Remembering the special patient

EDITORIAL

Many quips about dentistry cross my desk daily, but this particular item caught my eye. It was an article about one dentist's experience at a small institution for children which, like many others today, was populated largely by profoundly handicapped children. The dentist was donating time to a local dental hygiene program that served the home's clients with periodic screening and hygiene services. The author described the severity of affliction of the children, the dedication of the staff, and his own awakening to this world so very different from his own. What struck me about the article wasn't the plight of these children, nor the dedication and caring of the staff. What struck me was that, in 1991, a dentist would find this situation so unusual that he would feel compelled to write about it.

As a pediatric dentist, care of the special patients is second nature to me, but as a hospital dentist, perhaps my experience is skewed. I did a "reality check" with some pediatric dentist colleagues in practice and they, too , see patients with special needs. Quite a few have relationships with institutions like the facility mentioned in the article. But, what about the general dentist? Twenty years after the heyday of dentistry for the handicapped, have goals of normalization of care been realized, and is the special patient any better off than a generation ago?

The precedent for questioning the state of special patient dental care has been established by society's recent recognition that health care of children has declined, despite gargantuan expenditures and miracle discoveries. Despite vaccination programs, a child a week dies from measles. It's fair to ask if special needs patients are as well off as we'd like to believe. Professions have flitted from one needy group to the next, often claiming victory, but leaving the job unfinished. In dentistry, we've moved through the handicapped, the medically compromised, the hospital patient, and the elderly in about two decades. Today's focus is the patient with infectious disease. At the termination of the Robert Wood Johnson Foundation programs in education of predoctoral students in dentistry for the handicapped, it was concluded that, "the principal barrier to dental care for the handicapped — an inadequate supply of providers — has been virtually eliminated..."(Campbell 1983). Despite this claim, indications are that many dentists do not treat special patients.

A lingering problem is economic. Reimbursement for care remains a problem. According to Dr. Larry Coffee, executive director of the National Foundation of Dentistry for the Handicapped, an organization which has led the way in innovations to address the economic problem, the situation remains very much like it was 20 years ago. He noted that care has improved for many patients, but that the gap between the haves and have nots remains and is growing with the economic woes of our society.

I'm not convinced that the entire problem is economic in nature. A survey reported in *Special Care in Dentistry*, in its November-December, 1990, issue, cited difficulties encountered by group homes in finding dentists for mentally handicapped patients who were cooperative and manageable (Burtner 1990). After inadequate reimbursement, dentists reported lack of training as the reason they did not see these patients.

Dental education has taken a step backward in training students to care for the special needs patient. The *Accreditation Standards for Dental Education Programs* (Commission 1988) now only require that predoctoral dental students," should be competent in assessing the treatment needs of special patients." This means that dental schools need only provide didactic or classroom experiences, although clinical experiences are encouraged. Today's graduate need only be competent to assess the need. Treatment of need is another story. With dental education's current tack toward simulation rather than stimulation, it is doubtful that hands-on experiences will increase. I found out several years ago that dental schools have not reached out to the handicapped and medically compromised as a source of teaching patients (Porter 1986). Perhaps that is changing. There is a trickle down effect from dental school-based general practice residencies which have, by necessity, taken on the role of care provider for many handicapped adults in this country.

The dentist in this article suggested that all dentists be required to spend a day in one of these facilities, as a kind of a wake up call on the needs of special patients and their own humanity. I spoke with Dr. Dan Jolly, president of the Academy of Dentistry for the Handicapped, who felt that care for the handicapped patient in the community *was* better for those mildly affected patients. He cautioned that tertiary care for the more involved patient was still a problem, especially in smaller communities where resources are not available for difficult patients. His feeling was that general practitioners have heeded the call to care for the handicapped, but the system may have failed in providing them with adequate referral sources for

those cases beyond their ability or desire to treat.

Perhaps the most encouraging event of the last decade is the formation of the Federation of Special Care Organizations, a union of hospital dentists, gerodontologists and dentists interested in the handicapped. Among the founders of this group were pediatric dentists. The annual special care conferences held each spring in Chicago at the ADA headquarters are excellent sources of continuing education.

All in all, things may be better than they were 20 years ago and my response to the article exaggerated. Yet, I wonder, as I write this, how many other dentists are unaware of the plight of the handicapped, and have declined the opportunity to benefit in the same way as the dentist I read about. Truly, the loss is theirs not to have experienced the reward and the emotion of helping one less fortunate. Perhaps as significant, though, is the realization that patients like these are missing the chance to be treated by practitioners with the skills to heal at least some of their ills.

Burtner AP, Jones JS, McNeal DR, Low DW: A survey of the availability of dental services to developmentally disabled persons residing in the community. Spec Care Dentist 10:182–84, 1990.

Campbell JT, McCaslin FC: Evaluation of a dental training program for care of the handicapped. Spec Care Dentist 3:100–107, 1983.

Commission on Dental Accreditation: Accreditation Standards for Dental Education Programs. Chicago: American Dental Association, 1988.

Porter TC, Casamassimo PS: The status of the handicapped and medically compromised as predoctoral teaching patients. J Dent Educ 50:538–39, 1986.

Paul S Casamassimo DMD MS

Pediatric Dentistry, The Journal of the American Academy of Pediatric Dentistry promotes the practice, education and research specifically related to the specialty of pediatric dentistry.

Pediatric Dentistry is the official publication of the American Academy of Pediatric Dentistry, the American Board of Pediatric Dentistry, and the College of Diplomates of the American Board of Pediatric Dentistry. The Academy invites submission of reports of original research, case history reports, scientific review articles, editorials, statements of opinions pertinent to pediatric dentistry and papers of scientific, clinical, and professional interest which are presented at the annual sessions of the Academy. Contributions do not necessarily represent the views of the Academy, nor can the Academy guarantee the authenticity of any research reported herein.

Pediatric Dentistry (ISSN 0164-1263) is published bimonthly in February, April, June, August, October, and December. Second class postage paid at Chicago, Illinois and additional mailing offices. *Publications Department:* American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Return postage guaranteed.

Subscription Information: Contact American Academy of Pediatric Dentistry, Publications Dept., 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Subscription rates: NONMEMBERS — individual subscription - $65; institutional - $80 (add $20 per volume for delivery outside USA); single copies - $17 (add $4 per issue for delivery outside USA). MEMBERS receive *Pediatric Dentistry* as a benefit of membership and can order back issues at $45 per volume and $14 per single issue. Checks and money orders in US dollars payable to American Academy of Pediatric Dentistry. Cancellations are not accepted.

Change of Address: POSTMASTER: send address changes to *Pediatric Dentistry*, American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Six weeks' advance notice required. Claims for nondelivery must be made to this address within 30 days (US) or 60 days (foreign) of issue date.

Advertising: All inquiries and insertion orders for retail and classified advertising should be sent to Advertising Manager, American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Telephone inquiries can be made at 312-337-2169.

Pediatric Dentistry reserves the right to accept or reject all advertising submitted as well as the right to withdraw any ad. Placement of an advertisement in *Pediatric Dentistry* should not be construed as an endorsement by the Publications Dept. or the American Academy of Pediatric Dentistry.