

# HAVE WE FORGOTTEN PALLIATIVE CARE?

BY NANCY W. BURKHART, BSDH, EdD

Debil-  
itated  
patients  
still seek  
oral care

George, a 73-year-old male, is your patient today. He suffered a stroke several years ago and was confined to his home for over a year. George has not seen a dentist in an office setting for some time, but he was able to receive dental care during his illness through an unknown resource.

Although his treatment for the stroke was successful, his family realized that his mouth and teeth had been forgotten. George was in pain and needed dental care. He was unable to travel due to complications related to the stroke and his family discovered a dental resource that assisted in his total care (dental care for homebound patients). Dental care is part of palliative care and a crucial part of wellness and total health care for the patient.

What is palliative care? We all learned about palliative care in dental hygiene schools. Palliative care has been given various names in recent years, and it really does still exist in various forms. A recent article in *The Wall Street Journal* addressed the issue of palliative care and why it is so rare today. The author, Barbara Sadick, interviewed Dr. Diane Meier, who is the director of the Center to Advance Palliative Care, a national organization based in New York that helps start and sustain palliative-care programs around the country.

Palliative care has usually meant “end-of-life care,” and this is a misnomer. The program at the Center to Advance Palliative Care focuses on assisting the patient and the family in securing the best possible care, and often that means palliative care is administered simultaneously alongside disease treatment. In the palliative-care concept, a complete team approach involves the patient, family members, physicians, nurses, social workers, and dental professionals.

One such segment that can have a huge impact on the health and well-being of the patient is dental care. The deterioration of the dentition can have a huge impact on both the physical and psychological well-being of the patient (See list of concerns for senior patients). Pain and poor dental function affects eating, speaking, and the psychological health of patients who are in a debilitated state.

Xerostomia is a huge factor in debilitated states due to medications and poor health in general. Xerostomia also contributes to dental caries and depending upon the length of time the patient is in a debilitated state, dental destruction may continue to progress at an accelerated rate.

Many patients may need dental care but cannot leave their homes, or they are in such a physical state that dental

care becomes a secondary concern for the patient and family who may need to provide the transport of the patient to a care facility. Other needs of the patient take priority in the health-care status. Just obtaining the needed medical care is often very difficult for the patient and the family.

I contacted Dr. Meier at the Center to Advance Palliative Care, and asked her some questions about palliative care.

*Do patients who have serious illnesses receive dental care before or only after treatment for their medical condition?*

**Dr. Meier:** To my knowledge there are no nationally representative data on access to or utilization of dental care among people living with serious illness. Such data (which would make the case that we have a serious gap in access to core dental services) are urgently needed. My estimate based on both my family’s and on my professional experience is that most do not receive dental care unless there is an oral pain crisis such as infection or fracture.”

*How can a palliative focus be incorporated in the dental community? Do you think that this could be instrumental in CE courses for dental professionals?*

**Dr. Meier:** As with other disciplines — medicine, nursing, social work, chaplains — it would be great if national dental organizations established a palliative-care special interest group. This group could decide on educational, public awareness, and research priorities and begin to move this issue up the priority list for the field. We have to start somewhere to get the needed change.”



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*Palliative care, at one time, was standard in both dental and dental hygiene programs but I think it has been replaced with a treatment/prognosis focus. Patient education is so important, but amazingly, written information is rarely given to a patient. Patients forget what they were told, especially when they have been diagnosed with any illness. There is also the "White Coat Syndrome." The patient is apprehensive when being seen for treatment of any kind. Patients with serious problems may feel more secure with treatment in familiar surroundings. How important do you believe this is to the patient?*

**Dr. Meier:** Seriously ill people have a lot on their plates, and those things involve family caregivers. Getting to a dentist's office is often impossible. Getting a dentist to your home requires an act of Congress and/or independent wealth. Even if it is possible to get to the dentist's office, most dentists are not prepared to handle people with significant mobility impairments, cognitive impairments, psychological distress, significant physical discomfort (such as shortness of breath or pain unrelated to the mouth). This requires training (midcareer as well as undergrad and graduate dental and dental assistant education); changes in payment; and accreditation/certification policy. To accomplish these will require organized advocacy and political activity from the dental field.

