

RIBBON RIBBON RIBBON RIBBON

by Patti DiGangi, RDH, BS

Craze

THE ROLE OF THE DENTAL PROFESSIONAL

Humble beginnings often wind their way down unexpected paths toward unthinkable destinations. Ribbons we wear, ribbons on our cars, and wristbands have become not only methods to bring awareness of various cancers and causes; they have become a fad of nearly epic proportions. Discovering the history of the ribbon craze is tricky, with different groups and individuals taking credit. Some give credit to the black armbands worn in Victorian times or the yellow ribbons from the Tony Orlando song. But whatever the origination, these symbols can bring attention, understanding, and most importantly, funding to organizations and individuals struggling with disease.

For several years, oral cancer awareness and screening has had a part in each program I give, for some very specific and personal reasons. Using my skills and intuition as a dental hygienist, I saw a suspicious area on a client. The client denied it, saying she wasn't a smoker. The lesion was on the palate. The client said it was from eating taco chips. There was something about it that just didn't resonate for me. I had to talk her into allowing a brush biopsy. The biopsy came back showing atypical cells; the scalpel biopsy showed early squamous cell carcinoma. The client was my sister. The good news was that we found it so early that the very early scalpel biopsy has thus far, after six years, seemed to have removed everything and there has been no recurrence. CDx Labs

(www.oralcdx.com) has been using my case study for several years as the first case they published about an RDH. My sister had none of the usual risk factors; the location of the lesion was not one of the most common sites and could easily have been missed if I hadn't been specifically looking.

This was followed by another experience with a 29-year-old school teacher, again with seemingly no risk factors. She complained of some TMJ discomfort, often had swollen glands, and noninflammatory enlarged tonsils. After evaluation and careful documentation, she was referred to her physician. Her physician did not pick up on her situation right away and gave the usual rounds of antibiotics. Finally the symptoms were pursued, and based on my suspicions and referral, she was diagnosed with lymphoma earlier than she might otherwise have been.

My stories are not really different from those of many other hygienists. Many of us have saved people's lives through our efforts. But we aren't doing it well enough yet.

Dr. Michael C. Alfano, DMD, PhD, dean of New York University College of Dentistry, states, "Right now the majority of oral cancer is still diagnosed by physicians. That's because it is diagnosed late, when people are symptomatic."

In my presentations, I have often said it's too bad there is not more public awareness of oral cancer like a ribbon or walk. Recently, it came to my attention that head and neck cancer



**SPOHNC ORAL AND
HEAD AND NECK
CANCER AWARENESS
RIBBON
(WWW.SPOHNC.ORG)**

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does have a ribbon. SPOHNC, which stands for Support People with Oral Head and Neck Cancer, is a patient-directed, self-help organization dedicated to meeting the needs of oral and head and neck cancer patients. SPOHNC, founded in 1991 by an oral cancer survivor, addresses the broad emotional, physical, and humanistic needs of this population. During the last several years, SPOHNC has received numerous inquiries about a ribbon to help raise awareness of oral and head and neck cancer. On June 3, 2001, at the 10th Anniversary Celebration of the Founding of SPOHNC, an awareness ribbon was introduced to the public for the first time. This ribbon consists of three stripes, one burgundy and two ivory, symbolizing oral and head and neck cancer. The ribbon will be sent to you at no charge by calling SPOHNC at (800) 377-0928. SPOHNC

cancer available for many years. Now, with a pin we can get the message out even more, but will we really change our behavior? Dental health professionals KNOW about oral cancer, yet our statistics on early detection are abysmal. According to many sources, oral cancer is the sixth deadliest cancer in the world with close to 390,000 new cases accounting for 4 percent of all cancers diagnosed annually. Approximately 8,000 Americans die each year — an average of one per hour — compared to cervical cancer with 3,710 deaths per year. Sixty-six percent of the oral cancer cases are not diagnosed until they are in the late stages, and approximately 50 percent of the victims will die within five years. This death rate is higher than Hodgkin's disease and cervical, skin, ovarian, and brain cancers. The real issue is that oral cancer is 80 to 90 percent survivable if caught early. The bad news for dental professionals is that mortality rates have been basically unchanged for 50 years.

