Letter of Opposition to AAOP Application for Specialty Recognition

Submitted by Clayton A. Chan, D.D.S. — Las Vegas, Nevada

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Ms. Catherine Baumann, Director
National Commission on Recognition
Of Dental Specialties and Certifying Boards
211 East Chicago Avenue, 6th floor
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RE: RESPONSE TO THE ADA COMMISSION TO DENY ADA RECOGNITION OF AMERICAN ACADEMY OF OROFACIAL PAIN (AAOP) SPONSORED OROFACIAL PAIN SPECIALTY

To all members of the National Commission on Recognition of Dental Specialties and Certifying Boards:

Your careful review of the content of this letter is my request to consider the history, precedent and political motivation of AAOP organization's control over dentists' freedom to practice dentistry.

I am a concerned general dentist in Las Vegas, NV who has been practicing general dentistry for 31 years. I am a treating clinician, educator, mentor to many and have a dental practice that focuses on caring for and treating patients who suffer from a constellation of problems that includes masticatory dysfunctions, temporomandibular joint dysfunction (TMD) and pain. My patients fly from different parts of the United State, North America, and countries outside of the U.S. seeking my care and treatment for their unresolved dental problems.

My freedom to practice dentistry as a licensed dentist is on the line due to the AAOP's (American Academy of Orofacial Pain) unrelenting attempt to once again control and set their bio-psychosocial philosophy standards (agenda) over a majority of dentists who practice and abide by bio-physiologic philosophy standards using ADA and FDA recognized objective measuring instrumentation used as diagnostic and treatment aids in treating and meeting my TMD patients. My ability to diagnose, use my expertise, knowledge, good sound judgement and skills to treat my TMD patients is in jeopardy!

The failure of the AAOP to fulfill the six requirements for ADA specialty recognition MUST result in a rejection of their application.

There has been an organized campaign waged by a very small group of academics who continually persist to sway the dental profession and mislead them in trying to re-establish a new "Standard of Care" via the psychosocial model which has been unproven both scientifically and clinically. This group tries to hold a higher standard of scientific scrutiny to those who value the use of bio-instrumentation as adjunctive to the conservative, reversible and comprehensive diagnostic and treatment approach

implementing the bio-physiologic/neuromuscular/occlusal model of care. This wrong!

AAOP would like us to believe that "they are for good science and for good patient care". They are not qualified (scientifically or clinically) to set the standard of care for TMD diagnosis and treatment. Occlusion is the foundation of dentistry. To deny the role of occlusion, as the initiating and or perpetuating factor in the etiology of TMD, clearly disqualifies them from gaining specialty status.

This small group of dentists positioned in dental schools and in the AAOP have an agenda to control and discredit a bio-physiologic approach to treatment and the use of electronic instrumentation as aids in the diagnosis and treatment of TMD. This group have historically used their influence with the ADA, FDA, insurance industry and NIH in an attempt to also put the manufactures of neuromuscular instrumentation out of business, and deny dentists freedom to practice for the benefit of their patients. Their influence actually disparages dentists who used measuring instrumentation in their practices and in some cases to compromise individual dentist's licenses.

For three decades the ADA has denied "specialty" recognition applied for by the AAOP in their attempt to control and set standards that are not accepted by a majority of dentists and organization who also diagnose and treat Temporomandibular disorder (TMD). It is well recognized that TMD is a complex multi-causal, multifaceted group of illnesses, which affects cranial, mandibular, cervical, masticatory muscle function and the oral cavity/dentition. There is no mutually exclusive nor universally accepted single diagnostic protocol nor agreed upon single treatment modality that can successfully treat all forms of cranio-facial/orofacial/cranio-mandibular/neuro-muscular/TMD disorders and dysfunctions.

To date, there is no clear method that has been agreed upon regarding what is TMD and its associated craniomandibular and neuro-vaso-cervical muscular and occlusal issues. Research has been promised for years, yet our patients who are suffering can't wait any longer! Their lives are at stake and they seek answers and treatment that works for them. Many of the dentists who are familiar with these conditions have discovered effective, objective means to treat the TMD patient, but researchers have not shown a willingness to work with the clinicians who actually contending with these problems daily and find effective success.

No single dental organization should be given the credential and authority with which to establish their de facto: "Standard of Care" as per their philosophy alone which has not been scientifically or clinically proven successful in regards to education, diagnosis and treatment of TMD/orofacial pain. The dental profession recognize that orofacial pain is not a clearly defined condition, which largely falls within the of existing medical specialties.

The ADA should not recognize the AAOP application for "specialty" status or give a sponsoring organization power to dictate their Standard of Care for the treatment of TMD and Orofacial pain over others who are having success. The ADA should deny the application based on the failure to fulfill the ADA's established six requirements.

Requirement #1: NOT FULFILLED

The AAOP represents a minority, unreflective of the special area of dental practice and does not represent "the community of interest" of the majority of ADA members in the field. AAOP's denial of the role of occlusion in TMD is in opposition to the mainstream position.

The AAOP with its approximately four hundred members does not represent the thousands of dentists that constitute the community of interest in this field and AAOP should not be arbiter or be given the authority to establish a Standard of Care for the diagnosis and treatment of Orofacial Pain and TMD to

the majority of who don't endorse their philosophy and agenda.

Requirement #2 and 3: NOT FULFILLED

The proposed specialty does not delineate a "distinct and well-defined field" and is not "separate and distinct from any recognized specialty or combination of recognized specialties…or be accommodated by modification of recognized specialties". The stated purview of this ill-defined specialty includes current jurisdictions of dentistry and medicine. We concur with the ADA Council on Dental Education & Licensure's prior opinions that AAOP describes a medical, not a dental specialty.

