How could the public be at less risk with such a plan?

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Oral Medicine Specialty? Response to Dr. Vincent

In reply:

We thank Dr. Vincent for his letter to the editor. Diversity of opinion is what makes this country strong and our profession stronger. Having said this, it is important that the discussion directed at specialty recognition be viewed in full context at the historical level as well as its present status.

Dr. Vincent has held the longstanding belief that the American Dental Association (ADA) should serve as the sole designator of specialty recognition. He uses a single case to illustrate his opinion. This example of the closing of an oral medicine program at the University of Iowa unfortunately represents an N of 1; such case reports are considered low-level evidence and have the danger of being overinterpreted.[1,2] The lack of success of Iowa's program expressed by Dr. Vincent may be based on other reasons, including a lack of financial or academic support by the department or college, poor intercollegial cooperation, a lack of adequate teaching faculty, a lack of awareness and understanding of the unique knowledge and skills offered by the specialty of oral medicine, inadequate marketing, or a lack of desire to live in a particular location.

In contrast, there have been many examples of stellar advanced education programs in oral medicine at prestigious institutions over the years (e.g., Carolinas Medical Center, Harvard University, University of Pennsylvania, University of Washington, University of California at San Francisco; see http://www.aaom.com/residency-programs).[3] Furthermore, since 2007, 2-year advanced education programs in new fields of dentistry have been approved by the Commission on Dental Accreditation in oral medicine, orofacial pain, and dental anesthesiology, under the approval of the U.S. Department of Education. Graduate education programs in these new specialties have flourished with academic programs in the United States and Canada in orofacial pain (n = 14), dental anesthesiology (n = 10), and oral medicine (n = 10).[4,5] Hundreds of graduates from each of these programs have gone on to teach, establish clinical practices, improve patient health, and gain research funding from the National Institutes of Health. In fact, we are proud to be among them and have contributed new clinical and scientific knowledge to the profession of dentistry with over 50 combined years of such research funding.

The growth of new fields is a testament to the fact that the profession of dentistry is not stagnant, as Dr. Vincent suggests, but rather evolving to include many new areas of knowledge and clinical expertise that cannot be achieved by expanding existing dental specialties. In fact, the growth of these new specialties has equaled or exceeded that of some existing dental specialties. For example, the numbers of board-certified diplomates in dental anesthesiology (201), orofacial pain (251), implant dentistry (366), and oral medicine (198) are comparable to existing dental specialties including dental public health (146), oral and maxillofacial radiology (131), and oral and maxillofacial pathology (280).[4,5]

Unfortunately, Dr. Vincent fails to recognize the fact that the ADA specialty recognition is a political process, as acknowledged by recent litigation in Texas, Florida, and California. It is also independent of Commission on Dental Accreditation approval and heavily influenced by the self-serving special interests of existing dental specialties. Dr. Vincent notes that the invoking of ADA specialty application requirement number 3 has resulted in the ADA's failing to recognize several specialties, including from the American Boards of Oral Medicine, Orofacial Pain, and Implant Dentistry. Dr. Vincent fails to explain why dental anesthesiology passed all six ADA specialty recognition requirements four separate times; nevertheless, each time, dental anesthesia was rejected by the political process invoked by the ADA House of Delegates. Over the last 30 years, the ADA has rejected 90% of specialty recognition applications. This meager success rate suggests that the ADA specialty recognition process is flawed and the House of Delegates does not embrace the growth and evolution of the dental profession.

Dr. Vincent also fails to appreciate that oral medicine specialists treat tens of thousands of patients who have chronic orofacial pain conditions, salivary gland

disorders, oral mucosal disease, and medically complex conditions, because these patients cannot find dental providers who have the knowledge, skill, and experience to manage their conditions. Clearly there is unmet need. The implication that oral and maxillofacial pathologists are providing care to these patients is grossly exaggerated, because current evidence shows that over 95% of all clinically based income for oral and maxillofacial pathologists is derived from histopathology services, not from direct patient care (unpublished data).

Dr. Vincent also takes issue with the lawsuit involving the Texas Dental Board and claims that such action can "dilute the integrity of the dental health care profession." Here, we believe that Dr. Vincent fails to appreciate the growth that the profession requires, which can only come from a hard look internally at the ADA specialty recognition process and the need for improvements in self-regulation. He expresses concern that the public is at risk with such a plan; however, he provides no justification of how the public would be harmed if the knowledge and skills in new dental fields available to the general public were to be expanded. Consistent with this, in U.S. District Court, Judge Sam Sparks noted that consumers would not be harmed by the court's decision.[6]

In closing, the repetitive actions and decisions of the ADA have forced emerging specialties to go outside of the ADA. The American Board of Dental Specialties has been specifically developed to transcend this longstanding political process in order to achieve an objective process in approving dental specialties. While some may consider this as unfortunate, we believe that the public will benefit from more dental specialties with dental professionals who have advanced knowledge and skills in these exciting emerging fields. This clearly contrasts with Dr. Vincent's opinion and is another example of how oral medicine is different from oral and maxillofacial pathology.

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Disclosure: Dr. Miller has served as chairman of the Specialty Recognition Committee for the American Academy of Oral Medicine since 1988. He is a member of the founding Board of Directors and currently serves as a director of the American Board of Dental Specialties. Dr. Fricton has served as chairman of the Specialty Recognition Committee for the American Academy of Orofacial Pain since 1988. He is a member of the founding Board of Directors and currently serves as a director of the American Board of Dental Specialties.

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Mandibular changes on panoramic imaging after head and neck radiotherapy: a commentary

To the Editor:

We read with great interest the recently published article by Chan et al. titled "Mandibular changes on panoramic imaging after head and neck radiotherapy."[1] We would like to congratulate the authors for their original study, as there are no published case series that characterize the different types of radiographic changes in the jaws post radiotherapy. However, we had a few queries and would appreciate if the authors could provide further clarification:

1. It is not clear why patients with osteoradionecrosis were excluded from the study, as it was not defined in the study's exclusion criteria.
2. We had a little difficulty understanding how the bone changes can be attributed to radiotherapy alone. In the study there is no clinical correlation with the periodontal health status of the patient postradiotherapy,