*The focus right now is on "oral medicine" as a specialty area. Do you see the incorporation of such individuals seeking a fellowship in palliative care?*

**Dr. Meier:** There are no dental palliative-care fellowships. We'd have to create one. Participation in a palliative medicine fellowship would partially address the issue but would not help with the oral medicine aspects, per se.

According to the *WSJ* article by Sadick on palliative care, there is a lack of United States hospitals offering palliative care for the patient under treatment. The article also stated that one of the largest factors involved in getting palliative care for a patient is that most of the health organizations view palliative care as "end-of-life care" rather than an adjunct to the current treatment.

Dr. Meier stated that one of the largest deterrents is that undergraduate medical school is costly, and graduates tend to select the higher paying specialty areas because of the huge debt that they are saddled with after medical school. She suggests that patients should demand to be treated in hospitals that provide a palliative-care program.

People 65 years and older numbered 39.6 million and represented 12.9% of the population in 2000. By 2030, according to the Administration on Aging, there will be about twice the number of those 65-plus as found in the year 2000. The National Palliative Care Research Center suggests similar statistics, and by 2030, 20% of the United States population will be over 65 years old.

#### ORAL HEALTH CONCERNS FOR OLDER PATIENTS

- Dental decay, root caries, and periodontal disease cause pain and discomfort. Moderate to severe pain affects the quality of life.
- Life-threatening infections may result in the chronic use of medications.
- Increased risk for heart disease, stroke, diabetes, and osteoporosis accelerates with age along with other chronic disease states.
- The risk for respiratory disease, especially pneumonia, in older patients increases in debilitated states.
- Loose teeth can be aspirated and are of great concern. This may even be difficult for families to recognize within the homebound patient.
- Xerostomia affects both speaking and eating. Older patients may be taking numerous medications promoting xerostomia and also promoting dental caries and ultimately tooth destruction.
- Oral cancer is known to increase with age, as immune function is not as efficient in older adults.
- Poorly fitting dentures not only affect eating but cause friction, ulceration, and chronic inflammation. The patient may not even wear the dentures when homebound and this may affect eating.
- Malnutrition is sometimes due to the inability to eat properly because of the conditions occurring in the mouth.
- Altered communication is accentuated with poor dental health. This may lead to depression and adds to difficulties for the caregivers. Diminished quality of life, including poor self-image, poor self-esteem, and depression are common problems.
- Expensive emergency dental care and restorative care places a burden on the family and the patient. Early intervention is cost effective and promotes total health by taking into account the major implications of dental health.

The National Palliative Care Research Center states, "Palliative care focuses on relieving suffering and achieving the best possible *quality of life* for patients and their caregivers. The development of the specialty of palliative medicine has been a critical step in addressing the unmet needs of patients/families with serious illnesses. The growth of this field has been remarkable. From 2001-2003, the number of hospital-based palliative-care programs has grown by over 60% such that now one in four U.S. hospitals has a palliative-care program and all U.S. medical schools must provide training in palliative medicine."

The positive aspects of providing palliative care is that patients may be able to remain in their homes if homebound, it is less costly, and it also is less expensive for taxpayers in the long run. With the influx and need for care of baby boomers, the value of palliative care is substantial. It has been reported that patients in a debilitated state may go without dental care for three or four years.

If dental care is made a part of standard palliative care, the patient is treated early and may avoid extensive dental work

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## ■ Oral Exam

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later. Dental infections, restorations, crowns, and tissue destruction may be avoided or limited. Often, families need to address the life-threatening ramifications of an illness, but poor dental health may be a contributing part of the problem for the patient as well. A team of health-care providers may overlook the dental implications and their effect on the total recovery of the patient. There is also the fact that some health-care providers may believe that the person will die anyway, and this procedure of dental care is just a wasted effort.

