Editorial

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Preventing Oral Disease

Years ago, there was a cute commercial on television for a fast food chain. The advertisement had an elderly lady looking at a small hamburger on a large bun and asking "where's the beef?" Most people thought that was a humorous way of comparing one product with another. That commercial came to mind when I considered the research papers being presented in this issue of the Journal.

Several of the topics in this issue focus on preventing oral disease and extending access to oral care for underserved populations. These articles are encouraging as our profession needs to be able to demonstrate regularly to government agencies, legislators and policy makers that we have sufficient data to demonstrate our effectiveness as preventive health specialists.

Case in point, I recently received an email from the Israeli delegates to the International Federation of Dental Hygienists requesting assistance from other country delegates with providing data that demonstrates that dental hygienists have a positive effect on preventing oral disease. This was followed by the release of the Institute of Medicine report "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." In this report, there was recognition that state laws needed to be amended to maximize oral health care. In particular, the report emphasized that oral health professionals need to be able to practice to the full extent of their education and training in a variety of settings. Upon release of the report, the Academy of General Dentistry challenged this notion, expressing concern that vulnerable populations would be placed at a greater disadvantage and their oral health might be threatened. The thought occurred to me that if we have greater information about the impact of dental hygiene services, we could easily address these concerns.

As a profession, we do need to take notice of this issue. It is not enough to claim a title. We need the evidence to support that we do, in fact, prevent oral disease. If you asked a dental hygienist in clinical practice about this, that person would strongly state that oral disease is prevented daily with the treatment provided in clinical practice. If you asked a dental hygiene educator, that person would tell you students are taught all about prevention in their entry level dental hygiene programs. However, if you ask the chair of a component, state, national or even international legislative committee, these individuals will provide a different perspective. We may think we are preventing oral disease, but we don't really have all the pieces in place to verify that concept.

So how do we change this picture to turn the concept into a reality? There are several approaches we can take to bolster our preventive efforts. First, we can re–examine our international and national research agendas to evaluate our emphasis on prevention. Second, we need to coordinate our efforts across the globe to create complimentary models of preventive research. This effort will enable us to gather substantive data that can be used to verify our preventive efforts.

Another approach that would be beneficial is to document in clinical practice and community settings the outcomes achieved by preventive dental hygiene interventions. Tobacco cessation programs need to include profiles that detail the number of individuals counseled, types of quit programs recommended and used and effects of those programs with respect to the number of individuals that were able to quit smoking, time elements of sustaining the ability to refrain from smoking and descriptions of any oral pathology associated with smoking behaviors (past and present). Oral cancer screening programs should have outcome parameters that examine comparisons of the comprehensive oral examination with other adjunct screening technologies, and the number of cases of dysplasia and carcinoma identified.

Sealant programs and CAMBRA protocols provide additional examples of preventive programs that can be used to assess the prevention of caries. Items that can be studied include risk factors, efficacy of products used, level of caries identified and treated and quality of life parameters.

With greater emphasis on systemic and oral health, our profession could be studying the ef-

fectiveness of taking vital signs in practice and community settings to identify those who may be hypertensive, and the use of interventions to prevent cardiovascular diseases. Or, consider the benefit of providing oral health education to individuals who are pregnant to explore the impact of this education on the oral health of the mother and infant in preventing periodontal disease and early childhood caries. In addition, there are opportunities to investigate the effectiveness of oral preventive measures in various settings. Consider the value of having data that demonstrates the power of prevention in long–term care facilities, hospitals and rehabilitation centers. Models that examine prevention from an inter–professional domain would be another avenue of research.

The intent here is not to create a laundry list of research ideas. Rather, the intent is to raise the profile on oral health prevention research. There are multiple opportunities to capitalize on the magnitude of these studies. Joining forces with our colleague around the globe to design and implement prevention studies would further the goal of demonstrating our development as a profession and our commitment to improving the health of the public.

If we, as a cadre of prevention specialists, challenge ourselves to conduct research on oral health prevention, we may find that we will have ample evidence to support the utilization and further development of dental hygienists in a variety of settings that address the current and future needs of the health care system. When someone asks us "where's the beef" about oral health prevention, won't it be nice to have the answers?

Sincerely,
JoAnn R. Gurenlian, RDH, PhD