is judged on its merits at the moment, with little thought to future transactions. The focus is egocentric and the world is seen as competitive. The value of a practice that is built on transactions can be read in the CDT codes. Its market value is its monthly billables.

Dr. T attended a focus group based on transaction terms—to get something in exchange for something. Dr. R hosted a conversation based in relationships. Patients were there because he showed particular interest in them as individuals. Relationships, like transactions, are built on exchanges. But it is not the deal that matters; it is one’s personal sense of worth. The calculus is slightly different. In a transaction, success is measured as the excess of reward to expense. In a relationship, success is measured in terms of whether the world I live in with others is better than one without them. Relationships tend to be investments and furnish the basis for personal growth. They are open: no one ever heard of a role for a “closer” in relationships, even in offices where this is delegated to a staff member. They extend over time and across settings. That is how Dr. R could get us together in his waiting room at an inconvenient hour and get us to open up for almost twice the announced time.

The watchword in relationships is effectiveness, just as the leading idea in transactions is efficiency.

Of course, relationships are not always based on mutual positive values: there may be reciprocal animosity. There are individuals, political factions, and entire countries whose sense of identity is built around hatred for others. Research suggests, unfortunately, that those who define themselves in terms of who they dislike stand on principle and find it repugnant and insulting to consider moving to an exchange basis built around rational transactions. Terrorists cannot be “bought off.” Occasionally we encounter dentists who build part of their identity on negative relationships with regulators, insurance companies, and even—amazingly—with certain kinds of patients.

In a relationship, success is measured in terms of whether the world I live in with others is better than one without others.

Of course, dentistry must be concerned at some basic level with the efficiency of transactions. But it seems more and more to be turning productivity into a religion. A fundamental difference is that relationships can readily be transformed into transactions, but not so much the other way. I am in awe of those who have surrounded themselves with rich relationships. There are likely an inexhaustible supply of patients who feel the same way.
To Whom It May Concern,

My name is Kevin Kai. I am a dental student and recently won the Grand Prize in the 2017 ADA Dental Student Ethics Video Contest, along with two of my classmates.

I found the American College of Dentists ethics resources on the web and followed up with some back issues of the journal. It is obvious to me that the American College of Dentists is the place where discussions of what should be of vital interest to students and young dentists are taking place. Issues such as substance abuse, treatment of undocumented patients, how we interact with the legal system, and more are essential to both distinguished and future dentists. In regard to these ethical topics, new dentists or students like myself definitely would like to contribute our experiences and perspectives. However, the dental arena does not provide a platform for us to open this dialogue, and access to your journal articles is limited at best. As a result, students and new dentists are likely unaware of the valuable knowledge collected by the American College of Dentists.

This divide may be due to generational differences—the internet and social media are common outlets for the younger generation as opposed to a hardcopy journal. It may be because students have not encountered as many ethical challenges compared to experienced dentists. Whatever the reason, there needs to be a bridge between the brief introduction to ethics we get in dental school and the hard choices I imagine are coming before we solidify our practice habits.

My point is that there is value to your ethical messages, but it is not reaching the younger generations. In fact, these ethical discussions might even be bolstered by providing a younger perspective. Eventually, I hope you consider giving all dental students, residents, and new graduates information about how to access these journal articles or even add a novel online component as a line of communication. I have already seen positive results from the video I created with my peers, and I know that the American College of Dentists can benefit with similar concepts.

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Editor, Journal of the American College of Dentists:

I thought the spring 2017 issue of the Journal of the American College of Dentists was excellent, both for its content as well as the many questions it raises concerning the quality of care that dentists provide to the public.

While the state dental boards have a responsibility for the public’s health and safety concerning dental treatment provided, they must also consider the use of an effective system for the supervision of the dentists that provide the treatment. A few questions occurred to me that the profession should be discussing:

- Does proof exist that requiring continuing education without patient contact ensures the quality of treatment that is provided?
- Should dental boards require comprehensive treatment cases be submitted to maintain one’s professional license?
- Should dental boards do in-office reviews of dentists for the quality of treatment delivered? If so, at what intervals?
- Should insurance companies take a greater role in monitoring the quality of care delivered by program participants, or are they only interested in a “price point”?

As you stated in the Journal, “Boards of dentistry provide a voice for minimal standards in oral health treatment.” Shouldn’t someone be responsible for raising these standards toward broad excellence? Perhaps there is a role for the College here.

I hope that above points can start an in-depth discussion on how the dental profession can assure the highest quality of dental treatment is provided to the public.

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Dear Dr. Chambers,

Once again, thank you for raising an important issue for discussion, that is, what is the ethical response to perceived substandard care? The evil twin of justifiable criticism is unjustifiable criticism.

As I noted in the *Nevada Dental Association Journal* in 2013, the single common denominator generally seen to be associate with a dissatisfied patient is unjustified criticism from another dentist. The critical opinion is usually proffered informally in that it is never put into writing for regulatory or legal analysis, but is certainly enough to prompt the patient to seek redress from the imagined wrong. The majority of wrongs are imagined because most regulatory or malpractice complaints filed are decided in the defendant dentist’s favor. For instance, as reported in the Nevada State Board of Dental Examiners Investigations and Board Action Report for the 2016-2017 fiscal year, 247 complaints were received, 119 investigations were conducted, and 14 actions were taken. These included ten corrective/nondisciplinary plans and four disciplinary stipulations. When adjudicated in courts of law, historically defendant doctors prevail over 75% of the time (https://www.injurylawyerdatabase.com/blog/2013/09/77-of-medical-malpractice-jury-trials-result-in-defense-verdicts).

Unjustifiable criticism is a recognized area of concern for professional associations. As mentioned in the American Association of Oral and Maxillofacial Surgeons Code of Professional Conduct, the duty to peers is often mentioned as second only to our duty to patients. A proven way to avoid unjustified criticism is to consult with the dentist that provided the care in question. If the goal is accuracy and optimal treatment planning, no one should be uncomfortable with such a consult, an indispensable part of a legitimate history. Such consultation may be viewed as essentially man-datory. If the patient in question refuses to grant permission for consultation with the original dentist, it is likely reasonable to dismiss the patient for refusing information which is critical for an accurate diagnosis, absent the rare case of *res ipsa loquitur* (the thing speaks for itself). After such consultations, the original treatment rendered may morph from questionable to heroic. Why would an ethical dentist obliviously criticize and then abandon the patient to a system that is wasteful of time, dollars, and resources, all of which statistically does not help the patient?

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Dear Dr. Chambers,

I just finished reading the last issue of the *Journal of the American College of Dentists* and want to complement you on putting together another outstanding issue. I look forward to receiving the *Journal* because it is different from the other professional publications I read. Granted, those other journals and newsletters provide technical and scientific information, but the *JACD* provides articles on topics that speak to the core of our profession such as ethics, educational and practice philosophies, and advocacy. You present factual information regarding divisive issues. It is such a refreshing change, and I hope that you will continue to provide those topics for our consideration. You have always published such a quality journal! Thank you.

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Community Dental Health Coordinator

The Value Proposition of Navigation

Jane Glover, DDS, MPH

Abstract

Many patients would benefit from help converting their oral health needs into effective participation in the dental care system. Such management is broadly defined to include a consumer-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services. The American Dental Association has developed a model curriculum for dental assistants and hygienists to learn the skills to help individuals become better patients. More than 100 assistants and hygienists have been trained to date and they describe their experiences in their own words.

In an era of Fitbits, electronic portals, and instantaneous Internet experts, it has never been easier to get health information. Some people can quote their vital statistics and track the number of steps they take as they count their daily number of calories.

But in addition to finding health information, how do people act upon what they have learned? Specifically, many people know they should exercise, lose weight, or quit smoking but need help to do those things. How many people know oral health is important, but do not know the first step in accessing care?

Here is another line of interprofessional thinking: how many medical providers appreciate that oral health is important to overall health, but do not know how to get their patients to engage? How many physicians make the connection that the conditions in their patient’s mouth could be impacting their health outcomes?

The short answer to the above questions is: they do not. That’s why the American Dental Association developed a program called the Community Dental Health Coordinator (CDHC). The concept began with a question: what difference could dental professionals make if they had in-depth community health worker skills?

What Is a Community Dental Health Coordinator?

Community health workers have been shown in other fields to improve health outcomes and reduce ER use, while engaging patients meaningfully in better self-care and increased compliance with medical directives. What could happen if a community health worker skill set could be integrated into the working world of dental assistants and hygienists?

The CDHC program curriculum can teach key community health worker skills to dental professionals. While hygienists and assistants already know the basics of the dental disease process, clinical terminology, and appointment protocols of a dental office, the community aspects of health promotion tend to take a lesser priority.

That situation no longer has to exist, nor should it. Patients with chronic conditions such as diabetes, hypertension, cardiovascular disease, or HIV often cannot effectively manage both their medical and dental care and may need help scheduling visits for procedures that someone can explain in plain language. Many people need assistance with insurance enrollment, understanding what dental services are being recommended for their families, and how to best maintain optimal oral health.

The people best suited to perform those tasks are community dental health coordinators; now numbering over 100 out in the workplace, with another 120 in training. Their community health worker skills comply with state practice acts, and their clinical duties depend on whether they were originally trained as hygienists or assistants.
The duties of CDHCs depend on where their skills and services are used. They can work in private practices, health centers, community clinics, health departments, social service agencies, or hospital ERs. They can work in any venue where people need care coordination (navigation) or case management. They can work in conjunction with existing community health workers.

How is case management defined? It is a consumer-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services. It is intended to meet an individual’s health needs through communication and available resources to promote cost-effective quality outcomes.

Professionals with case management skills, such as those of a community health worker, are experts in communication styles and motivational interviewing, and they have the ability to ensure that patients are receiving the right care at the right time.

Training and Employment
The ADA developed the CDHC curriculum over a two-year period, resulting in a licensed and trademarked program that educational institutions, such as a dental assisting or hygiene department, can offer as a six- or twelve-month continuing education series. In addition, the CDHC curriculum can be “stacked” within an existing assisting or hygiene curriculum, thus enabling both programs to be offered simultaneously, with all competencies being met.

