

## Authors' response

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## LETTERS

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### LOCAL ANESTHETICS

Dr. Virginia Powell's August JADA article, "Articaine Is Superior to Lidocaine in Providing Pulpal Anesthesia" (JADA 2012;143[8]:897-898), does not indicate if the solutions contained epinephrine or not—and, if they did, what the concentration was.

Regardless of the solution, it is not possible to determine accurately if one anesthetic is superior to the other. There are too many variables to consider, including

- variations in a patient's perception of pain;

- variations in a tooth's response to electric pulp testing or ice;
- the inability of the dentist to deposit the exact same amount of solution in the exact spot in the same patient;
- variations in oral anatomy from patient to patient;
- variations in the dentist's decision as to where to inject;
- the morphology of the tooth, the density of the bone or the tooth's position in the bone could affect the result;
- the needle may be deflected on insertion and the patient may close [his or her] jaw during the injection.

Consequently, making a choice between anesthetic solutions ends up being an opinion. Another dentist could conclude differently.

At a meeting I attended on pain control some years ago, the panel of speakers was asked why it was harder to numb a patient who was in severe pain. The answer was that there should be no difference. If you get the solution to the right place, then it will work regardless of the type of pain.

**W. Braden Speer, DDS, MSD**  
Dallas

**Author's response:** Dr Speer's letter regarding anesthetic choices states, "[I]t is not possible to determine accurately if one anesthetic is superior to the other. There are too many variables to consider ... ." He correctly lists many variables that may affect anesthetic success and, in fact, there are probably even more factors than the ones he listed.

According to Fletcher and Fletcher,<sup>1</sup> random allocation of patients to a test or study group is the best way to "study the effects of a clinical intervention free of other effects." In other words, it is impossible to consider all the possible factors that

may influence the success or failure of any given treatment.

Therefore, the current recommended strategy for "working around" this complication is to create test and control groups that have an equal chance of having a given characteristic; thus, randomized clinical trials are the strongest tool we have in determining which treatment is most successful.

We were summarizing the systematic review written by Brandt and others.<sup>2</sup> They compared the results of 13 RCTs for a total of 560 participants. The best evidence collected by these authors can be interpreted as supporting the conclusion that 4 percent articaine with a vasoconstrictor provided successful anesthesia more reliably than 2 percent lidocaine with vasoconstrictor. This conclusion is not a recommendation. Ultimately, it is the responsibility of each individual dentist to choose the anesthetic for any given situation. The conclusion of this review is just one thing to consider in making that decision.

**L. Virginia Powell, DMD**  
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American Dental Association

1. Fletcher RH, Fletcher SW. Clinical Epidemiology, *The Essentials*. 4th ed. Baltimore: Lippincott Williams & Wilkins; 2005:132.

2. Brandt RG, Anderson PF, McDonald NJ, Sohn W, Peters MC. The pulpal anesthetic efficacy of articaine versus lidocaine in dentistry: a meta-analysis. JADA 2011;142(5):493-504.

### SOCIAL COUPONS

The ethical problem presented in Dr. Richard Rosato's September JADA Ethical Moment, "What Are the Ethical Implications of Using Social Coupons to Expand My Patient Base?" (Rosato R. JADA 2012;143[9]:1035-1037), revolves around fee splitting.

There was discussion regarding the potential problems with a prospective patient

paying a third-party social coupon service. The third-party company keeps a portion and then pays the dentist performing the treatment. What about the patient who pays Delta Dental, which keeps a percentage and then pays the dentist for the treatment? Or the patient who pays the owner-dentist, who keeps a portion and then pays the associate who treated the patient a percentage? The waters still seem a bit cloudy on the issue.

There were important points made about insurance billing. But the comments about patients moving from their “dental home” and having dentistry become a commodity means the next stage of the discussion should involve closed-panel insurance plans and preferred provider organizations, because the dental home became very mobile a long time ago.

