In Support of Geriatric Dentistry at the Undergraduate Level

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In October 2005, I participated in a geriatric dentistry workshop sponsored by the British Columbia Dental Association (BCDA). The topic of my presentation was delivering dental care to the patient and a facility in a mobile setting. I believe the reason that this workshop was successful was that the faculty of dentistry at the University of British Columbia, with the support of BCDA, has begun an undergraduate program in geriatric dentistry and a mobile dental clinic that services long-term care facilities in the Greater Vancouver Area. This program was initiated by Drs. Chris Wyatt and Michael MacEntee, who have researched and written extensively about delivering dental care to the geriatric population, a growing segment of our society.

Two other undergraduate geriatric dentistry programs are taught in Canada, one at the University of Manitoba and the other at Laval University. Many good quality programs are also offered in the United States. One excellent program offered at the University of Iowa, under the leadership of Drs. Ronald Ettinger and Howard Cowen, deals with the important relationship between medicine and dentistry in the geriatric setting.

More dental schools in Canada need to introduce undergraduate students to the problems of oral health care in the geriatric population. Dental students need to learn about the relationship between medicine and dentistry as early as possible in their education. Geriatric dentistry is on the cutting edge in its approach to this topic. Geriatric dentistry gives dental students practical experience that exposes students to this interrelation of medicine and dentistry. For the most part, geriatric patients have underlying medical conditions. They are more likely to be on multiple medications or suffer from cognitive problems that complicate their treatment and need to be dealt with.

Elderly patients who have been receiving high-quality professional care, such as crowns, fixed bridge work, removable prosthodontics, cosmetic or restorative dentistry, and implants, should not suffer simply because they enter a nursing home or long-term care facility, or become homebound. Unlike medicine, which is mandated by law to assign one or more medical people to each institution as medical directors, dentistry has failed at all levels to provide similar care for these patients.

The dental profession has not prepared itself for this serious problem, which is evident only when patients are examined in nursing homes. Such examinations reveal failing fixed bridge work, rampant decay, dentures that do not fit and cause infections, hypertrophied tissue, root tips that are infected and hidden under tissue, undetected cancer and much more that is undiagnosed. Because the dental profession has not thought it important to educate the allied professions, nurses and doctors do not understand the extent of destruction that neglect of oral health can cause. Lack of oral hygiene, yearly examinations and treatment can destroy oral health tissue and cause loss of teeth, which can have a severe

impact on patients' quality of life. Further, poor oral health can greatly affect immunosuppressed patients who are struggling to stay healthy. Allied professionals need to be educated about developing successful geriatric dental programs in long-term care facilities.

In 2003 the Ontario Dental Association (ODA) did a survey entitled *An Assessment of the Oral Health Care Provided to Special Needs Patients by Ontario Dentists*.[1] Of the 6,280 questionnaires sent, only 1,784 were completed, representing 26% of dentists in the province. Of those dentists responding, only 531 treated institutional patients and 7 provided full-time care in Ontario.

Data for care provided to institutionalized patients in 12 months are summarized here:

- "Although over a third (35%) of dentists (185) provides care to the institutionalized irregularly, about 24% (127) do so monthly." The average time spent treating patients was only 24 hours per year in institutions.
- "Generally dentists who provide oral care for institutionalized patients see on average about 43 patients a year and they report that this makes up about 6% of their total yearly practice hours. Upon closer examination of the results the distribution is quite broad with a range from 1–1,000 patients. Only 7 of the 531 dentists who provided care to the institutionalized indicated that they do so full time (100% of practice). The most common response was 6% of practice time by 37% of dentists who provide care to the institutionalized."
- Younger dentists (those practising less than 10 years) treat slightly more geriatric patients than those practising more than 10 years.
- In offices and in institutions, an annual total of 22 hours were spent delivering preventive care, 26 hours on regular care and 13 hours on emergency care.

According to Statistics Canada, more than 109,000 patients live in long-term care facilities in Ontario.[2] Based on the data from the 2003 survey, current dental services fall far short of providing basic dental care for this growing segment of our population.

Everyone talks about access to care. We hold symposiums and conferences, have discussions with governments, and write articles about it. The bottom line is that we hold the key to access to care. Whether we like it or not, this growing aging segment of our population will require dental care. Our choice is to either lead in the provision of that care, and do so on our terms, or wait until governments force us to provide it. It is clear that oral health is not a priority in our health care system. Governments are struggling to keep up with spiralling health costs and growing demand, and oral health is not on their radar. It is therefore incumbent on us, as dental health care professionals, to deal with this need and provide access to care for elderly patients in long-term care facilities who can no longer care for themselves.

Who is going to pay for the dental care of these patients? ODA has put out a fee guide for nursing home patients. In my experience, those who want and need treatment will pay, whether through insurance coverage or family assistance. If the treatment is necessary and will improve the well-being of the patient, payment is not an issue. The majority of families will gladly pay for services that their loved ones need.

The College of Dental Surgeons of British Columbia (CDSBC) is looking at setting up an insurance program for seniors in health care facilities that can be purchased privately. In Ontario, ODA has a company called Accetera that administers benefit plans set up by a network of brokers for their clients. Perhaps through this company ODA could administer an insurance program similar to that of the CDSBC. If we wait for the government to act, it may be too late.

According to Statistics Canada, by the year 2010, the Canadian population over the age of 65 will be greater than the population of children under the age of 12 years. If we do not act soon, we as dentists will fail the group of patients who have supported us for the last generation. We need to change our approach to geriatric dentistry and we need to do it at the undergraduate level. Geriatric dentistry cannot become the orphan child of the profession, living off of the generosity of a benevolent few. It needs thinkers and advocates. Further, we need advocates other than dentists to help us to lobby governments for geriatric dental care. We must take action now and hope that governments will follow. Geriatric dentistry needs to become an integral part of the education of our current and future oral health care professionals. Research and clinical skills must be taught early in the educational process so that we can develop good oral health care for geriatric patients in need. We need to develop teachers who can lead, and we need to do it now.

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