What followed after an ADA team developed the curriculum in 2006 was a three-year pilot program resulting in over 80 case studies demonstrating effective outreach and positive outcomes. The diverse locations of the pilot included tribal, urban, and rural sites. The 34 individuals within the original three cohorts who completed the pilot program found their CDHC skills enabled them to branch out and grow into positions of increasing responsibilities.

One particular dental assistant found herself switching from a chair-side position to care coordination (medical and dental) for the entire Chickasaw Nation. Another dental assistant moved up the job ladder to become the dental clinic manager for his health center. All of the graduates discovered the value of spending time within their communities performing outreach to targeted populations balanced with in-office clinical duties.

As many dental offices report challenges filling weekly schedules and the ADA Health Policy Institute reports that approximately 60% of commercially insured patients seek dental care, the value of community outreach has never been greater. This outreach can begin in small ways with significant results. The following story illustrates that point.

A private practice general dentist decided to share some information on topical varnish with the staff of a pediatric group located across the street from his office. He engaged them in a one-hour “in-service” on oral health and the opportunities to promote prevention at well-child visits. They thanked him for his
presentation and he walked back across the street, satisfied that he shared important information that could reduce early childhood caries in their patients.

Months later, he was reviewing the year-end metrics for his dental practice. While he typically saw very few new child patients each year, he noticed that for this particular year, 250 new child patients entered his practice. Where did they come from? Of course...the pediatrician’s office across the street.

The value of community outreach cannot be overemphasized. As part of a post-pilot phase of the CDHC program, one graduate participated in a “work demonstration project,” spending four months in a New Mexico health center. At the end of this four month pilot, the CEO of the health center called a two-day meeting of community and state oral health stakeholders to share some exciting news.

This CDHC was a hygienist, he declared, but after reviewing four months of health center data, the big story was that her community outreach efforts and in-house integration of oral health with the medical patients resulted in increased encounter numbers for both the medical and dental departments, accompanied by decreased broken appointment rates. “Her community activities,” he stated, “generated more revenue than she could have generated clinically by performing hygiene duties.”

Dental professionals tend to make many assumptions. We assume that printing out a treatment plan filled with clinical terminology is something patients understand and will continually act on. We assume that everyone has a toothbrush and floss, knows how to use them effectively, can understand when to seek care, and can understand the importance of regular dental visits, beginning at age one. We assume that all health professionals understand how the dental world works, that pregnant women can safely receive care at any time, that older adults already know everything about changes occurring within their oral health system, and that everyone who interacts with young children grasps the destruction that sugar sweetened beverages can cause to tooth enamel.

The concept began with a question: what difference could dental professionals make if they had in-depth community health worker skills?

In Their Own Words
CDHCs are ready to be the “bridge” between the community and dental care access points, which are in place, but often significantly underutilized. Here are some comments from a recent graduate of one of the several programs taking place nationally who happens to be a hygienist with more than ten years of experience in a community health center. Her observations regarding the program are remarkable:

- The experiences throughout the program have been many. They vary widely; learning, emotional, physical, clinical, relational, etc. It would take a book to describe them all. I have chosen to discuss a few.
- The educational (learning) experience has been very different from past classes I have taken. I enjoyed how from the very beginning we progressed through a process leading us to a final project and its outcomes. Like parts of a puzzle falling into place, it has been a gratifying, exciting, and challenging experience.
- I learned from every class. The subjects I learned most from were cultural competency, humility and discrimination, communication, body language, document readability, behavior change, motivational interviewing, OARS [open questions, affirmation, reflective listening, and summarizing], change talk, DARN [desire, ability, reason, and need to change] and CAT [commitment, activation, and taking steps], elicit-provide-elicit, and rolling with resistance.
- The skills I learned from these lessons have improved how I practice clinically, by improving client outcomes. It has also improved my relationships and how I view my community.
- I found myself enjoying a better understanding of state requirements, ethical decision making, scope of practice, risk management, state benefits, dental
The 34 individuals within the original three cohorts who completed the pilot program found their CDHC skills enabled them to branch out and grow into positions of increasing responsibilities.

care financing and insurance, as well as the community oral health profile analysis. These are activities that, in the past, I would not have found enjoyable.

Another CDHC graduate, also a hygienist, from a different state summed up the value of the program and its impact in this way:

I see navigators going in all directions, but I guess it just depends on the motivation of the navigator. I see them in private practices, public health offices, and hospital, while acting as consultants or outreach administrators, who partner with other health agencies and non-profit organizations.

I’m optimistic to see navigators as part of care teams for long-term care facilities, often working on mobile dental vans serving rural areas of the state, bringing dental screenings to patients who have not been assessed in some time. I think the future is bright for navigators; it just depends on how bright one wants to make it.

In my opinion, there are specific skills a person needs to possess to be an effective navigator, so I will list a few. The first is being able to communicate with all sides of the spectrum from patients to providers and stakeholders. You should be able to articulate well and present your points quickly and effectively to providers and partnering agencies, to best utilize time spent.

Secondly, compassion is important because your heart needs to be open for the people you are serving and caring for.

Thirdly, this job requires a good amount of organizational skills and time management. You need to be good at working with a team, as well as independently to finish and complete your assigned tasks.

What is the value of navigation to a practice or clinic? Aside from additional patients flowing into the practice, there is the positive word of mouth, which we all know is the best compliment a practice can receive. This can be the positive feedback of knowing that there is a facility in the area that is bridging gaps in dental healthcare and the patients in need of services.

Depending on the business practice model, a navigator can create outreach activities in order to be able to quickly assess patient needs and channel them into the facilities I partner with or supporting agencies, which can increase the percentage of the population able to receive care.

CDHCs, in their own words, have explained the value proposition of the program and the unique dimensions it has added to their professional lives. One graduate has shared her thoughts in this way:

The CDHC program has become the cornerstone for my non-profit and validates my mission to bring preventative dental care to rural, impoverished areas.

You will be pleased to learn how well the program was run, how inspiring and informative the professors were, but most importantly, how appreciative I am to the ADA for providing me with a scholarship that allowed me to attend the program.

Full steam ahead, it’s now my turn to do my part and document my successes, thus turning action into meaningful data.

The Community Dental Health Coordinator program has brought a new conduit into the dental profession. Patient navigation and dental case management will only expand as patients and payers demand better health outcomes accompanied by a brighter spotlight on prevention of disease.

The relatively new dental case management codes involving dental care coordination, motivational interviewing, and increased patient health literacy will improve dental quality with decreased costs—a natural focus of third-party payers. How fortunate the timing is for expansion of the CDHC program that teaches dental professionals how to perform all of the duties associated with those codes.

The future is focused on oral health becoming increasingly promoted across communities and integrated into overall health status. Are we astute enough as a profession to realize this opportunity?
M y journey into the dental profession was unconventional. During my third year of attending the Rutgers University undergraduate program, majoring in psychology, I was working part-time in a bakery located across the street from an endodontic specialty office. The owner of the practice was a frequent customer and just happened to one day ask me if I knew anyone who was looking for a part-time job. I quickly decided that I could easily trade the bakery position in for an employment opportunity in a dental office. During the impromptu interview I was introduced to a role which would entail both dental assisting and reception duties. I was fascinated by the chance to learn something completely new and accepted the position.

Over the course of the next few years I attended school full-time and worked part-time in the office. I was also a proud mother and wife. I had the ability to learn both the clinical aspects of endodontics and also the broader domain of the “front desk.” As time went on, I found that my niche was at the front desk. I enjoyed interacting with patients over the phone and in person. Since I too had a busy life, I could appreciate the patients’ desire to schedule around their personal and professional lives. In the office, I maintained the daily schedule for multiple endodontists, completed and submitted patient insurance forms, explained patient co-pay responsibilities, and worked as a mediator for any patient concerns.

The work was both meaningful and rewarding, however I felt myself needing more.

After graduating Rutgers in 2011, I applied for a position which was titled “dental comprehensive care coordinator” at Rutgers School of Dental Medicine (formerly New Jersey Dental School). During my interview, the position was described as unlike anything I had ever experienced before. Instead of working in a small private practice, this position entailed providing administrative support concerning day-to-day clinical operations for one of the four undergraduate group practices in the dental school. I was intrigued by the opportunity to broaden my skill base and to see what experience I could gain by working in the field of higher education. When I was offered the position, I was excited beyond belief, but I had no idea what I was actually signing up for!

What a Coordinator Does

The role of the Dental Comprehensive Care Coordinator is to be the ultimate “patient navigator.” There are four group practices at the school. Carolina Vega assists Dr. Nathalie Scarpa-Lota in managing Group A; Patricia Perry assists Dr. Barry Simon with Clinic C; and Eneida Martinez assists Dr. Nawal Khalil in Clinic D.

On my first day in the position, I was introduced to the dynamic
personality of the group practice administrator whom I would work side by side with to help manage the undergraduate dental clinic. Group B has 58 third- and fourth-year students and is managed by Dr. Robert Shekitka, a past board member of the American College of Dentists, and by far the most entertaining, dedicated, and caring supervisor I have had the privilege of working with. Each dental student builds a patient pool of active and recall patients over the course of two years. Each student’s family of patients numbers between 20 and 30.

The essential terms in my job title are “comprehensive care” and “coordination.” The key concept is management. Good dental care is not just one procedure after another, and practice management is not passively driven by whatever a collection of patients happens to feel at the moment. On a regular basis, Dr. Shekitka meets with each of our dental students and reviews their active patient list to ensure that patients are being seen on a timely basis and that care is continuing in an optimal fashion. Part of my job is assisting in the management of student clinical schedules to ensure that optimal patient care is achieved for every patient assigned to each student.

The job of the whole team is to optimize the fit between those learning to become dentists and their patients. Think of dentistry as having a technical aspect wrapped in a context of information, attitudes, and the limitations of other things in our lives. Our job is to make the non-technical aspects run smoothly. We are the link between patient concerns and student concerns. Maximizing opportunities for oral health with more than 200 students and 5,000 patients is a large job. We like to think that every wrinkle we can iron out so that chair time is used effectively is leveraged into better dental care.

