Debate
& OPINION

Nuances in Standards Terminology and the Care of Individuals with Special Needs

H. Barry Waldman, *DDS, MPH, PhD;* **Steven P. Perlman,** *DDS, MScD, DHL(Hon)*

Contact Author

Dr. Waldman
Email: hwaldman@notes.cc.sunysb.edu

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Dental school accreditation standards set the foundation for preparing graduates who provide oral health services to millions of people with special needs in Canada and the United States. Increasing numbers of such people now reside in local communities and depend on neighbourhood dentists for needed care. The challenge is to ensure proper preparation to provide such care and eliminate obstacles to its delivery.

Nuances in terminology used in accreditation standards may (or may not) foster efforts to provide basic and clinical science experiences to dental students. Nuances are the slight variations in tone and meaning of words that enhance our communication. For example, "must" denotes compulsion, obligation, requirement or necessity; "should" expresses duty, propriety, necessity; and "may" connotes a possibility or likelihood.

Although these definitions seem straightforward, the nuances of meaning become more complicated when these words are used in formal directives. For example, consider the varying language in the training requirements for graduates of dental schools in Canada and the United States regarding care of people with special needs:

> Graduates must have sufficient clinical and related experiences to demonstrate competency in the management of the oral health care for patients of all ages. Experiences in the management of medically-compromised patients and patients with disabilities and/or chronic conditions, should also be provided. (Standard 2.4.1, Commission on Dental Accreditation of Canada)[1]

> Graduates **must** be competent in assessing the treatment needs of patients with special needs. (Standard 2-26, [United States] Commission on Dental Accreditation)[2]

The accompanying "intent" statement for the latter standard specifies:

> An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, or social situations may make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need. These experiences should be monitored to ensure equal opportunities for each enrolled student.[2]

The use of the word "must" in the Canadian standard expresses compulsion "to demonstrate competency in the management of oral health… for patients of all ages." When it comes to patients with disabilities or chronic conditions, however, the directive is somewhat

Table 1 Prevalence of disability by age group, Canada and the United States, 2006[3,4]

Age group, years	Proportion disabled, Canada, %	Age group, years	Proportion disabled, United States, %
0–14	3.7	5–15	6.3
15–64	11.5	16–64	12.3
65+	43.4	65+	40.9
All ages	14.3	5 and over	15.1

toned down to a "should," which expresses a sense of duty.

In contrast, the directive "must" is emboldened in the US standard, but only "in assessing the treatment needs of patients with special needs." Nowhere is there any specific reference to the "treatment" of patients with special needs. This omission was not by accident, but rather a compromise with those opposed to the effort initiated through Special Olympics (by the authors of this article) to bring about the needed addition to US dental school curricula.

The disagreement over curriculum changes had never been over numbers or prevalence of people with disabilities. In Canada, 4.4 million people (14.3% of the population) and, in the United States, 41.2 million people 5 years of age and older (15.1% of the population) had 1 or more disabilities in 2006.[3,4] The proportion of people with disabilities increases with age (e.g., strokes, heart attacks), reaching more than 40% among those 65 years and older (**Table 1**). This progressive increase takes on added significance in view of projections for the next decades when baby-boomers will reach their senior years: 1 in 5 US residents will be 65 years and over; in some states, the proportion will reach 1 in 4.[5]

The disagreement had instead been over the limited availability of trained faculty to provide basic and clinical needs, physical resources and needed finances.

Dental School Curricula in the United States Before and After the Introduction of Standard 2-26

At the end of the 1990s and early 2000s, a series of studies found that, during 4 years of education, more than half of US dental schools provided fewer than 5 hours of classroom presentation and about 75% devoted only 0%–5% of patient care time to the treatment of patients with special needs.[6-9] Half of students reported no clinical training in the care of patients with special needs, and 75% reported little to no preparation in providing care to these patients.[10]

Thus, one should not be surprised that only 10% of general dentists say that they treat children with cerebral palsy, intellectual disabilities or medically compromised conditions "often" or "very often"; 70% "rarely" or "never" treat children with cerebral palsy in their practice.[11]

A national study of dental hygiene programs[12] reported comparable findings: 48% of 170 programs included 10 hours or less of didactic training in care of the developmentally disabled (14% had 5 hours or less), and 57% of programs reported no clinical experience.

However, during the first years after the introduction of Standard 2-26, dental schools had gone beyond the "must" directive to ensure that students were competent in assessing treatment needs.[13] In fact, students at the surveyed schools were providing care to patients with special needs.