**Robert Knudson, DDS**  
Bellingham, Wash.

**Author's response:** I thank Dr. Knudson for his comments. I believe both scenarios that Dr. Knudson describes are distinguishable from the use of social coupons in that neither is for a specific service that the patient may or may not need. Utilizing the services of a social couponing marketing service typically involves the dentist's splitting revenue with the company for promotion of the service. In these cases, the social couponing company collects the fee for services from the patient and then forwards a predetermined portion of the fee to the dentist. The revenue is divided between the social couponing company and the dentist, regardless of whether the service is provided.

Dental insurance and payment to an associate are forms of reimbursement that are not intended to drive treatment

decisions, and such payments are made only after a service has been provided. The purpose of fee splitting is also quite distinct from the purpose of reimbursement or payment to an associate. Fee splitting is payment for a referral rather than payment for a service that has been rendered.

It should be noted that some social couponing companies have recognized the difficulties that exist with the payment model described above and have proposed other arrangements that may be less problematic.

It also should be kept in mind that discounts offered via social coupons, for example, may violate the terms of a dentist's contract with a third-party payer. Some contracts with insurers require that the fees of the dentist billed under the contract reflect the lowest price charged by the dentist for a particular service. Thus, if the dentist is providing a service to a social coupon holder at a lower rate than is being billed to an insurance company under such a contract, that may be contrary to the terms of that agreement. Social couponing, while a method of payment for services, is more a marketing or an advertising tool than it is a reimbursement mechanism for services provided to a patient.

Given the differences discussed above, and also the legal uncertainties concerning the social couponing payment arrangement discussed above that exist in many states, exercising caution when promoting services through social couponing is warranted at this time.

**Richard Rosato, DMD**  
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## PATIENT SAFETY

I read Dr. Rachel Ramoni and colleagues' September JADA guest editorial, “From Good to Better: Toward a Patient Safety Initiative in Dentistry” (Ramoni RB, Walji MF, White J, et al. JADA 2012;143[9]:956-960), with great interest.

I want to state at the outset that I have no quarrel with working to ensure patient safety. Having said that, I want to comment on the premise that many folks (exact numbers not known) may be the recipients of faulty care or subject to mistakes in diagnosis and treatment of a more severe nature. I make my comments based on over a half-century of practice and on having served for 41 years on a hospital staff at an active staff rank.

As the article states, the current conditions in our profession seem to promulgate the circumstances that led to a feeling that there now is a need for some further kinds of guidelines/programs/controls to obviate the perceived need to reduce patient risk of adverse outcomes.

From the perspective of a half-century of practice and the support of having been very active in all levels of dental society activities from local to international, I decry much of what I see happening today and believe the acceptance of many of the deviations from what used to be considered good practice have produced this concern for the patient's welfare.

People I meet in social settings continually ask me for my advice about treatment proposals. I have become quite appalled at the number of times that the patient has been told he or she needs care that is not substantiated to the patient's satisfaction. And often, after I ask a few basic questions, I doubt that the care is appropriate.

I point to the laxness in our current rules that allows for nearly unfettered advertising by practitioners. I further am concerned about the suggestion of care that is extremely costly or, at least, the suggestion that only very expensive care is the way to go.

We live in a very complex world in which dentistry as a professional way of life must be in competition with many other factors. A letter such as this cannot attend to all of the reasons why dentistry should be more dangerous today than it was in past times. However, I feel that the demise of what was considered ethical dentistry a few decades ago and the acceptance of the “rules of the road” of today contribute to this concern for patient safety.

My fellow practitioners and I, who exposed ourselves to challenging, yet satisfying critiques from medical personnel, took patient safety as a basic gospel. An untoward outcome for a patient was very rare. “Mistakes” were prevented by our applying ourselves diligently to the care of the patient, not to what our next ad campaign content would be.

Maybe, just maybe, it is time to reassess where our profession is today and where we will be tomorrow if the materialism and hucksterism of some, certainly not all, of our colleagues are allowed to continue.

