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***On Why the Dental Therapists ‘Movement’ in
the United States Should Focus on Children--Not Adults***

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On Why the Dental Therapists ‘Movement’ in the United States Should Focus on Children--Not Adults

Ever since I began advocating for an expansion of the dental workforce in the United States by adding the internationally recognized dental therapist to the dental team, I have designated such a person a *pediatric oral health therapist*; and have argued that therapists should focus their care on children, not adults.^{1,2} As the ‘movement’ to improve access to care through expanding the dental workforce to include therapists has gathered momentum, I have become concerned that some are suggesting that dental therapists should also care for adults. In this brief essay I will advance seven reasons why the profession should focus the care of dental therapists on children and not adults. The justifications concern issues of ethics, prevention, safety, complexity of care, experience and research, economics, and professional barriers.

Ethical considerations support *therapists* focusing their care on children. Philosophers Kopleman and Palumbo have published a thoughtful and compelling paper in the *American Journal of Law and Medicine* entitled: “*The U.S. Health Delivery System: Inefficient and Unfair to Children.*”³ The paper explores the four major ethical theories of distributive or social justice: utilitarianism; egalitarianism, libertarianism, and contractarianism. The authors conclude that no matter which theoretical stance you take, they all support the perspective that children should receive priority consideration in receiving health care.

In one of the most influential books written on political philosophy in the last century, *A Theory of Justice*, Harvard Professor John Rawls carefully explicates the nature of justice.⁴ One of Rawls’ three principles basic to a system of social justice is that “social and economic institutions are to be arranged as to maximally benefit the worst off.” Given this view of social justice, our nation’s health care system, if it is to be just, must be committed to maximally benefiting the “worst off.” Poor and minority children, the most vulnerable individuals in our nation, and the worst off, have the highest prevalence of oral disease, the poorest access to oral health care, and the poorest overall oral health. Justice demands they be maximally benefited in order that they ultimately have equal opportunity to do well.

Norman Daniels, professor of bioethics and population health at the Harvard School of Public Health, argues that a just society should provide basic health care to all, but redistribute health care more favorably to children.⁵ He justifies this conclusion based on the effect health care has on equality of opportunity for children, with equality of opportunity being a fundamental requirement of justice.

The recent report of the Pew Children’s Dental Campaign identified eight benchmarks for evaluating states’ responses to the crisis in dental health among American’s disadvantaged children.⁶ Among the benchmarks was the “authorization of a new primary dental care provider.” The work of the Pew Center for the States in promoting workforce innovations reflects an understanding of the priority that children must have in the provision of oral health care.

Congress also understands the importance of prioritizing oral health care for children as social policy. The recent reauthorization and expansion of the Children's Health Insurance Program (CHIPRA) calls for an investigation into the use of "mid-level providers" to increase access to care for children.⁷

The opportunity to realize one's potential in life is markedly affected by one's childhood. What happens in the life of a child is determinative of whether that child will have a fair opportunity to fulfill his or her unique potential. The worthiness of a society can be evaluated in terms of its concern for and care of the health of its children. President John F. Kennedy expressed it well: *Children may be the victims of fate—they must never be the victims of neglect.*"

Prevention of dental disease supports *therapists* focusing their care on children. Clearly the goal of the profession is to eradicate oral disease, thus ensuring a lifetime of oral health for all. Prevention starts young. Goethe put it straightforwardly: *He who is wise begins with the child.* If a lifetime of oral health is to be gained it must be initiated in childhood. Habits that promote oral health begin in childhood. Preventive therapies, such as topical fluorides and fissure sealants, must be provided in childhood to have their intended effect. Dental disease in childhood is a predictor of dental disease in adulthood. If prevention is to be prioritized it must begin with children. An expanded workforce that facilitates access for children must not only effect primary preventive dentistry, but also implement secondary and tertiary preventive strategies such as restoration of primary and young permanent teeth, pulpal therapy, and extraction of infected primary teeth.

Safety considerations support *therapists* focusing their care on children. In 1995, the Institute of Medicine published its landmark report Dental Education at the Crossroads: Challenges and Change.⁸ Among the several recommendations was that student dentists should spend clinical rotations/clerkships in internal medicine, as graduates are not adequately educated to care for the changing profile of patients in America's population; that is, the increased number of elderly, as well as the increased number of individuals who are biologically and/or pharmacologically compromised. (Unfortunately, there is no evidence that dental education has followed this recommendation.) The statistics are significant:

73 million Americans have high blood pressure.

7 million Americans have coronary artery disease.

18.4 million Americans have chronic obstructive pulmonary disease (COPD).

4.8 million Americans have congestive heart failure.

2.2 million Americans have atrial fibrillation.

21 million Americans are diabetic.

51% of Americans are taking at least one prescription drug; up from 40% in 1992.

75 % of Americans who are older than 65 are on a prescription drug regimen, with 28% of women and 22% of men take five or more prescription medications regularly.

