R. Calnon, DDS, said in a news release, “We hope that our few areas of disagreement do not obscure our welcoming Sen. Sanders to this fight. His bill aims high, and that has long been needed. We fully support his intent to help extend good oral health to all Americans.”

The proposed legislation addresses much of what the subcommittee heard from witnesses in February. That testimony frequently focused on the costs of dentistry and dentistry education — and the impact such costs have on where dentists practice and the types of patients they most typically serve (those with dental insurance or other means of paying for care).

At the hearing’s 90-minute mark Subcommittee Chairman Sanders said, “Generally speaking, dentists make a pretty good income. Why is it that we have a dental shortage in this country? Why do we not have enough dentists?”

In response, Shelly Gesham, MMP, director of the Pew Children’s Dental Campaign, Pew Center on the States, based in Washington, D.C., said the supply of dentists ebbs and flows with the economy, with the 1960s and 1970s producing a large contingent of dental school graduates before recessions forced closures of dental schools. As a result, today’s large number of dentists retiring every year exceeds the annual number of dental school graduates. Dr. Whitmier, MMM, said two directors at Community Health Centers of the Rutland Region, Rutland, Vt., said his organization just hired two recent dental school graduates to fill vacancies for more than $50,000 in debt from financing their educations. He said it was only because of the National Health Services Corps and loan repayment assistance that the two were able to take the positions, which focus on delivering care to underserved populations.

Burton Edelstein, DDS, MPH, professor of dentistry and health policy and management at Columbia University, New York, NY, said that dental training requires universities to fully fund their own operations and high-end equipment purchases, unlike medical schools, which can rely on non-university hospitals for clinical training. Dr. Edelstein said dentists in training face similar expenses. The result: Providing dental services and/or training is a highly expensive proposition.

Gregory Fobe, DDS, president of Outreach Dentistry in Lafayette, La., which is primarily a mobile concept serving the poor, disabled and elderly, praised the federal income tax system’s “incurred medical expense allowance,” which he said enables him to earn enough to focus his practice on underserved populations. But he acknowledged his high income places him in the lower 10 to 15 percent of the profession in earnings. He spoke in support of the Special Care Dentistry Act, which he said enables development of a stronger infrastructure for delivering treatment to underserved populations.

Subcommittee members repeatedly referred to the access-to-care issue as a crisis.

Sen. Bernard Sanders, I-Vt., chairman of the U.S. Senate Subcommittee on Primary Health and Aging, leads the hearing on “Dental Crisis in America: The Need to Expand Access.” Photo Provided by U.S. Senate Committee on Health, Education, Labor and Pensions

See page D2 for the American Dental Hygienists’ Association stance on the access-to-care proposals.

Sander’s said more that 130 million people in the United States lack dental insurance; and for those who have it, benefits typically are capped at $5,000 to $10,000 per year, which covers only basic services. He said 47 million people live in areas where it is a challenge to find dental care. “This is an issue of enormous importance, and does not get the attention it deserves,” Sanders said.

The proposed legislation references the need for nearly 9,500 additional dental practitioners to deliver needed care to underserved populations. But he acknowledged the financial impacts on hospitals that have seen increasing numbers of patients using emergency rooms as their only option for dental care, which typically means just immediate symptoms are being addressed, not underlying causes and prevention.

The proposed legislation takes a multi-pronged approach with a variety of programs that would make it more financially viable for dental professionals to provide care to people falling outside of current care-delivery models. “We’re going to shine a spotlight on an issue that is not much talked about and we are going to do our best to solve this problem,” Sanders said.

Dr. Dennis Tartakow
Dr. Irwin Smigel
Dr. Chester Redhead
Dr. Dan Nathanson
Dr. Carl E. Misch
Dr. Karl Leinfelder
Dr. Harold Heymann
Dr. Howard Glazer
Dr. Fay Goldstep
Dr. David Garber
Dr. Carl E. Misch
Dr. Karl Leinfelder
Dr. Harold Heymann
Dr. Howard Glazer
Dr. Fay Goldstep
Dr. David Garber
Dr. Carl E. Misch
Dr. Karl Leinfelder
Dr. Harold Heymann

Letter to the editor in chief

Questions on American Heart Association’s stance on periodontal disease and heart health

Dear Dr. Hoester,

The recent article in the American Heart Association’s journal Circulation, (titled “Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association?” A scientific Statement From the American Heart Association (published online 4/18/2012), combined with the American Heart Association’s press release of the same day, was discouraging in and of itself, and made more so by the prototypical way The New York Times reported on the story the next day.

Although I suspect that Circulation is not responsible for the AHA’s press release, the statement in the announcement that researchers who showed a “stronger relationship between” chronic periodontitis (PD) and ASVD “didn’t account for the risk factors common to both diseases,” is incorrect and inconsistent with the manuscript.

Unfortunately, the Circulation article is similarly afflicted, insofar as its authors appear to have had an agenda that went beyond the scientific publications they reviewed.

Although I agree with the authors that an unquantifiable number of ill-informed or uncritical practitioners engage in hucksterism with regard to the several putative periodontal-systemic disease links, the statement in the article’s abstract that “Patients and providers are increasingly presented with claims that PD treatment strategies offer ASVD protection, these claims are often endorsed by professional and industrial stakeholders” is not supported by the data presented in the review.

Also revealing of the authors’ apparent bias is the final sentence of the article, which reads: “Statements that imply a causative association between PD and specific ASVD are either claim that therapeutic interventions may be useful on the basis of that assumption are unwarranted.” Hence, it appears as if the AHA’s recommendation to dentists, dental hygienists and others may be accurately paraphrased “Although we at AHA acknowledge that there are unexplained links between the incidence of PD and ASVD, because we can find no clear causal links, it is unwarranted for dental professionals to inform patients that better oral health is associated with better cardiovascular health in any way if used to encourage better periodontal health and improved oral hygiene.”

Do the Circulation authors, editors and the AHA really believe that this is a sound message, especially in light of the reality that an overwhelming majority of experts believe the “interventions” described in the final sentence of the manuscript consist of encouraging improved (and inexpensive) dental hygiene self-care at home?

Regards,

Michael P. Rethman, DDS, MS

• Diplomate, American Board of Periodontology
• Vice President (Scientific Research), American Dental Association Foundation
• Clinical Associate Professor (Adjunct), University of Maryland School of Dentistry
• Clinical Assistant Professor (Adjunct), College of Dentistry, The Ohio State University
• Former Chair, Council on Scientific Affairs, American Dental Association
• Past President, American Academy of Periodontology
• Past Director, U.S. Army Institute of Dental Research
• Former Chair, The Columbia Association

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