Maybe, just maybe, it is time for the “learned profession of dentistry” to reestablish the rules and limitations that made it great and curb the activities that, in my mind, lead to the lack of attention to the patients’ welfare, which, in turn, leads to the errors that harm those we most want to protect.

**Stephen G. Sinykin, DDS**  
Bloomington, Minn.

**Authors’ response:** We

wish to thank Dr. Sinykin for his perspective on our editorial. While we will allow the readership of JADA to come to their own conclusions about Dr. Sinykin’s assertion that a rise in “materialism and hucksterism” has detracted from patient welfare in the dental office, we will comment and expand upon a number of our colleague’s points.

Dr. Sinykin is quite right in saying that dentists and the profession as a whole have no way of knowing how often mistakes and adverse events occur in the dental clinic. One benefit of a patient safety initiative is that dentistry will be armed with the information it needs to ensure that patients are receiving—and continue to receive—care that is appropriate and safe.

Dr. Sinykin described the critiques he received from medical staff personnel as “challenging, yet satisfying.” We expect that the knowledge generated from a dental patient safety initiative will have a similar effect on practitioners, as it will both reveal failings and point the way to improvement.

While Dr. Sinykin’s letter focused on overtreatment, this is not the only way a practitioner can stray from the narrow path of quality and safety. In his article, “New World of Patient Safety,” Dr. Lucian Leape,<sup>1</sup> our mentor and one of the fathers of the patient safety movement in medicine, highlighted work showing that half of Americans fail to get effective treatments they need, at least a third receive treatments of little or no benefit and 10 percent or more are significantly harmed by preventable mishaps. It bears repeating that dentistry is entirely in the dark with respect to how often overtreatment, undertreatment and mistreatment happen in the dental clinic.

We would also respectfully

submit that the practice of dentistry itself has been changing under our feet. In “The Checklist Manifesto,” Atul Gawande,<sup>2</sup> whom we quoted in our editorial, said it eloquently:

For nearly all of history, people’s lives have been primarily governed by ignorance. This was nowhere more clear than with the illnesses that befell us. We knew little about what caused them or what could be done to remedy them. But sometime over the last decade—and it is only over the last several decades—science has filled in enough knowledge to make ineptitude as much our struggle as ignorance.

He then goes on to describe how, since the 1950s, our knowledge of the impact of high blood pressure, cholesterol, genetics and smoking on the incidence of heart disease has grown exponentially. There is so much for today’s practitioner to remember that it is easy to slip into ineptitude.

Dentistry also has experienced the same explosion in knowledge. Consider the care of the diabetic patient: at a minimum, the dental care team should discern whether a patient has diabetes, what type of diabetes he or she has, how he or she controls the diabetes and how well the diabetes is controlled. Despite this, a survey of dentists and dental hygienists in Arkansas conducted by Efurd and colleagues<sup>3</sup> found that only 10.8 percent of dentists and 8.4 percent of dental hygienists recorded the glycated hemoglobin (HbA<sub>1c</sub>) levels of their diabetic patients, and only 19 percent knew that an HbA<sub>1c</sub> > 8 percent is an indicator of poor diabetic control. Dental care teams clearly are having a tough time keeping up with all that there is to know, which may be putting their patients at risk of experiencing preventable adverse events.

We close by again thanking

Dr. Sinykin for sharing his views. We encourage all dental care team members to embrace the lifelong journey to betterment by continually examining their own practices for threats to patient safety.

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## ADA ANNUAL SESSIONS

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## CORRECTION

There was an error in the  
December JADA article "The  
Integration of Diet and Nutri-  
tion Lifestyle Management  
Strategies Into the Dental Office  
Visit for Diabetes Risk Reduc-  
tion and Management" by  
Maura Bruno, RD, CDE, DCN  
(JADA 2012;143[12]:1320-1323).  
Reference no. 7 should have  
read thus: Lamster IB, Lalla E,  
Borgnakke WS, Taylor GW. The  
relationship between oral health  
and diabetes mellitus. JADA  
2008;139(10 suppl):19S-24S.  
JADA regrets the error.