Why aren't dental health professionals doing more to bring this information forward? Whose arena is oral cancer? How much pathology can you identify? How much have you seen but possibly didn't notice? Do you ever find yourself performing tasks by rote such that you don't pay attention? That last question is the heart of the issue when it comes to oral cancer screening.

The learning cycle

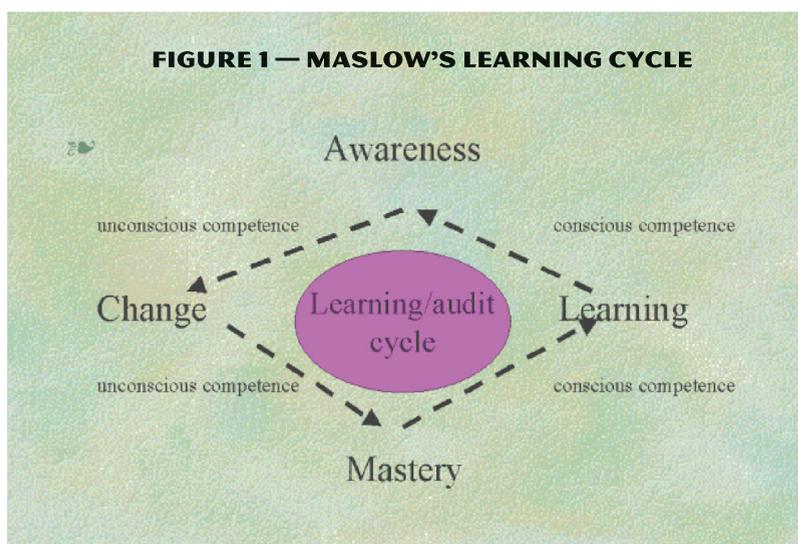
Dental hygiene, like most other work, includes repetition. Repetition is one of the ways new skills are acquired — practice, practice, practice is the mantra for learning. Though this is very true, it can lead to performing repetitive

tasks nearly unconsciously.

Abraham Maslow describes the four stages of skill development: unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence (Figure 1). These stages can be illustrated by following the efforts of a person who is learning to surf.

The first day, after much effort, the new surfer may be half-standing, half-stooping on the board fighting each swell of the water. The surfer is "dumb and happy" and perhaps a little sunburned. He is ignorant of the deeper skill level required to become a master surfer. He has found the *unconscious incompetence* stage of skill development. If he sticks with the task, he will quickly move to the *consciously incompetent* stage. At this stage, he is now aware of the skills he lacks, but resolved to learn more. He knows what he doesn't know. He will eventually move, with practice, to the *consciously competent* stage of skill development. At the third stage of the cycle, the surfer can skillfully catch a wave, knows a lot about the equipment, and has a good time each day on the beach. But he returns home exhausted by his efforts. He then crosses an invisible frontier in which

FIGURE 1 — MASLOW'S LEARNING CYCLE



also offers an enameled pin that can only be purchased online through their Web site at www.spoync.org or by calling (800) 377-0928. It is SPOHNC's hope that by wearing and displaying this ribbon in various forms, we can all do our part in supporting cancer survivors and raising public awareness of this disease.

Awareness alone doesn't change behavior

"Dental lifesavers: An oxymoron? Perhaps not. We know that dentists and hygienists are not thought of by the public, and do not think of themselves, as people who engage in the saving of lives. After all, they are not ER doctors. But when either of these dental professionals finds an oral cancer in the course of their examinations, especially at an early stage one or two, they have undoubtedly saved a life."

This is a quote from Brian Hill, oral cancer survivor and founder and executive director of The Oral Cancer Foundations, Inc. (OCF). The question is: Do you really believe it?

There is and has been a world of information on oral

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surfing gets easier. He takes on a bigger wave at exactly the right moment on a beach he knows as well as the curves of his face. He comes off the wave energized and exhilarated, not exhausted. He has found the fourth level of competency — *unconscious competency*.

Just as with our surfer, dental hygienists believe they have attained this level of unconscious competency a few years into their clinical practice. Some new graduates like to think they have attained this level of competency by the end of their initial educational process. During our educational years, each step of the dental hygiene process of care is evaluated. Our educational process teaches us to perform to the level that is *inspected*, rather than to a level that should be *expected*. This behavior pattern carries over to clinical practice. Often dentists do not inspect the dental hygiene process of care, because they expect that it has been completed. This is assuming the dentist truly understands each of the aspects of the dental hygiene process, which is a highly questionable assumption.