Matching Patients and Students

First impressions matter and, of course, these are not going to be with the dentist. The initial appointment for patients in a dental school is typically in the Screening Department. Patients deemed appropriate for the school are assigned to one of the four group practices or to specialty clinics. Dr. Shekitka and I review the radiographs and admissions data of the patient and the patient load and skill level of the students. We assign and then monitor the assignment.

This model differs from what is usual in traditional private practice where the patient chooses his or her dentist based on personal and other lay considerations. It is also different from what is seen in some corporate models where patients are not assigned to specific dentists who personally oversee the comprehensive provision of care. Matching patients with dentists is a really important factor in oral health care and one that the marketing and advertising departments may not handle very well.

Harmonizing Clinic Schedules

Our dental students perform treatment under the supervision of faculty members from the departments of Diagnostic Sciences, Restorative Dentistry, Periodontics, Oral Surgery, and Endodontics. With the exception of Oral Surgery, most procedures are performed in the undergraduate clinic space. A vital part of my role is scheduling students with faculty. Each coordinator manages the schedule for their respective clinics. We each have 40 dental units that are divided into treatment disciplines with faculty members assigned to each. Our dental

The essential terms in my job title are “comprehensive care” and “coordination.” The key concept is management.
students submit appointment requests into our software program, and all day long we are receiving these requests and working towards scheduling both the students and patients into the appropriate slots. This is a very time-consuming and detail-oriented task.

We also serve as the contact center for our patients and students. Often patients have changed their phone number and forgot to update their information with their dental student. When this happens, a student will come to me and explain that they are not able to get in contact with the patient. I work to mend the broken communication because that can mean an undesirable break in comprehensive patient care. I am also responsible for maintaining our group’s “recall list.” These are patients who have completed their treatment plans but will receive future maintenance visits for either prevention, periodontal care, or postoperative check-ups. Each month we send out recall letters to patients who are due for an appointment. We also are the primary contact for our patients to call in order to get in touch with a student they have trouble reaching, to discuss concerns and comments regarding treatment, and to schedule emergency appointments.

Keeping Patients in the System

Another primary responsibility attached to our title is the assignment and scheduling of emergency patients. The dental school accepts walk-in emergency patients at all times during operating hours. When a patient comes in to the dental school with an emergency, he or she reports to the staff at the front desk. The staff member checks our database to see if the patient is assigned to an undergraduate group. Any patient who was treated by Group B becomes my responsibility. The Group Practice Administrator and I check the availability of students who might have had cancelations. Often these “emergencies” are really patients who have neglected to follow through on their part of comprehensive care. I try to find out why and get them back into the system. Sometimes that is just human nature, sometimes life events, and occasionally a disconnect between the assigned student and the patient. In a system without a navigator who has access to alternatives (just the patient and the dentist), we would lose more patients than we need to.

Why I Love this Job

The role of the patient navigator is essential. I honestly am not able to imagine our school running as efficiently as we do without the Dental Care Coordinators. I have proudly served in this role for the past six years, and the position is evolving all the time. Our school’s transition to an electronic health record system three years ago was a strong indication of this. We add value to our school’s clinical program by being an approachable and reliable source of assistance for patients to discuss their care. Our patient’s value the fact that even though our school is much larger than a private practice, they are not processes as standard units or bundles of treatment codes. There is someone whose primary job is to match their dental needs with those who can best meet them. They know that they each have a student, a Dental Care Coordinator, and a Group Practice Administrator, all looking out for them.

I feel that the most valuable skill in this position is the ability to listen to what both our patients and students are trying to communicate. All patients want to feel reassured and know that they are important—not just as a patient but as a person. The dental chair can be a scary place and we often treat patients who come to us with a fear of the dentist and a history of putting things off. But over time we are able to build their trust and ease their anxiety. Every day when I walk through our clinic I am blessed with the opportunity to see patients and students talking, smiling, and connecting throughout their appointments. One of the greatest rewards of this position is to experience a patient feel that their dental student has made an impact on their life by changing their smile and in effect changing the way they approach the world around them.
Navigating with Special Needs

Pamela Alston, DDS, FACD
Monica Chadwick
Ada Sosa

Abstract
The barriers to accessing oral health care increase dramatically for those with special health conditions such as HIV. Navigators can improve utilization by listening, connecting with services, coordinating schedules and life demands, working out miscommunications, and promoting health, personal, and care-seeking habits. These services have the additional benefits of promoting overall health, increasing collaboration with other healthcare providers, and lowering the cost of dental care delivered through emergency rooms. Two navigators share their personal stories.

Who you are says a lot about how you access oral health care. Oral condition alone is not determinative, nor is need plus means. Some people would benefit from help in getting to the dental office just because of their overall health condition. Obviously this includes those with disabilities that affect their mobility or their capacity to endure lengthy dental appointment. Dealing with large health issues drives down the relative salience of oral health, and there are interactions between dental treatment and some health conditions that present barriers. There may be stigma attached to some conditions.

The Ryan White HIV/AIDS Program is the largest federally funded program targeted at providing low-income people living with HIV with a comprehensive system of care. Through grants awarded to states, counties, and community-based organizations, the program provides a safety net for outpatient HIV care for uninsured or underinsured patients. Alameda Health System (AHS) receives Ryan White grant funds to provide core medical, oral health, and support services to patients. Support services must be linked to medical outcomes and may include non-medical case management, medical transportation, and linguistic services. In addition to this, AHS is recognized by the University of Pacific, Arthur A. Dugoni School of Dentistry to receive Ryan White funding to train some of its dental students and residents to deliver dental care to patients with HIV at Highland Hospital in Oakland, California.

Despite the fact that low-income AHS patients with HIV can qualify for free dental services through the Medi-Cal (the state’s Medicare system) or Ryan White programs, a significant number do not seek or obtain non-urgent oral health services on their own. The medical providers at Highland Hospital’s Immunology Clinic use clinic staff to assist HIV patients in obtaining available oral health services at AHS dental clinics. Specifically, a medical assistant (MA) and a community health outreach worker (CHOW) serve as oral health navigators. Their effectiveness in obtaining consistent oral health care for their patients with HIV improves overall medical outcomes. Their support in linking patients to dental care also helps keep the dental clinics financially sustainable.

How these professionals improve the chances of individuals living with HIV receiving oral health care may best be told in their own words.

Medical Assistant: Monica Chadwick

It is takes tenacity to navigate patients to oral health care. For example, I had been working with a particular patient for some time trying to motivate her to agree to obtain dental care. Each time I offered to help her, her response was a sigh. It was not until relatives from Louisiana were relocating to the
Who you are says a lot about how you access oral health care. Oral condition alone is not determinative, nor is need plus means. Some people would benefit from help in getting to the dental office just because of their overall health condition.

Linking patients to services and keeping them retained in care requires building them up and empowering them.

San Francisco Bay Area after Hurricane Katrina that she approached me to enroll in the Ryan White dental program. She did not want her relatives to see the condition of her teeth. The last time they had seen her, they commented on her teeth. She felt ashamed. She expressed that she was ready now for me to make an appointment for her to see a dentist. The dentist created a treatment plan that included full-mouth extractions and complete dentures and the patient followed through. Taking that step encouraged her to seek an appointment for eyeglasses. I made her an appointment. She came back to the clinic one day specifically to show me her new look.

As she explained that she felt like a new woman, she started crying. She expressed that she no longer had a reason to be ashamed of her appearance. She had no reason to fear being put down. She said she felt like a star in her relatives’ company. I was overcome by her gratitude to me for not giving up on her. I have continued to follow her. The transformation with dentures and glasses was more than superficial. Her attitude was also transformed. She has been sober ever since and in a stable relationship. It is people like her that motivate me to work even harder.

But she is not unusual among our patients with HIV. Just because dental care is available, conveniently located, comprehensive, and free does not mean that patients will access it. That is why I make it a point to discuss the importance of oral health in relation to people’s overall health. I take time to explain to patients that because they are immunocompromised, they can develop opportunistic infections and other dental conditions in their mouths.

In the 17 years I have worked in the Immunology Clinic, I have had a variety of functions. At one time, I served as a Linkage and Retention-to-Care Coordinator. This support service was funded under the Ryan White Program. It is an important function because we know that treatment of HIV infection can be effective only if patients are retained in care on a long-term basis. This is where my natural skills came into play.

I am a naturally motivating and interactive person. Linking patients to services and keeping them retained in care requires building them up and empowering them. I maintain a relationship with them that includes healthy boundaries. One of the key components is trying to find out what is most important to them and their immediate needs. Sometimes they are preoccupied with not getting into care or getting medication from their doctor. Their immediate need may be housing. They may have food insecurity. That was the situation with the woman whom I helped to obtain dentures. She was not adherent with her medication. But she said, “I need teeth. My family is here. I really need dentures. I don’t know what to do. I don’t want to be around my family the way my teeth are.” I seized the moment. One has to be where those in need are when they recognize that need. And I have to know where to find help. I told her, “Hey, let’s work on that.” I functioned as her health coach. Once patients start to see what is working for them, they are ready to take more steps. In fact, the patient told me, “Okay, this is really working for me. My teeth are out. I am waiting on my dentures. Okay. I am feeling better about myself. Can I get an eye
appointment for glasses? Now I am getting things done.”

I am passionate about finding a way to relate to each individual in our diverse patient population, but inarguably my African-American ethnicity is helpful in relating to our African-American patients. Even though we communicate in English, I use a vernacular which makes them feel more comfortable and relatable to me. It is so easy for medical professionals to drift into a lingo, using medical terms and making assumptions patients do not understand. Professionals often wait for patients to come to them and complain when they do not. First and foremost, I let them know that their HIV diagnosis is not the end but rather a beginning. My job is a higher calling. I remember this on days when I encounter patients who are not adherent. My gifts are that I am a natural motivator with an ability to strike up a rapport with patients easily. I can genuinely acknowledge to them that we are not perfect. Everyone makes errors and gives up sometimes. I encourage them to start again. I meet them where they are. We pick up the pieces and keep going.