If student dentists graduating from our nation's colleges of dentistry are inadequately trained to provide care for the increasing number of adults who are biologically and/or pharmacologically

compromised, clearly dental therapists with the standard two years of post-secondary training are not equipped to care for these adults. Most all children are healthy, and when they do have a health problem, it is not ‘silent,’ is known to parents, and is well-controlled. The international experience of almost 90 years of dental therapists treating children with general supervision demonstrates that therapists are able to treat *children* safely.⁹

Complexity of adult care supports *therapists* focusing their care on children. Adult dental care is complex, involving a myriad of symptoms, signs, and problems requiring significant diagnostic expertise, and a large repertoire of therapeutic interventions. Many adults, especially those presenting in a safety net setting, present with dentitions that have been ‘mutilated’ by dental caries and/or have significant periodontal disease. Therapy requiring extraction of permanent teeth is not uncommon. In contrast, dental care for children is not nearly as complex. Care for children is primarily preventive. Dental caries is managed with a relatively basic regimen of amalgams/composites and stainless steel crowns; pulpal disease in primary teeth is treated with pulpotomies; and extraction of primary teeth is generally uncomplicated. An ADA study found that the four most common procedures rendered in children’s dentistry were: periodic oral evaluation (recall), bitewing radiographs, prophylaxis, and topical fluoride.¹⁰ In my judgment, it is not possible to train a paraprofessional in a period of time less than that of the traditional education of dentists to provide care, even basic restorative care, for the complex scope of oral health issues presented by adults.

Economic considerations support *therapists* focusing their care on children. All dental care, whether provided by dentists, hygienists, or therapists must be reimbursed if a system of care is to be viable and sustainable. As a result of the expansion of the Children’s Health Insurance Program (CHIP), the majority of children have public dental insurance either through Medicaid or CHIP--40 million of America’s 78.6 million children.¹¹ All of the legislation on health care reform passed by Congress includes dental benefits for children. None of the health care reform legislation includes adult dental benefits. There is currently minimal public financial support for dental care of adults. Adult Medicaid coverage has always been limited, but coverage has recently become reduced or eliminated due to state financial exigencies; 22 states have adopted cuts or are considering cuts or elimination. There is no adult Medicaid coverage in six states; emergency only in 16 states; limited service in 13 states; with only 16 states offering basic care.¹²

International experience and research supports *therapists* focusing their care on children. The overwhelming preponderance of experience of dental therapists internationally has been in the care of children, not adults. Because of the isolation of tribal villages in Alaska, the Alaskan dental therapists do provide some limited care for adults, with video monitoring by dentists in hub clinics.¹³ Still, 75% of all dental therapists’ care in Alaska is for children. Internationally, there is preliminary movement in some countries to permit therapists to care for adults under specific circumstances. However, essentially all of the currently identifiable international research on the safety and quality of the care of dental therapists is with children.

Professional barriers support *therapists* focusing their care on children. The American Dental Association has been opposed to anyone other than a dentist providing basic restorative care. This is evidenced by the aggressive stance initially taken against dental therapists practicing in Alaska.¹⁴ However, society is becoming increasingly distressed with the profession's opposition to programs that could effectively address the issue of access to care for our most vulnerable population, our children. A not insignificant number of dentists do not want to treat children, and many who do, decline to care for children with public insurance. As indicated, the majority of America's children, and those with the greatest burden of oral disease, are now covered by public insurance. It is possible that the dental community will be less threatened, and will more readily accept a paraprofessional on the dental team whose focus of care is not adults but rather children, particularly children whose care is being reimbursed through public insurance.

Conclusion

Oral health problems and issues of access to care are significant among both the adult and child population. However, there are insufficient resources to provide adequate care for everyone. Therefore, priorities have to be assigned and efforts directed to where they will do the greatest good. In terms of social justice and practical applicability, the oral health needs of children deserve the highest priority. Thus in the context of inadequate resources, both human and financial, and in the context of the history and tradition of dental therapists' training and experience in providing care, children must be the focus of attention in the addition of dental therapists to the expanded dental team.

References

1. Nash DA, Nagel RJ. A brief history and current status of a dental therapy initiative in the United States. *J Dent Educ* 2005; 69(8):857-859.
2. Nash DA. Developing a pediatric oral health therapist to help address oral health disparities among children. *J Dent Educ.*2004; 68(1):8-20.
3. Kopelman LM, Palumbo MG. The U.S. health delivery system: inefficient and unfair to children. *American Journal of Law and Medicine.* 1999;XXIII:319-337.
4. Rawls J. *A theory of justice.* Cambridge: Harvard University Press, 1972.
5. Daniels N. *Just health care.* Cambridge University Press, 1985.
6. The cost of delay: State dental policies fail one in five children. Pew Center on the States. Washington, DC and Philadelphia. February, 2010.
7. Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, February 4, 2009. Accessed at www.cms.hhs.gov/chipra, February 24, 2010.
8. Fields M, ed. *Dental education at the crossroads: Challenges and change.* Washington DC: National Academy Press, 1995.
9. Nash DA, Friedman JW, Kardos TB, et al. Dental therapists: a global perspective. *Int Dent J.* 2008; 58(2):61-70.

10. American Dental Association, 2005-06 Survey of dental services rendered. American Dental Association, Chicago, Illinois.
11. Kaiser Commission on Medicaid and the Uninsured. Oral health coverage and care for low-income children: The role of Medicaid and CHIP. Kaiser Family Foundation. April, 2009. Publication accessed February 25, 2010 at www.kff.org
12. McGinn-Shaprio M. State Health Policy Monitor. Medicaid coverage of adult dental services. October, 2008. National Academy for State Health Policy, Portland, Maine.
13. Nash, DA Nagel RJ. Confronting oral health disparities among American Indian/Alaska Native Children: The pediatric oral health therapist. Amer J of Public Health. 2005; 95(8):1325-1329.
14. American Dental Association, House of Delegates Proceedings, ADA Annual Session, Chicago, Ill. October, 2004.