Beyond that, in the transition from our educational years to the real world of clinical practice, the alligator of time starts nipping. To fulfill what are generally artificial time parameters in clinical practice, steps in the dental hygiene process of care are skipped, dropped, or quickly glossed over. Hygiene professionals believe they are practicing at a level of unconscious competency when, in reality, they have slipped back into unconscious incompetence. Just like the surfer, the hygienist is “dumb and happy,” or maybe not so happy but the bills are being paid.

What steps are skipped, glossed over, and performed by rote? Review of medications and implications, vital signs/blood pressure screening, occlusal evaluation, periodontal charting, complete documentation, and the subject of this article — oral cancer screening ... to name a few.

It seems like “dumb and happy” or maybe “not so happy but the bills are being paid” is a choice you may have been able to get away with in the past. But as Bob Dylan said back in the 1960s, “The times they are a-changin’.” Our clients expect and believe they pay for mastery.

Our clients want more

The world is speeding up. Expectations are rising. Our clients expect service and responses right now. We expect and demand that our problems be solved right now. We are impatient and demand more than we previously expected. We can make airline reservations online, shop for cars online, make appointments online, and find lots of information online. The aging population is now more health conscious than ever before. Americans want to stay young and healthy regardless of their age. Take a look at the amount of plastic surgery going on, the personal trainer phenomenon, and more. While much has been made of the fattening of America, there is a group on the other end of the scale that is more health conscious than ever.

Speaker and coach, Dr. Greg Tarantola (www.tarantoladentallearning.com)

said our clients expect and even demand genuine, individual attention. They are Internet savvy and are used to having information available at their fingertips. They expect a broad choice of therapeutic options. They think for themselves and are less likely to take the word of authority figures than previous generations. They further expect to be active participants, at every level, in their own health care because of a strong self-image. They view themselves as healthy and active.

How will this affect oral cancer screening? Clients will help drive the profession to do what we are trained to do. They will demand this service more and more just as the public has been the driving force in nutritional supplements. If the professionals don't do it, consumers will find a way to do it for themselves.

There are still other driving forces that influence dentistry, including our standards of care and the insurance industry.

Standard of care and dental benefit codes

Oral cancer screening should be a routine part of every evaluation procedure; our standard of care requires it. But just what does the term *standard of care* really mean? The Dentist Insurance Company (TDIC) describes it this way:

“The standard of care is a relative standard, not a strict legal prescription. It is based on the actions of the reasonable person of ordinary prudence. Since the conduct of a reasonable person varies with the situation he or she is confronted with, negligence is, therefore, defined as the failure to do what this reasonable person would do under the same or similar circumstances. In other words, the standard represents the *minimum level of conduct* (author emphasis) below which members of society must not fall. Persons with a higher level of knowledge, skill, and intelligence — such as dental health professionals — are held to a correspondingly higher standard. The conduct of the dental health professional will be judged by the conduct of other dental health professionals practicing under the same or similar circumstances.”

Standard of care is NOT a maximum standard, but a minimum level of conduct below which we should not fall.

So what creates a standard? Standard of care is created by research, rules, laws, professional organizations through guidelines, position papers, parameters of care, statements, policies, and codes, including the Common Dental Terminology (CDT) codes. The CDT coding process is created by the American Dental Association. In 1986, the ADA Council on Dental Benefits elected to develop an educational manual. As stated by the ADA, the goals of the CDT manual are to serve as an educational resource, communicate accurate information, and act as a *standard* to document procedures. Therefore, it follows that the ADA states that CDT is part of the standard of

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care or the minimum level of conduct.

Whether a practice or a practitioner chooses to be involved with insurance benefits is a philosophical choice. Practicing below the standard of care is not. Examination and evaluation are routinely performed daily in clinical practice. The CDT codes for evaluations commonly used in clinical practice include D0150 Comprehensive Oral Evaluation and D0180 Comprehensive Periodontal Oral Evaluation. In the CDT descriptor of these codes, it states:

“This would include the evaluation and recording of patient’s dental and medical history and a general health assessment. It may typically include the evaluation and recordings of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), *hard- and soft-tissue anomalies, oral cancer screening, etc.*” (emphasis by author)

It therefore follows that because the CDT code includes oral cancer screening in the descriptor and the code helps create our standard of care, to NOT perform an oral cancer screening is falling below the standard of care. Further, to submit for these codes without performing oral cancer screening could be considered insurance fraud because it would be submitting for care not performed.