As I gained more experience in my Linkage and Retention-to-Care Coordinator position, I became adept in navigating with our patients with HIV to support services. I would readily discuss with patients the different support services, make referrals, give vouchers, and schedule appointments. There are a lot of referrals generated because of the chronic illness that comes along with HIV. Early on, I was aware that dental services were available to patients at Ryan White funded clinics. I thought it was a great service but I did not push it because I did not see the correlation between oral health and overall health. After years of working in the Immunology Clinic and following up on their missed appointments, I saw a pattern. If they were missing their dental appointments, they were also missing other specialty appointments to which I referred them. I had to learn why the specialty appointments were important in order to explain their importance to the patients. I realized that I had to raise my own oral health literacy level before I could raise my patients’ oral health literacy levels.

Once the patients perceive the value of oral health, I get pragmatic. I ask myself, what do they need in order to keep their dental appointments? When I first started to schedule their dental appointments, I reminded patients about them too far in advance. I also tended to schedule the appointments at times that were inconvenient to the patients. I did not fully consider their personal schedules. Just because patients have HIV and just because they are low-income does not mean that they are not working. They may also have partners, spouses, children, or elders whom they are responsible for. They have full lives and other commitments.

In the beginning, I would say, “The first available appointment is at 4:30 PM.” They would respond, “Okay.” They did not tell me, “But I have a child to pick up from school at 4:30 PM.” They simply did not keep the appointment. Some of our patients do not work at jobs where they can take off time from work. Many of our patients are dependent on public transportation. A 30-minute car ride is a 90-minute ride on public transportation. I find that what works best is to take the time to become acquainted with the patient in order to figure out what is the best appointment time. It is helpful to know their lifestyles. Is the patient a morning person or not? I speak with the dental clerk directly and will request an appointment time that the patient is most likely to keep. I will also check the computer to see the kept appointment history to get a sense of what time of day is best. At one time, two AHS sites had dental clinics. I scheduled appointments at the dental clinic site that was closest to the patient’s residence. I found that if our patients kept their initial dental appointment, they were likely to keep future dental appointments. I am also
sensitive to the environment in which our patients with HIV feel most comfortable. They want to be assured that dental clinic personnel will keep their HIV status confidential because they do not want to be singled out and stigmatized.

We have found that some of our patients with HIV consistently keep their dental appointments but miss their HIV medical appointments. As I have a good working relationship with the dental clerks, I ask them to tell the patients I am trying to link back to HIV services to call me when they are present for their dental appointments. We also have implemented a requirement that dental patients must submit to their dentists semiannually their latest serology test results showing their CD4 counts and HIV viral load. We also require that they submit a printout of their medications every six months to their dentists as a condition of continuing to receive their dental care funded by the Ryan White program. Dental care will be postponed until they bring in the serology results and medication list.

The strategy works. It is amazing how motivated the patients become to get their laboratory work done and their medications refilled when their continued access to dental care is jeopardized. When their dental care and oral health status become important, they will make and keep HIV services appointments to continue their dental care. So, access to dental care sometimes functions as a way to link some of our recalcitrant patients back to HIV care. As a patient navigator, the support services including dental care help my patients maintain continuous connectivity with the health care system. I am grateful to play a role in helping our patients with HIV build up to healthier outcomes.

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I am often the “person of last resort” for patients encountering problems related to accessing and receiving care. By the time patients reach me, they are frustrated and may be discouraged about further seeking dental care. I calm them down and listen closely to what the problem is. Then I go to work on addressing the problem and finding a resolution so that they can be relinked to dental care.

Ryan White patients receive free oral health services and even though they are told this, they mistakenly receive bills. They are understandably discouraged about seeking further dental care. One of our patients had received a bill that he had not anticipated and could not afford to pay. He had spoken to financial services personnel several times and was still unable to resolve the situation. What had happened was that he was unemployed when he first began to receive HIV services. Then he became employed and obtained medical insurance through his job. He transferred his medical care to an office that accepted his insurance. However, he continued to obtain support services at AHS, such as dental care and HIV group support.

Normally, on his way to the weekly support group, he would stop to greet me and exchange pleasantries. But his whole demeanor changed all of a sudden. He told me one day that he was worried because he was getting bills for $4,000 worth of dental care he received, and the bills were more than he could afford. He said he had been in touch with a financial counselor who offered to set up a charity (sliding scale) plan. The financial counselor required that he bring in some
financial documents in order to continue to receive dental care. He was having a hard time gathering the papers. He asked for my help. I told him that if the financial counselor contacted him again, he should direct her to call me. The financial counselor called and I explained that the patient’s dental services are covered by the Ryan White Program and that he should not have any out-of-pocket costs. This kind of confusion can happen to people whose job it is to know the system: imagine its effect on those struggling with a foreign system.

Dental care is a needed support service for patients with HIV. They often do not take the initiative to seek dental care on their own, but dental-related questions often come up during physical examinations. For patients who express that they want or need to see a dentist, their primary care physician sends me a referral for the patient. If the patient is still in the clinic, I will meet and chat with him or her before scheduling the dental appointment. Alternatively, patients can stop by the front desk to get a referral for dental services.

In addition to providing oral health navigation, I work in the clinic and field performing HIV testing and counseling. When patients test positive, I explain the benefits of the Ryan White medical program, HIV medications, and supportive services including dental services that are available to them. While I cannot deny to them that the HIV diagnosis is serious, taking the time to explain how to access support services, which includes dental services, positions them to achieve the best possible health outcomes under the circumstances. I am making a positive difference in the lives of our patients with HIV, and I am grateful to have the opportunity to be their oral health navigator.

The Value of Oral Health Navigators for Those with HIV

As Monica Chadwick and Ada Sosa demonstrate, medical assistants and community health outreach workers with proper training, resources, cultural humility, compassion, and keen interpersonal skills can help patients who are vulnerable obtain the oral health care they need. Low-income adult patients with HIV often present to their medical providers with a backlog of oral health treatment needs due to the instability of dental payer sources, complexity of their dental needs, and difficulty in navigating the health care system on their own. The oral health navigators at AHS guide patients away from Highland Hospital’s Emergency Department for episodic care and to the general dentistry clinics where they can obtain definitive dental care. This is a cost savings to AHS. Getting patients into dental care may assist in retaining patients in overall HIV care. This strategy improves their HIV outcomes. The oral health navigators meet the patients with HIV where they are. They work with the patients to overcome barriers to care that the demands of daily living impose. They offer support services. These strategies improve the chances that the patients will keep their dental appointments in order to improve their oral health and overall health outcomes. When the patients in the Ryan White program keep their dental appointments, it supports the dental clinics’ financial sustainability.

The patients with HIV who are linked to dental care because of patient navigation have demonstrated the effectiveness of this strategy. Fortunately, the Ryan White funding makes it possible for HIV services to have personnel to serve as oral health navigators and for the dental clinics to be reimbursed for providing comprehensive care. Just as patients with HIV face barriers to oral health care, patients with other chronic conditions face similar challenges. They experience difficulty navigating the health care system on their own. In a public hospital system such as AHS, we envision patient navigators stationed in other selective chronic disease clinics to guide their patients to available dental services where positive health outcomes are demonstrable.

The oral health navigators meet the patients with HIV where they are. They work with the patients to overcome barriers to care that the demands of daily living impose. They offer support services.
Navigating the Cultural Dimension of Oral Health Care

Huong Le, DDS, MA, FACD
Andrea Akabike
Curtis Le

Abstract

Although policy leaders have consistently pointed out that oral health is essential for overall health, the fact that dentistry has a separate deliver and reimbursement system increases the burdens on minorities for accessing care. This is especially so for groups that are culturally and linguistically distinct. A model of Federally Qualified Healthcare Centers with patient navigators is described as one means for bringing more patients into the oral healthcare system.

Though oral medical science and healthcare has advanced leaps and bounds over the years, the importance of maintaining oral health continues to be underestimated by the public at large. U.S. Surgeon Generals (U.S. Department of Health and Human Services, 2000) and Secretaries of Health and Human Services have spoken forcefully about the importance of oral health in overall health. Unfortunately, there are still great disparities across the nation with regard to oral health access. Those of low socioeconomic status and cultural/linguistic minorities are among those most affected by these inequities. Children within these groups are at elevated risk for developing dental caries, the single most common chronic childhood disease in the United States, despite being completely preventable (Petersen et al, 2005).

Federally Qualified Health Centers (FQHC), commonly referred to as community health centers (CHC), are community-based organizations designed to combat these health inequities by serving the underserved. Working with governmental services, the goal of many FQHCs is to engage in public outreach to provide comprehensive, preventive care services to populations who otherwise would have difficulties obtaining care. All new FQHCs are required by statute to offer oral healthcare services.

Unfortunately, as of now, the majority of patients and communities in need of such services still remain untreated for a variety of factors. Recent censuses conclude that of the 48.6 million uninsured people in the United States, only 7.3 million actually visited and received services at FQHCs.

The underserved are a more difficult group to serve. The factors leading to these populations’ inability to access care exist on both patient and provider sides. For patients, language barriers, immigrant status, geographic challenges, and lack of adequate insurance prevent them from accessing care. Providers, on the other hand, struggle with meeting patients’ needs in those capacities, as well as facing challenges with limited capacities and infrastructures as they presently exist. However, according to Almufleh and coauthors (2015), perhaps the most important factor lies in communication between patients and providers. While FQHCs attempt to reach out to these communities, Almufleh explains, “many of the most vulnerable patients, however, may continue to have difficulties accessing and navigating the complex U.S. healthcare delivery system.”

Fundamentally, the key is allowing the underserved to express and communicate their concerns and needs, and then following up to meet these issues. One of the ways that we might address this is through the use of patient navigators to conduct deep community outreach directly to those who are outside the current systems.
Natalie-Pierre et al wrote in their article “The Role of Patient Navigators in Eliminating Health Disparities” about the importance of patient navigation and concluded, “patient navigators can not only facilitate improved health care access and quality for underserved populations through advocacy and care coordination, but they can also address deep-rooted issues related to distrust in providers and the health system that often lead to avoidance of health problems and noncompliance with treatment recommendations. By addressing many of the disparities associated with language and cultural differences and barriers, patient navigators can foster trust and empowerment within the communities they serve.”

