

Thinking Critically

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We don't know what we don't know.

Some decisions are difficult to make even when we know all the facts. Some decisions are difficult to make because we cannot know all the elements of the problem. Some decisions are a matter of conjecture based on assumption, but most decisions are better when based on good evidence. That is, of course, the rationale behind an evidence-based practice of dentistry.

This is not about evidence-based dentistry per se; this is about gathering good evidence and making good decisions about dentistry and oral health care in the future. It is easy to think we already know everything we need to know to make a good decision. In many ways, the less we know, the easier the decision. Dr. David Nash, of the University of Kentucky, College of Dentistry, recently told the Board of Trustees, "We don't know what we don't know." We need more information to make good decisions about dentistry and the future of oral health care.

The first step in critical thinking is to understand the scope of a problem. The second is to gather the pertinent information. The third is to remain skeptical and critically evaluate information before incorporating it into a well-justified conclusion. Finally, one needs to be able to tolerate a considerable level of chaos. By this, I mean that answers are frequently untidy. Life is messy and conclusions are equally so.

I had a classmate in a geography course in college who was always frustrated because she wanted each topic wrapped up with a proper answer and no loose ends. Instead, each system we studied began with some beautifully simplified representation



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that, upon research and reflection, proved to be far more complex and unpredictable.

There are those who maintain that money is all we need to eliminate oral health disparities and access to care problems. In a very simple sense that is true. Unlimited funds applied in unrealistic manners could possibly solve the problem. But oral health disparities and access to care are not simple problems. It is really misleading to use the word "problem," because that implies, like a puzzle, there exists a "solution." It is more like a "dilemma" because there is no simple answer. We must choose among alternatives, each of which may have associated unattractive ramifications. It is a multifaceted issue with no single silver bullet solution.

The Surgeon General's 2000 Report documented advances in the oral health status of the U.S. population over the past five decades. We know how to deliver excellent oral health care. Dentistry is health care that works, but it is not working for everyone.

Oral health disparities in the United States are not simply a supply side problem. Improved reimbursement would clearly improve provider participation, but there are so many other aspects that need to be addressed.

There are patient-related access barriers. These include, but are not limited to, geographic, linguistic, mobility, cultural,

and transportation barriers, family income, lack of insurance, education level, child-care services, health care literacy, patient age, case complexity, fears and phobias, health fragility, and economic exigencies. The coordination of services may present a health care system too complex to successfully navigate.

Each practice owner is familiar with the provider-related barriers. We not only provide oral health care; we must operate our practices in a sustainable manner. Dental practices exhibit demand-based market distribution. Inadequate economic support means the traditional economic model cannot be sustained. This makes it impractical for new dentists, trying to repay student loans, to locate their practices in high-need/low-income communities. Low reimbursement rates, administrative burdens, patient compliance issues, and the dentist's fear of loss of control over his/her exposure to low reimbursement all work against attracting more providers to participate in current programs.

The constellation of barriers may vary from place to place and over time. An effective program in one area may not be effective in another. What works in urban California may not work in remote, rural areas. What works in a culturally homogeneous community may be useless in a multicultural context. What works in a target group of individuals of high oral health literacy

may be ineffective in groups with low oral health literacy. Where prevention is not valued and practiced, surgical intervention will be the default recourse.

Recent resolutions to the ADA House of Delegates included a description of the Community Dental Health Coordinator (CDHC) pilot program. It is envisioned that the CDHC would work in community health centers and nontraditional dental settings, e.g., schools, churches, senior centers. They would still be under a dentist's supervision, in some cases using remote communications. Recruited from the community they serve, they would be oral health educators and case managers. They would be trained to provide preventive ser-

vices, temporary fillings, and simple cleanings. In California, many of these functions are already performed by assistants with extended functions or other individuals as part of community-based, outreach, and case management programs.

The reference committee at the House of Delegates heard extensive testimony from many parties concerning the appropriateness of the ADA's CDHC pilot program. Criticisms were wide-ranging and sincere but at the end of the day, the delegates voted to support the project. There is no expectation that this program alone will end the access to care problem. It will not address every variable for every community. It will not, by itself, end oral

health disparities in the United States. It will not give us a proper answer with no loose ends. It will let us test some ideas. It will tell us more about what we don't know. It will give us more evidence with which to make better decisions about dentistry and oral health care in the future. ■■■■

REFERENCES

- Dr. David Nash's address to the California Dental Association Board of Trustees, Oct. 11, 2008.
Oral Health in America: A Report of the Surgeon General, May 25, 2000.
Albert H. Guay, DDS: Report of the Future of Health/Universal Coverage Task Force Report to the ADA House of Delegates Referral Paper, October 2008.

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