Dr. David Blende is a dentist who makes house calls and is able to complete dental work for homebound patients. If the patient cannot come to the office for a consult, the group works with surrounding dentists, periodontists, or other specialty groups to assess the patient and send the needed materials to the group for a treatment plan. Carla Caramat, a managing partner of the organization, stated during a recent interview that people are often amazed at the equipment that is available to the family of a homebound patient. Everything that is needed for treatment can usually be found in the portable equipment that is brought in by the trained professionals.

Dental professionals are usually familiar with the dental van units, but not as familiar with treating patients who are bedbound in their own home surroundings. The organization originated in the San Francisco area but has now begun in the New York City area as well. The dentists associated with the group also have hospital privileges for patients who may need more extensive care. Ms. Caramat anticipates that this concept will continue to expand with the aging baby boom population in the next few decades.

As always, keep asking good questions and always listen to your patients! RDH

### REFERENCES

1. Sadick B. Palliative Care. Wall Street Journal, September 15, 2014, pg R2. <http://online.wsj.com/articles/straight-talk-about-palliative-care-what-everyone-should-know-1410724839?KEYWORDS=Health+Care%3A+Palliative+Care>.
2. [getpalliativecare.org](http://getpalliativecare.org).

### ADDITIONAL RESOURCES ON PALLIATIVE CARE

1. The Blende Dental Group, [blendedentalgroup.com](http://blendedentalgroup.com)
2. The Center to Advance Palliative Care, [capc.org](http://capc.org)
3. National Palliative Care Research Center, [npcrc.org](http://npcrc.org)
4. Find a provider for palliative care, [getpalliativecare.org](http://getpalliativecare.org)
5. Smith L. Blissful Dreams for Phobics, [rdhmag.com/articles/print/volume-28/issue-6/feature/blissful-dreams-for-phobics.html](http://rdhmag.com/articles/print/volume-28/issue-6/feature/blissful-dreams-for-phobics.html)
6. Administration on Aging, [aoa.acl.gov/Aging\\_Statistics/index.aspx](http://aoa.acl.gov/Aging_Statistics/index.aspx)

## POWER UP, KIDS

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toothbrush for children.

As children become proficient with power brushes, they also tend to prefer using them. I've had teen orthodontic patients ask their parents either to purchase an additional power brush so they can take it with them to school, or for permission to take the one from home to school daily. With access to multiple brush head sizes and power modes for children, we are able to bridge the gap from childhood oral hygiene to teen and adult by recommending power toothbrushes.

As patients reach their teens, periodontal disease becomes an issue for many of them. According to the American Academy of Pediatric Dentistry's Facts and Figures 2014: *"Gum disease (also called periodontal disease or gingivitis) is not just a dental health risk, but also poses a risk to a teen's appearance. It affects six out of ten teenagers, causing red or swollen gums, bleeding gums or bad breath. The best prevention is brushing, flossing, and regular dental visits."*

Education is key for all of our patients regardless of age. That "look good, feel good" behavior is not for adults only!

Power toothbrushes with built-in timers help motivate children to brush for a full two minutes. The AAPD states: "There is even a children's power toothbrush that is programmed to gradually increase kids' brushing time. It lets beginners brush for one minute. Then, gradually, over a period of about three months, it builds up to the recommended two minutes." A timer that signals with a beep (or even better, music!) every 30 seconds when it's time to move to the next part of the mouth encourages lifelong brushing habits. This added benefit is essential to reach the dental professional's recommended two-minute brushing duration.

Events such as National Brush Day, which comes after Halloween every year, are becoming well known and can be your first "prep step" in a conversation about home care as well as nutrition. Thanks to you, as our patients age and become our adult patient population, they will already have incorporated power toothbrushes into their daily oral health regimen and realized the benefit of the investment. A dental master plan beginning with children will create a patient base of better educated, healthier adult clients while making your clinical experiences happier, healthier, and more rewarding! RDH

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