Asian Health Services as a PN Model
Asian Health Services (AHS) was founded over 42 years ago in the San Francisco Bay Area and currently serves patients of many demographics who speak 13 different Asian languages. In 2005, recognizing the barriers of access to care that existed in some emerging Asia communities, AHS created the patient navigator (PN) position to serve the growing Chinese and Vietnamese communities. It has since expanded to encompass six different ethnic communities.

What PNs Do
Because of the vast variety of duties PNs are tasked with, they often state there is no true definition or job description. The combination of the U.S. healthcare system being complex and the diverse needs of different communities requires PNs to take on multiple functions that adapt to each community as needed.

Community advocacy including community outreach is perhaps the most important component of their role, but how they may conduct this is often dependent on other tasks they may also need to perform in order to teach patients their options. Oftentimes PNs will act as phone receptionists and translators to inform patients of their options within a given FQHC. They may also be responsible for advising patients on their insurance choices and on how to apply for or renew options such as Medi-Cal (Medicaid), Covered California, or other specialized health plans for low income residents. PNs can also be found as liaisons between providers and patients, usually as an interpreter during clinical visits or assisting in scheduling referrals to specialists.

Furthermore, because of language or education barriers, PNs may commonly find themselves in charge of following up on patients’ health care compliance with regards to health coaching or drug compliance. Ultimately, the role of the PN could be regarded as an all-purpose member of a clinic who specializes in giving the patient confidence in their care.

Currently, AHS has a team of patient navigators who communicate with patients in Chinese, Vietnamese, Korean, Khmer, Filipino, and Mongolian. The PNs ensure patients and community members have a point person to guide them through the complex internal and external health care system. Over the course of the program, AHS PNs have found that patients with English as second language (or otherwise limited-English proficiency) had greater needs for assistance when accessing service outside of AHS. For certain communities, especially those that rely on the PNs, language barriers often discouraged or even prevented proper care in institutions without a dedicated PN program. As such, it is becoming increasingly obvious that PNs are an invaluable asset to underserved communities. Patients tend to
consider PNs as their “one-stop shop” as they are able to assist in various capacities in many stages of a patient’s health care experience. More often than not, PNs bridge the communication gap between the patient and health care entities to ensure the patient’s needs are addressed and their concerns voiced. No other position within AHS, and perhaps health care at large, can assist a patient at every stage of health care service, from registering new members as patients to AHS, to finding coverage for the uninsured under an appropriate health coverage system, to connecting patients to a primary care medical provider. PNs furthermore are a hub for communication among many systems (insurance, medical providers, dental providers, for example) to interact seamlessly. Without them, breakdowns in communication between any parties can lead to failure to adequately serve patients.

When patients find themselves in danger of losing health coverage, or otherwise being unable to pay for necessary health care, PNs are often the first aid they seek. PNs have demonstrated the ability to capitalize on our partnerships with the local county agencies to regain and maintain health coverage for hundreds of patients and their families. Whether it be interpretation or helping to reach the correct specialists for optimal care to even just educating a patient on their basic health conditions, PNs guide patients through the best path to health improvement. Furthermore, PNs are economically sound, even helping FQHCs generate revenue, thanks to their multifaceted efficiency in the field. In the case that a patient is uninsured, PNs screen and enroll the patient into the appropriate public health coverage or Covered California insurance plan, subsequently connecting the patient into care. PN activity and enabling services are also counted towards many of our agency grants. Their services will help showcase the additional services AHS provides our patients outside of the exam room. As for positive health outcomes, studies have illustrated many examples of how the PN model in other healthcare settings have eliminated health disparities for chronically ill patients.

The Skills of a PN
When interviewed, all PNs at AHS agreed that the most important skills they present are language interpretation, customer service, and efficient multi-tasking. Combined, these skills are integral to connecting to patients such that they understand their situation and trust that health care entities will serve their needs. One PN said, “Being able to connect with patients during face-to-face encounters and spend a greater amount of time outside of check-in and check-out are some aspects of the role that attracted me. Also interpreting for providers and assisting patients with insurances allow me to gain a greater medical knowledge and the way the U.S. healthcare system works.” Another PN shared, “In our role as PNs, we must be resilient, resourceful, and have the presence of mind to know that when one door closes, another door opens. PNs must practice compassion, commitment, have an intrinsic ability to multitask, and need to demonstrate CARE (Compassionate, Appreciate, Responsive and Empower) techniques with patients, their family members, colleagues, and all others they may encounter working in the safety net.” Strong language skills in English and the patient’s preferred language are important based on the given populations. Familiarity with advancing technology is also important to ensure the PN is able to adapt to the today’s growing dependency on technology.

Passion for the work they do is self-evident in PNs from the stories they share. In their opinion, there is no greater reward than the satisfaction of seeing a healthy patient. To them, a patient’s smile is compensation enough. Different from other frontline staff, all interactions between PNs and patients are direct. It is not uncommon for PNs and patients to become very familiar with one another due to the extended time that they spend together throughout the entire process of treatment. Being an asset for the community in order to support low-income underserved individuals and their families in getting access to quality care is an honorable role. Our patients are immigrants, refugees, or come from underserved communities. PNs have the opportunity to introduce the mechanics of health care in America to those underserved communities and educate and navigate them through to maintain a healthy well-being for themselves and their family. One patient navigator shares her experience as “Like many people who work at AHS, the greatest source of satisfaction is knowing that you were able to reduce barriers to care for patients and get low-income underserved individuals and their families access to health care services.
to achieve positive health outcomes. Helping people and being able to solve their problem is a great source of satisfaction as a PN.”

PN Trends

In 2017, The Alameda County (California) Public Health Department (ACPHD) will implement the Healthy Teeth, Healthy Communities (HTHC) pilot as part of the Local Dental Pilot Project (LDPP) of the Dental Transformation Initiative of Medical 1115 waiver. The project time line is four years: April 2017 to December 2020. The HTHC project is a cross-sector collaborative initiative to implement a county-wide dental health care coordination system to ensure Medi-Cal eligible children, birth through age 20, in Alameda County receive prevention and continuity of care services necessary to ensure their dental health. One of the objectives is to create a cross-agency workforce of community dental healthcare coordinators (CDHCC) who are linguistically and culturally responsive to the community. The goal is for these CDHCCs to reach out to 15,000 families in Alameda County and coordinate care for those who need it. The position may be identified by various names, CDHCC and PN, but the objectives will remain the same: to ensure barriers to care for these communities will be eliminated or decreased in the same capacity as patient navigators. The expected outcome is a reduction in health disparities for the most vulnerable populations.

Patient navigators support the needs of both the agencies they represent as well as those of the patients they serve. Their priorities will shift based on the needs of the agency and community, as well as the changes in legislations and other future conditions. As the safety net prepares for alternative payment reform, the need for PNs will be greater than ever. The needs of patients, providers, and the community are ever-changing, and with the future of health care political climate being always unpredictable, the importance of the versatility and commitment of PNs in the field cannot be understated. Successful care is dependent on the resources we need for positive outcomes in patient care, and correspondingly, validated data showing positive outcomes helps FQHCs gather the necessary resources to continue to provide excellent care to the underserved. Within this positive feedback cycle, PNs are key as their ability to improve access to health care and the quality of health care for patients is critical to the function of public health. As one PN said, “For me personally, the commitment and the advocacy piece and of the PN role is the most important part. From the moment a patient walks in to the moment a patient receives quality healthcare, PNs provide and can provide assistance in so many aspects of a patient’s healthcare, whether it’d be getting health coverage through grant and insurance, access to basic health care, doctor’s visits, and specialist appointments and even basic navigation in the country being a new immigrant.”

We would like to acknowledge the PNs at AHS: Judy Nguyen, Vicky Sin, and An Qi Xiao for sharing their stories.

References


Online Sources

The Challenge of Adolescent Competence and Consent

Abstract
A mature adolescent expresses preference for a conservative approach to treating a large carious lesion. Her mother prefers a more aggressive treatment. What are the dentist’s responsibilities and options?

The Case
Your patient is a 16 and a half year-old female who is accompanied by her mother. Clinical and radiographic findings reveal distal D1 caries on an existing #12 MO composite filling. The patient exhibits relatively low caries risk, good oral hygiene, and has little previous restorative work done. Your clinical opinion is that the filling should be replaced with a slightly larger composite MOD filling. A crown is a viable alternative, but obviously more aggressive.

You explain the risks, benefits, alternatives, and costs to the patient and her mother. You inform them that either alternative might fail or fracture in the future, and could even necessitate root canal treatment, although you are relatively confident that a new filling will suffice quite well. To your surprise the mother informs you that since her daughter’s dental plan ends when she turns eighteen years old, she prefers that a crown be placed now. The young patient, however, understands the clinical implications and thinks that a crown would be too aggressive at this point, and is also concerned about how a crown might look. The mother and child argue about this in front of you. Both the mother and the child are insistent in their differing points of view.
What do you do?

What follows is a series of responses from four experts, including one pediatric dentist, one attorney, one philosopher, and one psychologist. Each has more than 25 years of experience in dentistry or dental education.

Dr. Wood (Pediatric Dentist)

An adolescent patient, who is legally a minor, and her parent are presented with two treatment options. The risks and benefits of this case may not have been completely understood or explained to the parent and patient, but for the sake of discussion assume that each party has an adequate understanding. We may also need to assume that both treatments are clinically acceptable in order to highlight the ethical issues. We can then examine the case and the ethical implications from each individual’s perspective: the mother, the adolescent daughter, and the practitioner.

As a biological parent, the mother has the legal right of consent for her minor adolescent daughter. Legally—unless she wishes to declare herself an emancipated minor through the courts—the daughter does not have the right of consent based on her current age. The mother is within her rights to dictate treatment for her daughter if the law is interpreted rigidly. Ethically, part of the mother’s parental goal should be to help her daughter develop autonomy, dignity, and the capacity for self-determination, so that as an adult she will possess these qualities to competently manage her own life. Involving her daughter in this treatment decision could further that goal.