Individuals with special health care needs may not receive needed services for a variety of reasons, including financial barriers, lack of access to providers, competing family demands on time (particularly children) and unwillingness to cooperate to receive services. In the United States, 18% of children with special health needs were reported to need at least 1 health care service that they have not obtained in the past year.[14] Failure to obtain needed services is most common among poor children (32% had not received at least 1 such service) and uninsured children (46% needed at least 1 service not received). "The service most commonly reported as needed but not received was dental care."[14]

Are Things Any Different in Canada?

Deinstitutionalization, mainstreaming, increased life expectancy of those with special needs and reliance on community practitioners for health services are common developments in both Canada and the United States. Canadian dental school accreditation standards express the nuance of duty to manage patients with disabilities and/or chronic conditions,[1] but has this proved sufficient to ensure appropriate educational opportunities and to assure needed oral health services for those with special health care needs in the general population?

At the Association of Canadian Faculties of Dentistry 2009 Biennial Conference in Toronto, Sherman and Anderson reported that, in predoctoral dental programs in Canada in 2007, educational experiences in the care of patients with special needs were limited and varied (oral presentation: Carla Sherman and Ross Anderson, Special needs education in Canadian dental school curriculum: Is there enough?). Of the 10 Canadian schools of dentistry,

5 provided *no* didactic hours and another 5 provided *no* clinical hours devoted to special needs care.

In 2009, 73% of people with developmental disabilities reported being able to access dental services.[15] Less than 10% said that a dentist was unwilling to provide treatment. The refusals were for reasons similar to those reported in other studies, such as inadequate training, inadequate facilities and unwillingness to participate in government programs.

"Most persons with developmental disabilities in Ontario appear to be able to access dental care; however, those who require special modifications such as general anesthesia to receive dental treatment reported the greatest difficulty in obtaining care... [D]ental anxiety and inability to cooperate were more strongly associated with difficulty accessing dental care than environmental factors."[15] However, one of the authors of this study emphasized the fact that most responders were from large urban centres and were members of vocal/visible advocacy groups (personal communication: Dr. Michael Sigal, faculty of dentistry, University of Toronto, 2009).

In an Ontario study,[16] 80% of general dentists and 60% of pediatric dentists reported providing a full range of dental services to those with special needs. Most general dentists reported receiving training in the care of this population during their years in dental school. Most pediatric dentists had received such training during specialty training programs.[16] The number of people with special needs treated by individual dentists and the severity of the disabilities were not considered in this study (personal communication: Dr. Michael Sigal, faculty of dentistry, University of Toronto, 2009). In addition, patients, families and staff of group homes had continuing difficulties locating a dentist in their community willing to take on these patients.

The Challenge

Whether the standards stipulate that dental education "must," "should" or "may" include experiences to prepare practitioners to provide care for people with special needs, the challenge is to ensure that these efforts are carried over into actual practice. The reality is that many people with special needs are members of families already being treated in many dental practices.

A recent report[17] from the United States on dental students' attitudes toward the care of people with intellectual disabilities described a strong relationship between experience in dental school and ability to provide needed services, but emphasized the recommendation that "curricula include experiential learning with reflective components in order to develop students' comfort level in treating special needs populations." If one may assume that such findings are applicable in Canadian dental schools (and in combination with the above-mentioned statements on the difficulties in securing needed oral health services for those with special needs), then it does not seem out of place to recommend modification of the Commission on Dental Accreditation of Canada's Standard 2.4.1[1] to state that experiences in the management of medically compromised patients and patients with disabilities and/or chronic conditions *must* (rather than should) be provided.

Public officials should also be made aware of the extent of the problem. The number of people with disabilities in Canada (over 4 million) is important to know, but it is even more important to make legislators aware of the number of their constituents with disabilities in each province, region, city and even neighbourhood. The challenge is that we "must" provide needed oral health services to those with special health care needs.

THE AUTHORS

***Dr. Waldman** is Distinguished Teaching Professor in the department of general dentistry, Stony Brook University, Stony Brook, New York.*

***Dr. Perlman** is global clinical director, Special Olympics, Special Smiles and clinical professor of pediatric dentistry, Boston University School of Dental Medicine, Boston. He also maintains a private pediatric practice in Lynn, Massachusetts.*

***Correspondence to:** Dr. H. Barry Waldman, Department of general dentistry, Stony Brook University, Stony Brook, NY, USA 11794-8706.*

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