The most commonly used evaluation code D0120 Periodic Oral Evaluation includes this wording:

“An evaluation performed on a patient of record to determine any *changes* (emphasis by author) in the patient’s dental and medical health status since a previous comprehensive or periodic evaluation.”

Does that mean oral cancer screening should be included? Absolutely! The code and the standard it sets are an evaluation for changes. We can’t determine changes if we don’t look. Once again, filing a claim without performing the services could be considered fraud.

Behavior still hasn’t changed, but it can!

A published study in the *Journal of the American Dental Association* (Horowitz AM, Alfano MC. Performing a death-defying act. JADA Nov. 2001; Vol. 132:5S-6S) states that only 13 percent of those who visit a dentist regularly report having had an oral cancer screening. Brian Hill (www.oralcancerfoundation.org), a survivor of a late-stage oral cancer that was not found by three members of his dental team, says, “This is unfortunate when you consider that historically, the greatest strides in combating most cancers have come from increased awareness and aggressive campaigns directed at early

detection. It is now commonplace to annually get a Pap smear for cervical cancer, a mammogram to check for breast cancer, or PSA and digital rectal exams for prostate cancer. These screening efforts have been possible as a result of the increased public awareness of the value of catching cancers in their earliest forms, combined with effective technologies for conducting the examinations. Oral cancer is no different. Actually, it is potentially easier to obtain public compliance for oral cancer screenings, since unlike many other cancer screening procedures, there is no invasive technique necessary to look for it, no discomfort or pain involved, and it is very inexpensive to have your mouth examined for the early signs of disease. Education of the public regarding the risk factors that lead to oral cancer and the development of public awareness are primary responsibilities of the dental community.”

In focus groups, OCF found that dental office staff members from the business area to the assistants to the dentists were reluctant to begin a dialog with clients regarding oral cancer. They just wouldn’t do it. OCC offers buttons — “We look for it” for the business staff and “I look for it” designed for the hygiene staff and the doctor.



**ORAL CANCER FOUNDATION DIALOG
BUTTONS
(WWW.ORALCANCERFOUNDATION.ORG)**

These buttons can be an excellent way to begin the dialog with your clients about having a screening while they are in the office. The idea behind the OCF buttons is the clients see the statement which leaves them with a question in their minds. Clients then initiate the dialog prompted by the saying on the button. This presents an opportunity for the dental staff member to answer the question with a statement such as, “We look for oral cancer. While you are here today, we are going to see that you get a through screening during

your appointment.”

If you don’t feel you know enough, take a CE course such as was offered at *RDH Magazine’s* UOR meeting. Dental industry further supports our learning through the Oral CDx free online four-hour course at www.oralcdx.com. Zila Pharmaceuticals offers training at www.vizilite.com.

With companies bringing new diagnostic devices to the marketplace, organizations like OCF pushing for public literacy and awareness, and oral cancer now being called out by name in the Surgeon General’s recommendations, let alone in world-wide declarations from the World Health Organization, dentistry has a unique opportunity. Brian Hill sums it up when he states, “We must catch this wave of momentum and turn it into a positive force, reversing decades of past neglect.”

Each of us has an opportunity on a daily basis.

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Individuals can make a difference. Just ask yourself, what difference can I make today? How can I change the status quo? How can I change those statistics? On the back of the OCF business card I noticed a quote that reflects not only the organization's position about effecting change, but my own: "You must be the change you wish to see in the world" — Gandhi.

Note: This article is dedicated to my mom, Arlene Clinger, who recently lost her battle with kidney cancer. She was my life example of how to make a difference not just through our words but through our actions.

Patti DiGangi, RDH, BS, is a speaker, author, and practicing dental hygiene clinician offering CE courses to national audiences through her company, Professional Direction Conferences. Courses cover eagle-eye dental hygiene assessments, minimal intervention, high-tech diagnostics, and her favorite bobby horse — early oral cancer detection. She can be reached to schedule courses at pdigangi@comcast.net or (630) 292-1473.