The daughter seems to have a good understanding of the procedures as well as their risks and benefits, as explained by the practitioner. She seems to manage her own oral health responsibly as reflected by her low caries risk. While she does not have the legal right of consent for her own treatment (based solely on her age), her capacity for self-determination seems well-developed, and her autonomy and dignity should be strongly considered in any treatment decision. In pediatric medicine this is often referred to as a minor patient’s “assent.” While dentistry is largely silent on the topic of assent, the American Academy of Pediatrics (physicians) suggests that for older children and adolescents, based on their psychological development and capacity for decision-making, “serious consideration” should be given to their treatment wishes to the greatest extent possible. Their further recommendation is that physicians have an ethical (and legal) obligation to obtain parental consent for treatment of minor children, but also an obligation to solicit “patient assent” when developmentally appropriate and possible.

The practitioner in this case can also exercise his or her own autonomy in deciding what treatment he or she is willing to provide. This determination can be made by the practitioner based on many factors, including technical proficiency with a given procedure, comfort in managing outcomes, and the practitioner’s comfort with the minor patient’s acceptance of (assent to) the consented treatment. Practitioner-parent-patient conflict in any of these areas could lead to less than ideal treatment or management, and the patient’s best interest might be better served by receiving treatment elsewhere; that is, with a practitioner who is comfortable with the treatment...
Depending on the jurisdiction, some state laws allow a minor as young as 14 years old to receive medical or dental treatment without parental consent. Other states are more restrictive, requiring the patient to be 18 years or older.

Protocol that the mother and daughter settle on or with treatment without unanimous agreement. Practitioners frequently exercise their professional autonomy in referring a patient for specialty care where that practitioner feels that the outcomes for the patient would be better. In the specific case of conflict between a parent’s consent and a young patient’s assent, it has been suggested that pediatricians have a role in negotiating some kind of agreement between the parent and child, especially where the child has well-developed decision-making abilities. Additionally, the following goals should be respected: enhancing the minor patient’s autonomy, avoiding undue parental influence on the patient (coercion), recognizing and respecting the parent’s values and life plans for their child, all while serving the child’s best interests (King & Cross, 1989). It seems clear that this approach would be appropriate for dental practitioners as well.

The first consideration should be to confirm that the practitioner is presenting complete and accurate information to the parent and patient, and that this information is correctly understood. In this case, the more aggressive treatment is unlikely to be clinically appropriate, though the parent may need help in understanding why her preferred approach—even if not presented by the practitioner—is inappropriate. In a case like this the practitioner may need to help the parent and adolescent patient come to a mutually-acceptable treatment approach that is also acceptable to the practitioner. Ideally, the patient’s best interest should be the driving force to bring about a mutually agreed upon resolution acceptable to all involved.

Professor Zarkowski
(Attorney, Dental Educator, and Mother)

There is no definitive answer to this legal and ethical dilemma, only gray areas. This case immediately raises important questions that the facts do not resolve. The younger woman appears competent and understands her current oral health condition and the benefits and risks of either the amalgam or crown. It is clear that she is not an emancipated minor. Depending on the jurisdiction, some state laws allow a minor as young as 14 years old to receive medical or dental treatment without parental consent. Other states are more restrictive, requiring the patient to be 18 years or older. The provider must be familiar with state law as it impacts patients under the age of 18. Some states have described a “mature minor” as a minor who is emotionally and intellectually mature enough to give informed consent and who lives under the supervision of a parent or guardian, but is allowed to make health care decisions without parental consent. In addition, there may be no formal process in her state to declare a mature minor; it may be done at the discretion of a health care provider. Each state that has a mature minor doctrine establishes its own criteria, which may include considerations of the minors’ age, medical condition, emotional and intellectual maturity, as well as the treatment’s risks and necessity.

From the Provider’s Point of View

The provider is conflicted. The provider relies on guidelines generally suggested for informed consent, but is now faced with “consent” from the patient and refusal by the parent (or vice-versa), with the parent preferring a crown. The provider wants to respect the patient’s autonomy, which is connected legally to the parent’s right to make a decision about her child’s care. One could use the ADA’s Patient’ Bill of Rights as support for both the parent and patient. Specifically, patient rights include:

- Adequate time to ask questions and receive answers regarding the dental condition and the treatment plan for care
- An explanation of the purpose, probable (short and long term) results, alternatives, and risks involved before consenting to the proposed treatment plan
- To know the expected cost of the treatment

Patient responsibilities include:

- To participate in their health care decisions and ask questions if they are uncertain about their dental treatment plan
- To inquire about treatment options and acknowledge the benefits and limitations of any treatment offered
• Responsibility for consequences resulting from declining treatment or not following the agreed upon treatment plan

Given the highlighted patient rights and responsibilities, one could argue that the patient benefits from these guidelines, as she is “allowed,” as a patient, to participate in health care decisions.

The issue of dental neglect might also be examined. Most, if not all states have laws requiring parents to provide adequate dental care for their children. If the parent-child disagreement results in no treatment, does this constitute child abuse (i.e., neglect)? It might be useful for the dentist to raise this issue in the case of an impasse.

From a Mother’s Point of View

It is difficult to know the thought process of the mother. Depending on how treatments have been explained, she may believe that crowning tooth #12 is the ideal treatment from an oral health and financial perspective. It is unclear if she is a single parent responsible for the child, with no need to seek input from the child’s other parent. If there is another parent involved, seeking input from that parent may be one alternative to resolving the dilemma. Additionally, it is impossible to discern relevant family dynamics. It does not appear that the patient is simply trying to be oppositional and contrary, but reasonably does not want aggressive treatment or something as different as a crown in her mouth.

It is hoped that the provider has outlined some alternatives to the situation that include:
• Declining to provide treatment requested by the parent with the understanding that the mother may seek treatment from another dentist
• Educating the parent or parents about the possible risks and consequences associated with both procedures, acknowledging and supporting the patient’s wishes
• Postponing the conversation until research is done as to whether the minor has rights in this particular jurisdiction, or if there is a mature minor option, and honoring the patient’s request as her “right”
• Honoring the patient’s request and risking the parent’s anger and possible legal action
• Meeting with the patient alone to determine the family dynamics, especially if there is another parent who could be involved
• Bringing the bill of rights and patient responsibilities into the discussion as evidence that the minor patient should be involved in the decision making process.

Dr. Ozar (Professor of Philosophy)

The question of the daughter’s capacity for an autonomous choice is not simple, but at least two standards support the girl’s view as the ethically better one.

One of these depends on there being good evidence that the patient truly understands the implications. The case does not tell us that she truly understands the relevant non-clinical implications, namely the possibility that the MOD restoration might fail at a time when she does not have dental insurance or other financial resources to cover the restoration (which may be a crown, or even endodontic treatment). I will assume here that the girl did understand this and also that the dentist’s opinion of the adequacy of the MOD included consideration about how long the restoration might last.

Assuming adequate patient understanding, there is good reason to say that she is a capable decision-maker regarding the health care decision at hand. From an ethical point of view, the generally accepted professional standard is that decision-makers who are capable to make the decision-at-hand (regarding their own body) ought be allowed to make that decision as they judge best, and the dentist ought to treat them as they would any other capable decision maker.

How the dentist deals with the parent—because the girl is not legally competent to make this decision—is a complex matter. My conclusion is that, at the very minimum, the dentist would have a strong obligation to work hard to persuade the mother that her daughter’s point of view is clinically reasonable, that her daughter is a capable decision-maker on this matter at this time, and that a dentist has a professional obligation to treat in accord with a capable patient’s choices.

If the dentist proceeds to act on the girl’s decision over the objection of the mother, the dentist is exposed to legal and economic risk (i.e., the possibility of a lawsuit or board action, a horrible Yelp review, and the likelihood that the mother might refuse to pay for a treatment she did not authorize). Honoring the teen’s treatment choice without parental consent would be an act of conscientious disobedience, albeit one for which there is solid social and professional ethical support. The more complex ethical question is whether the professional’s general obligation to accept some measure of risk in order to properly treat a patient...
It is also important to ask what weight the girl’s judgment ought to have even if her understanding of the situation were incomplete in some respects. This could be an example of what is called a “partially capable” patient, and it raises the ethical question of how much weight the values and goals of a partially capable patient ought to have. If she did not completely understand the clinical options and likely outcomes, it would then be hard to claim that she was capable enough to make a compelling contribution to the decision. But suppose the girl did understand the clinical implications and did understand the future financial concerns her mother is anticipating, but naively assumes that “I will just figure it out whenever that happens?” This is partial, rather than full capacity, and she seems capable to a considerable extent in this case. I have suggested elsewhere (Ozar & Sokol, 1994, 112-118) that it is unethical to simply ignore the values and goals of partially capable patients, and I would be inclined to see the girl’s view as ethically better. But, assuming the inappropriateness of the crown is not great and assuming the same legal risk for the dentist as above, it is less clear that the dentist’s obligation to the patient would outweigh the risk. I would still require the dentist to make considerable effort to guide the mother into seeing that her daughter is at least partially capable in her judgment.

Suppose, as the case states, that the daughter understands “the clinical implications” but is naïve about the financial question regarding future repair of the tooth when the filling eventually fails. Notice how the conviction that she is capable enough to contribute significantly to the decision making weakens as her distance from full capacity grows (“full capacity” does not mean ideal capacity; few of us attain ideal capacity for decision-making very often. “Full capacity” is capacity enough, i.e., enough to be making decisions, and ought, therefore to be treated that way). At some point along a theoretical spectrum, as deficits in understanding or the other components of capacity grow more numerous, our judgment of a patient’s capacity will eventually see the person as resembling someone who is unconscious. This case highlights the importance of relative capacity on a spectrum. A view of capacity as binary (you either have it or you don’t) is not adequate.

**Summary and Recommendations (Psychologist Peltier’s Comments)**

Obviously this is a complicated situation with no easy answers. Three nationally respected experts offered varying opinions about the case. All three agree on one thing for certain: the patient’s needs and best interest must take priority. Dr. Wood, a pediatric specialist (while observing that a crown is unlikely to be an appropriate treatment from a technical-developmental point of view) offered the important advice that parents ought to be helping children develop effective independent decision-making skills and self-confidence that will serve them for the rest of their lives. This goal should serve as a “North Star” in a case like this, and it might cause a parent to concede a specific decision in service of their daughter’s overall development of healthy autonomy. Wood also makes the point that the agreement of a minor patient (“assent”) is of great import, and further, that coercion is unacceptable. Wood’s concerns about the technical appropriateness of a crown also supports the daughter’s preference.

