

Willingness of Rhode Island Dentists to Provide Limited Preventive Primary Care

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ABSTRACT

In response to the shortage of primary care physicians and the need for greater intercollaboration among health professionals, dentists with sufficient medical and surgical training are an untapped resource to provide limited preventive primary care (LPPC), such as chairside screening for chronic diseases. The objective of this study was to determine attitudes of Rhode Island dentists toward becoming more involved in the overall health of their patients.

Using a 5-point scale (1 being highest), a pretested survey was administered to 92 respondent RI dentists who were asked to indicate their willingness to become more involved in patients' overall health, and undergo additional training to provide LPPC. Their moderate level of willingness was offset by great concern for liability, with older dentists being significantly more willing to assume these additional responsibilities than younger dentists ($p < .05$). Rank order of designation of oral health providers among dentist, dental physician, oral physician, odontologist, stomatologist, and stomiatrist was still dentist first, but with no significant difference between the mean ranks of dentist and oral physician.

KEYWORDS: health care delivery, primary care, terminology, oral health, oral physician

INTRODUCTION AND BACKGROUND

Sixty-five million Americans live in areas with a shortage of primary care physicians.¹ The 2013 deficit of 8,200 primary care physicians will grow by 2025 to an estimated shortage of 12,500-31,000.² Despite these projections, medical schools are currently training only one-half the primary care physicians needed, with the majority of physician assistants and nurse practitioners choosing better paying, less demanding specialty positions other than primary care.³ In 2013 there were approximately 195,000 practicing, licensed dentists in the United States⁴ who were already sufficiently trained in medicine and dental surgery to be considered de facto oral physicians.⁵ Because patients see their dentists more often than their primary care physicians,⁶ there is an opportunity for dentists to provide limited preventive primary care, including chairside screening for chronic diseases such as diabetes, hypertension, hypercholesterolemia, osteoporosis,

domestic/child/substance abuse, and developmental disorders; and counseling for obesity and substance abuse; while monitoring patient compliance with prescribed and over-the-counter medications.

Moreover, the recognition of the reciprocal relation between oral and systemic health and disease, together with the increased need for more intercollaboration among health professionals, has fostered the reaffirmation that the mouth is part of the body.⁷ As such it is essential for survival, socialization, and self-actualization.^{8,9} Given some of the bases for these expanded roles, the insistence on continued use of the term "dentist" is too restrictive, referring to only the structure and function of the teeth, and does not connote what dentists can and should do as part of the health care team. Despite the intransigence of dentists who prefer their unaccountable business model, the term oral physician is being considered to better indicate their actual and potential scope of practice.

OBJECTIVE

Based on the need and opportunity for dentists to become more involved in the overall health care of their patients,¹⁰ the objective of this study was to determine the willingness of dentists in Rhode Island to undertake chairside screening for chronic disease.

METHOD

A 48-question plus demographics survey was developed to determine the attitudes of Rhode Island dentists toward being involved in LPPC. Following pretesting with California dentists, the questionnaires were emailed to a convenience sample of Rhode Island dentists. A one-to-five scale was used to indicate the importance of medical screening in the dental office, confidence in medical knowledge, willingness to be involved in the overall health of patients, and concern with liability and related insurance issues. Respondents were also asked to rank order their preferred titles for oral health professionals: dentist, dental physician, oral physician, odontologist, stomatologist, and stomiatrist.

RESULTS

Of 520 surveys distributed, 92 (17.7%) were returned by dentists, of whom 75% were male and 25% female, with a

TABLE 1. Age Differences in Willingness to Perform Selected Procedures

	≤50 Years, n=32	≥59 Years, n=25	p value for differences between age groups	Spearman rho	p value for Spearman rho
	Mean ± Standard Deviation	Mean ± Standard Deviation			
Obtain vital signs	3.09 ± 1.23	2.38 ± 1.10	=0.026	-0.234	0.027
Send body fluids to the lab for analysis	3.84 ± 1.17	3.0 ± 1.10	≤0.005	-0.317	0.002
Counsel for obesity and substance abuse	3.31 ± 1.09	2.48 ± 1.01	≤0.005	-0.293	0.006
Discuss physical and lab findings with patients	2.09 ± 1.06	1.42 ± 0.58	≤0.005	-0.282	0.007
Obtain additional training	2.34± 1.31	1.82 ± 0.66	=.060	-0.122	0.261

median age of 45 years. Based on the mean ± standard deviation response on the scale of 1–5, respondents acknowledged the relatively great importance of recognizing underlying health issues (mean=1.77±.41); were moderately confident of their medical knowledge (mean=2.70±0.96); were at slightly less than the midpoint of the scale for willingness to be involved with medical screening in a dental setting (mean=2.53 ±0.67); and, as expected, were quite concerned about liability and related issues (mean=1.44±0.49, $p<.01$).

Although there were no gender differences, there were significant differences between older (>59 years) and younger (<50 years) dentists in willingness to perform selected tasks (see Table 1), including obtaining vital signs, sending body fluids for lab analysis, and discussing lab and physical findings with patients; as well as a marginally significant greater willingness of older dentists than younger dentists to obtain additional training to provide these services ($p=.06$). Except for concern with liability for medical screening or conversely for not recognizing underlying medical risks during dental treatment, there were small but significant negative correlations between age and specific tasks which they were willing to undertake as part of being more involved in the overall health of their patients; that is, the older they were, the less negative they were about engaging in non-dental procedures which could add to patient welfare. Relative to the proposed change in nomenclature from dentist to oral physician to more accurately represent what dentists can and should do, the designation “dentist” was still preferred, receiving the highest rank order among the six possible designations, but with no significant mean rank difference between “dentist” and “oral physician.” (Table 1)

DISCUSSION

The results of this study are consistent with those of several other studies looking at the acceptance of expanded roles for dentists by physicians and patients. From a political and business point of view, most dentists prefer the status quo, in which they are unaccountable for appropriateness and quality of their treatment.¹¹ However, much change is expected with the advent of the Affordable Care Act, and

in another study it was found that dentists recognized the importance of medical screening and were even willing to consider providing it in their practices.¹² Patients see no problem regardless of whether dentists were called oral physicians or dentists.¹³ Similarly, patients were also willing to have medical screening for chronic disease done by dentists and to pay \$20 for it.¹⁴ In a study of physicians, they were found to have no objection to dentists doing limited preventive primary care screening in a dental setting.¹⁵ The observation that the older Rhode Island dentists are more willing than younger dentists to become involved may reflect their greater personal and professional security than the younger dentists, who may well be paying off debts associated with their expensive training.

CONCLUSION

Although most dentists preferred the status quo, they acknowledged the importance of medical screening as well as its potential liabilities. Older dentists expressed less concern than younger dentists about additional responsibilities with more willingness to receive additional training. Moderate support for the term oral physician was also noted.

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