Professor Zarkowski wonders if parental insistence on a less than optimal treatment might constitute neglect, a form of child abuse under the law. The answer is impossible to discern in the abstract, but it is unlikely that a child protective agency would be much interested in such a case, given the harsh and unrelenting demands already on their calendars. Zarkowski also wonders if there is a second parent somewhere in the picture. If so, should not that parent be consulted? Perhaps they might register a tie-breaking vote, or even promise future financial resources. Zarkowski then proposes six possible paths to resolve the problems found in the case.

Professor Ozar’s opinion hinges on the quality and extent of patient capacity. If patient understanding is complete, then the dentist has a “strong obligation to persuade the mother to respect her daughter’s choice.” However, if the daughter’s capacity is lacking in any significant way (e.g., possessing an incomplete understanding of the financial
implications and the bigger picture), then a parent might be justified in refusing to consent to the treatment the daughter prefers. He also provides an interesting introduction to the concept of capacity along a spectrum rather than a binary view. A patient might possess “partial capacity” or limited capacity in this view. People are not either 100% competent or incompetent to decide.

Obviously, a parent has formal legal authority to decide about consent, and it seems especially unwise for a dentist to provide treatment for a child when a parent objects. At the same time though, it also seems unwise to attempt a restoration in the mouth of a teenager who explicitly disagrees. Culture might play an important role in this case, because family mores and values vary from country to country and culture to culture. Some cultures cherish parental authority and respect, and a dentist might cross a significant cultural line by siding with a child. This is no small matter, and must be considered. While paternalistic and authoritarian parenting has become less popular in the United States, it is certainly easy to relate to a mother (especially a single one, if that is the case) who has concerns about her daughter’s future need for expensive treatment that might not then be covered. The facts of this case imply that this mother has her daughter’s interests in mind, as the treatment she prefers is actually the more extensive and expensive, and she worries about her daughter’s capacity to pay for her own care at a later date. It is possible, of course, that the mother anticipates having to pay for an expensive crown in the future if her daughter is not self-sufficient at that time. Parents often fear—correctly or not—that their children’s capacity for foresight is not fully developed. And it is impossible to know for certain whether your child will be ready to make a good decision once they have left the nest.

In conclusion, all four authors agree that the doctor should do what is in the patient’s best interest. If it is at all possible the dentist and the parent should use this conflict as an opportunity to help the daughter develop her decision skills and sense of responsibility and autonomy over her own body, along with positive feelings about dental care. Such a strategy would necessarily include a weighing of all the variables together (including the esthetic concerns of the teen patient). This will take valuable clinic time, but from a patient’s point of view, it would be well worth it. While this task is easier said than done, dentists are real doctors, and should not they be highly concerned with the overall development of a young patient under their care?

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Online Sources
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Ethical Considerations in the Management of Temporomandibular Disorders

Ronald S. Brown, DDS, MS
Charles S. Greene, DDS

Abstract
Temporomandibular disorders continue to challenge patients, practitioners, and researchers. This essay reviews the history of treatments and protocols, noting that research now clearly favors conservative and reversible approaches. In spite of such evidence, significant resistance to less-invasive treatment exists in the practitioner community. Three explanations are presented to explain this resistance, and the authors conclude that the profession has a moral duty to favor conservative and reversible modalities.

Research now clearly favors conservative and reversible approaches. In spite of such evidence, significant resistance to less-invasive treatment exists in the practitioner community.

The modern approach to managing temporomandibular disorders (TMDs) depends on a combination of evidence-based knowledge and ethical considerations. The healing professions have long held that their members should place their patients’ needs for proper diagnosis and appropriate treatment ahead of their own needs for income and advancement.

Reid and Greene reported in 2013 that the current controversies about appropriate treatment for TMDs revolve around the etiological issues of occlusal disharmonies and mandibular malposition, both of which lead to use of irreversible therapies such as occlusal equilibration, orthodontic treatment, bite opening, and mandibular repositioning, with subsequent prosthodontic treatment. However, the preponderance of scientific evidence presented in the past 30 years suggests a very different approach to TMD management, in which conservative and reversible modalities are almost always the best choice for primary care. In this paper we argue that dentists have a professional and moral responsibility to treat most TMD patients without resorting to irreversible procedures. This assertion will be supported by a review of the historical evidence that has led to this conclusion.

The Historical Perspective
For most of the last half of the twentieth century, the mechanistic concepts of etiology and treatment for TMDs described above dominated the field. In the last quarter of that century, however, evidence began to emerge and accumulate which challenged many of those concepts. A milestone marker in that journey occurred in 1996, when the National Institute of Dental Research (NIDR—presently known as the National Institute of Dental and Cranial...
Research—NIIDCR) and the National Institutes of Health Office of Medical Applications of Research convened a technology assessment conference on the topic of TMD (NIH Technology Assessment Conference Statement, 1996). The conference was cosponsored by the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Institute of Neurological Disorders and Stroke, the National Institute of Nursing Research and the NIH Office of Research on Women’s Health. This group of scientists and clinicians evaluated the literature regarding the diagnosis and treatment of TMDs. Their conclusions were that there was a lack of epidemiological information about these disorders, and furthermore, there was a lack of understanding related to the etiology of TMD conditions. Therefore, it was accepted that the diagnostic classification for each individual patient must depend primarily on the detailed description of symptoms and related clinical findings, and treatment needs should be based upon relatively specific diagnostic criteria in each case.

Their evaluation stated that no single treatment or combinations of procedures had demonstrated effectiveness in randomized controlled clinical trials (RCTs). Given the lack of that kind of evidence, no specific recommendations for treatment could be made. The preponderance of the information available at that point did not support the superiority of any particular method for initial management of most TMD conditions. It was noted that although some experts believed that occlusal adjustment may be helpful as a therapeutic modality, the data did not support such therapy to permanently alter a patient’s occlusion, so they suggested that it be avoided. Finally, it was stated that because most individuals with a diagnosis of TMD will probably experience improvement or relief of symptoms with conservative therapy, the vast majority of TMD patients should receive initial management using noninvasive and reversible therapies.

Also in 1996, the American Association for Dental Research (AADR) came out with a Scientific Information Statement about TMDs that was very brief. A revised statement was approved in 2010 and is contained in the side bar to this article.

In 2010, Greene (2010a, b, c, d) notified the practice community of this updated position. Other authorities from the U.S. and around the world in the TMD field have endorsed this evidence-based position during the past twenty years (McNeil, 1997; De Boever et al, 2000; Hagag et al, 2000; Tsukiyama et al, 2001; Mohl & Attanasio, 2002; Landi et al, 2004; Fricton, 2006; Toscano & Defabianis, 2009; Schiffman et al, 2014).

Guidelines should be balanced and unbiased with regard for treatment effects, side effects, patients’ values, and cost-effectiveness. These principles are gradually becoming incorporated into modern dental education.
Resistance from the Occlusion Advocates

Dawson (1997) replied to the initial NIH Consensus Conference of 1996 with an editorial that criticized the government for putting together such a conference. He argued that the viewpoints presented by the conference demonstrated a serious lack of awareness of the state of the art regarding differential diagnosis and treatment selection for specific masticatory system disorders. A particular issue he raised was the make-up of the NIH assessment panel, which consisted of eleven non-dentists and four dentists (The non-dentists included both PhDs and MDs). This appears to be a problematic argument, as a mixed panel would be expected to educate one another concerning each other’s understandings of the relevant issues.

Nevertheless, Dawson (1997, 1999) challenged the NIH to prove the non-relationship of occlusion to TMD. While it is virtually impossible to prove a non-relationship, it should be possible to prove an existing relationship, if in fact such a relationship exists. That would require the defining of a particular etiology of a particular TMD condition, and then formulating a root canal treatment (RCT) treatment efficacy study to determine if the hypothesis is correct. In 1999, Dawson proposed that the NIDR should produce evidence to sufficiently support their beliefs (McNeil, 1997; De Boever et al., 2000; Hagag et al., 2000; Tsukiyama et al., 2001; Mohl & Attanasio, 2002; Landi et al, 2004; Fricton, 2006; Toscano & Defabianis, 2009; Greene, 2010 b, c, d; Greene et al., 2010; Schi ffman et al, 2014).

Simmons (2012) responded to the AADR Scientific Statements with a strongly worded article supporting the mechanical basis of TMD etiology, in which he criticized the process that produced the 2010 AADR statement. He stated that long-term outcome studies have some value in determining proper care for the TMD patient, but RCTs are not the gold standard in answering all clinical questions. Furthermore, he stated that informed consent legally requires dentists to at least inform TMD patients that orthopedic TMD care is available. This is a question-begging proposition at best, as it assumes that so-called orthopedic care is a scientifically determined legitimate initial treatment option.

Further support for the mechanical concept of TMD etiology was promoted by Cooper in a position paper in 2011, in which he endorsed the concept that occlusion has a significant role within the diagnosis and treatment of TMDs as a causal, precipitating, or perpetuating factor. Cooper states that there are two principal schools of thought concerning the etiology of TMD, namely, mechanical and biopsychosocial. He goes on to say that his position paper establishes the scientific basis of the physical/functional/mechanical concept. He also states that the overwhelming majority of dentists treating TMD believe dental occlusion plays a major role in predisposition, precipitation, and perpetuation of these conditions, so therefore their opinions should not be ignored. However, Cooper and the neuromuscular dentistry community he represents have failed to demonstrate published scientific evidence that supports a dental-mechanistic view of TMD etiology and therapy. Like all of the mechanical advocates, they have failed to provide evidence of successful efficacy studies that account for the placebo effect by incorporating double-blinded RCTs. There is a distinct lack of evidence for the mechanistic viewpoints of the twentieth century, and this community has repeatedly disregarded scientific evidence that does not support their views.

Rejecting Old Concepts and Accepting New Ones

There are three major factors that influence the judgment of clinical dentists as they accommodate evolving concepts in their field. The first has to do with the quality of dental education; the second is related to failure to appreciate placebo effects; and the third is associated with the economic aspects of dental practice. Each of these will be discussed briefly in this section.

Dental Education

In 1926, the Carnegie Foundation for the Advancement of Teaching published the Gies report, which identified problems within dental education. The report noted that dental education of the time did not emphasize research and lacked the biologic science foundation found in medicine. The result was that dental education moved into a university education model with greater attention afforded to the biologic sciences as the supporting standards of dental education. In 1995, the Institute of Medicine (IOM) published
Dental Education at the Crossroads: Challenges and Change. This publication reported similar issues to those noted 70 years previously and called for greater integration between the basic and clinical sciences. Within the medical model, it is established that the defining of the diagnosis is paramount in evaluating diagnostically targeted therapies. While according to the IOM report concerning dentistry, clinical dentists may at times practice dentistry as procedure-driven rather than diagnostically driven (Ismail, 1999; Nadershahi et al, 2013).

In 2007, Iacopino noted that for many established dental clinicians, new technologies and concepts are perceived as disruptive, and are likely to be disregarded. Dentists (and dental faculty) understandably have a tendency to stay with what they were taught, and many are resistant to adopting new concepts and technologies. He noted that many dental schools have institutional missions which emphasize teaching and service. Also, they may lack an infrastructure that supports viable research programs, and they have few experienced faculty actively engaged in research and scholarly pursuits. As a result, the faculty and student body may not fully appreciate how new ideas and practices (which are evidence-based) need to be incorporated into the dental curriculum and patient care concerns.

In 2013 Faggion described the development of evidence-based guidelines in dentistry. Guidelines provide an important means of reducing the disparities between research-tested concepts and clinical practice. Dental guidelines should be

**AADR TMD Policy Statement Revision**


The AADR recognizes that temporomandibular disorders (TMDs) encompass a group of musculoskeletal and neuromuscular conditions that involve the temporomandibular joints (TMJs), the masticatory muscles, and all associated tissues. The signs and symptoms associated with these disorders are diverse, and may include difficulties with chewing, speaking, and other orofacial functions. They also are frequently associated with acute or persistent pain, and the patients often suffer from other painful disorders (comorbidities). The chronic forms of TMD pain may lead to absence from or impairment of work or social interactions, resulting in an overall reduction in the quality of life.

Based on the evidence from clinical trials as well as experimental and epidemiologic studies:

1) It is recommended that the differential diagnosis of TMDs or related orofacial pain conditions should be based primarily on information obtained from the patient's history, clinical examination, and when indicated TMJ radiology or other imaging procedures. The choice of adjunctive diagnostic procedures should be based upon published, peer-reviewed data showing diagnostic efficacy and safety. However, the consensus of recent scientific literature about currently available technological diagnostic devices for TMDs is that, except for various imaging modalities, none of them shows the sensitivity and specificity required to separate normal subjects from TMD patients or to distinguish among TMD subgroups. Currently, standard medical diagnostic or laboratory tests that are used for evaluating similar orthopedic, rheumatological and neurological disorders may also be utilized when indicated with TMD patients. In addition, various standardized and validated psychometric tests may be used to assess the psychosocial dimensions of each patient’s TMD problem.

2) It is strongly recommended that, unless there are specific and justifiable indications to the contrary, treatment of TMD patients initially should be based on the use of conservative, reversible and evidence-based therapeutic modalities. Studies of the natural history of many TMDs suggest that they tend to improve or resolve over time. While no specific therapies have been proven to be uniformly effective, many of the conservative modalities have proven to be at least as effective in providing symptomatic relief as most forms of invasive treatment. Because those modalities do not produce irreversible changes, they present much less risk of producing harm. Professional treatment should be augmented with a home care program, in which patients are taught about their disorder and how to manage their symptoms.
The Placebo Effect

Presently accepted evidenced-based viewpoints about treating TMD patients are based largely on a series of double-blinded RCTs conducted over the past 35-40 years that included various types of placebos as controls. These studies demonstrated that there were significant placebo effects inherent in nearly every treatment modality that has been applied to such patients. They also showed that irreversible dental procedures were generally not required to reduce symptoms or to maintain good treatment outcomes. These results have led to the conclusion that conservative reversible therapy should be regarded as the current accepted standard of care for the treatment of TMDs (Reid & Greene, 2013; Greene et al, 2009).

Treatment of TMD patients with the belief that what the clinician is doing is helping patients, followed by reduction of symptoms (an outcome that often is demonstrated to be due largely to the placebo effect) is re-enforcing to the psyche of the therapy provider. Winning at slot machines is also reenforcing to the gambler even though the gambler’s strategy is not typically responsible for those wins (Mann et al, 2016; van Holst et al, 2010). However, the failure to appreciate placebo effects, or to consider the possibility that “less may be more” when it comes to evaluating how much TMD treatment is needed, can lead dentists to false conclusions that are not in the best interests of their patients. Instead, dentists should embrace the placebo effect as a positive component in all of their treatment efforts. By doing so, they will increase the likelihood of positive outcomes while minimizing the possibility of over-treatment.

An argument can be made that TMD clinicians may effectively use the placebo effect to significantly lessen pain in a significant percentage of the TMD patient population. There are several important issues related to such an argument. The most significant ethical issue with regard to irreversible therapy for TMD is that the clinician is providing (and perhaps, selling) irreversible, expensive, challenging, and often unnecessary therapy when simply comforting, educating, and watching may result in the same outcome.

Economic Issues

In addition to the good feelings that come from treatment success are the positive effects upon the clinicians’ bottom lines. Financial enhancement can potentially create a direct conflict of interest with respect to evaluating clinical efficacy, and rationalizations such as the “Disregard Syndrome” can ease cognitive dissonance. Brown describes this phenomenon (2010) where “True Believers” cling to concepts without an evidence basis by disregarding scientific evidence which is contrary to their beliefs. Ethical issues regarding True Believers are complex, because they occupy a gray area. The fact that the True Believer may believe that he or she is helping his or her patients appears to place their actions outside of a conflict of interest framework.

But health-care clinicians are ethically bound to keep up with the
current literature regarding clinical patient care. Furthermore, clinicians are expected to keep up with emerging concepts and advances in the standard of care. In the end, we dentists are bound by our professional responsibilities to abandon diagnostic or treatment procedures that have been shown to be outdated or inappropriate, even if doing so will reduce our financial bottom line (Miller & Colloca, 2009; Curley & Peltier, 2014; Jenson 2014; Pugliese et al, 2014; Givel & Mejer, 2014; Khoury & Khoury, 2015).

Ethical Management for TMD Patients in the Twenty-first Century

Based on the above review and analysis of the clinical literature in the TMD field, it seems appropriate to ask what the current ethical standard should be for managing the pain and dysfunction associated with temporomandibular disorders. As Reid and Greene (2013) have pointed out, there is sufficient evidence to reject the twentieth century model of mechanistic therapies which focused on occlusal relationships and malposition of the mandible. That set of concepts has largely been replaced by conservative and reversible approaches that treat TMDs as medical orthopedic problems with strong psychosocial factors that also must be managed. Guidelines and expert opinions that support initial conservative therapies for TMDs over irreversible therapies are based on a large number of scientific studies several of which are cited here (Manfredini et al, 2015; Schiffman et al, 2014; Truelove et al, 2006; Egermark et al, 2003; Dworkin et al, 2002; Tsukiyama et al, 2001; Dao et al, 1994; Helm & Petersen, 1989).

It is clear that not all practicing dentists have become aware of these significant changes occurring in this field. Furthermore, it also is clear that many clinicians simply have not accepted those changing concepts, and as a result they continue to provide mechanistic, irreversible treatments for their TMD patients. This unfortunate reality was demonstrated in a recent study by Desai and colleagues (2016), who published a survey article evaluating the web sites of dentists who claimed expertise in TMJ/TMD management. These authors conducted a web search in 50 states and the District of Columbia to identify the types of dental clinicians advertising themselves as “specialists” on the Internet, with respect to TMD classification, etiology, or treatment offerings. Over two-thirds of these 255 specialist dental clinicians identified themselves as general dentists. Two-thirds of the respondents attributed TMD to occlusal problems or malocclusion. Over one-third of their web sites described TMD as a singular disorder rather than a group of disorders. Over half of these clinicians recommended occlusal therapy for the treatment of TMD.

As trust between dentists and dental patients is important, it is incumbent upon dentists to define standards of care that both enhance oral health, and protect dental patients. It is our assumption that dental patients do not expect dentists to take advantage of the dentist-dental patient relationship by withholding information to increase the bottom line. As Peltier and Giusti note (2008), dental patients are in a vulnerable position, because they are in pain and because of information asymmetry (dentists know a lot about TMD and patients know very little). Imagine what patients and the public might think if they discovered that complex, challenging, and expensive treatments were actually unnecessary and scientifically unsupported. It is unlikely to matter much to them whether treating dentists performed unnecessarily invasive treatments because of greed or practitioner ignorance or some sort of treatment bias.

In conclusion, it remains a challenge for the dental profession to resolve this issue in a manner that will protect TMD patients from inappropriate treatments in the twenty-first century. As dentistry is both a profession and a business, there
can be a perceived conflict of interest for dentists to favor diagnoses and therapies which are more beneficial to the bottom line than they are to the patient’s oral health. It is up to the profession to establish the standards of care with regard to the diagnosis and management of TMDs and all other areas of dental care. It is up to individual state dental boards to legally enforce ethical standards of care in order to advance the care and safety of patients. Finally, it is up to all members of the dental profession to support ethical clinical behavior for the benefit and safety of the public.

References


Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of *JACD*. These can be found on the ACD web page under “publications.” In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not publish clinical case reports or articles that describe dental techniques. The communication policy of the College is to “identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health.

The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the College.”

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A “desk review” is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer-review process typically takes four to five weeks.

Authors whose submissions are peer-reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on the ACD website under “How to Review a Manuscript for the *Journal of the American College of Dentists*.”

An annual report of the peer review process for *JACD* is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts reviewed and the consistency of the reviewers is in the phi = .60 to .80 range.

Letters from readers 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.] Where a letter to the editor refers specifically to authors of previously-published material or other specific individuals, they are given an opportunity to reply.

This journal has a regular section devoted to papers in ethical aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of the Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.