The "Standard of Care" of treating orofacial pain proposed by the AAOP organization are already and currently included in the medical providers specialties and general practitioners in both medicine and dentistry. If dentists who believe in the structural/functional basis of TMD are recognized as the providers of choice, their diagnosis and treatment should be initiated by general practicing dentists who are taught to recognize and initially treat in undergraduate dental school curriculum. This would disqualify any need for the ADA to designate specialty status to those who have an anti-instrumentation agenda.

Requirement #4: NOT FULFILLED

A substantial public need and demand for services which are not adequately met by general practitioners or dental specialists has NOT been documented. No single specialty in medicine or dentistry can be responsible for treating all of the applicant's stated diseases and disorders. Medical and dental professionals along with all the various allied health care professional collectively possess the required skills, knowledge and expertise are presently adequately serving the public.

Requirement #5: NOT FULFILLED

The specialty would not directly benefit some aspect of clinical patient care. The existence of a recognized specialty would result in a reduction not expansion of available clinical care by diminishing the credentials of practicing dentists. The ability of the majority of dentists treating these conditions to appropriately diagnose and treat would be severely challenged or curtailed if the ADA recognized the Orofacial Pain as a "specialty".

Requirement #6: NOT FULFILLED

The ADA requires that formal education programs of at least two years beyond the pre-doctoral dental curriculum must exist to provide the special knowledge and skills required for the practice of the specialty. Absent a universally acceptable delineation of the specialty, the need for two year post graduate university programs to provide "the knowledge and skills for the practice of the specialty" cannot be demonstrated. Undergraduate dental students can adequately train general dentists to provide initial treatments of patients with TMD.

When indicated, a general dentist can refer patients initially to other general practitioner dentists who treat TMD and/or to those in existing recognized dental specialties including Orthodontics, OMFS and Prosthodontists for initial or if necessary for long term treatment. It is therefore, not necessary to create new dental specialty. Orofacial pain with its bio-psychosocial perspective crosses medical specialties, Pain Management, Neurology, Oncology, Psychiatry, Psychology, Rehabilitation Medicine, Otolaryngology to name a few. One of the ADA requirements for specialty recognition is that the proposed specialty cannot include practices already covered by medical specialist or dental specialists.

An ADA recognized "specialty" status would give stature to those AAOP dentists promoting their bio-psychosocial agenda as "specialists" denigrating the majority of practicing dentists who have

proven to be qualified, educated, skilled and successful in diagnosing and treat patients with TMD. This decision would have adverse effects to me, many of my colleagues who treat TMD and our patient relationships.

Litigation and insurance claim processing would potentially cause a crisis in legal battles and fees. If this "specialty" status would be granted to them this would significantly create a crisis all over North America limiting patient care to a select few "specialists" who are historically averse to include the bio-physiologic approach that already treats complex TMD issue successfully. Accepting the AAOP's "standards of care" would be detrimental to public trust in their dentists as well as limit patient treatment options of care. Rather than resolving the physical/functional components of TMD, the AAOP "specialists"' TMD patients would be left with only an ameliorative, psycho-social approach, dependency on addictive medications and stress/anxiety counseling type care for chronic pain conditions. This is not acceptable!

The ADA is primarily composed of caring and very experienced general dental practitioners who have different views and perspectives as to how best to treat TMD problems. The AAOP group have a known agenda to control the TMD arena of care and impose their standards that have not been proven scientifically nor clinically within the medical and dental community. AAOP's standards have not universally been accepted by the majority of dentists who recognize bio-physiologic methodologies are effective, clinically relevant and scientific.

The ADA should be protecting the Freedom of Practice of its members who strive to provide optimal treatment for patient's health. We dentists educate ourselves, read and develop literature, teach, educate others in formal continuing education settings, do our own research and seek cutting edge information of current practices world-wide to meet the demands and needs of our patients. This is the very definition of Evidenced Based Dentistry according to ADA. The ADA should protect dentists like me who need the "Freedom of Practice" to provide the care my patients need without political interference.

There is sufficient supportive evidence showing efficacy for the use of low frequency transcutaneous neural stimulation (TENS), electromyography (sEMG), jaw tracking (Kineseograph/CMS) and Electro sonography (ESG) in the Diagnosis and Treatment of TMD. The FDA approved indications for use for the J5 Dental TENS and the K7 Evaluation System have been recognized. The K7's ADA Seal of Recognition (from 1986 to 1994) and ADA Seal of Acceptance (from 1995 to 2007) has been recognized as an aid for the diagnosis of TMD.

AAOP has an underlying agenda to limit dentists like me the freedom to practice general dentistry who recognizes impairing occlusal relationship as they relate to those TMD patients who present with temporomandibular derangements, masticatory dysfunctions and pain. I use these mentioned technologies in my practice which the ADA and FDA have approved and recognized to have met the standards of reliability and validity satisfying the requirements of sensitivity and specificity. Scientific testing, objective measured analysis data of the functioning and resting modes of my TMD patients routinely reveal dysfunction and physical impairment based on evidence-based testing, supported by literature, research and well established known functional parameters established by the Academy of Orthopedic Surgeons (AOS). Denigrating the validity of these scientific technologies and invalidity the usefulness of the bio-physiologic functional approach and protocols by recognizing AAOP's application limits the freedom to advance our dental profession toward scientific evidence-based inquiry and analysis.

If the bio-psychosocial agenda of the AAOP is recognized by the ADA as the Orofacial Pain "specialty" "Standard of Care", they will prevent and limit many clinicians from diagnosing and treating patients from a bio-physiologic structural functional basis (setting our profession backward by not encouraging the use of scientific instrumentation and objective measuring protocols) based on decades of success in helping TMD sufferers from orofacial occlusal related TMD problems. The former AAOP philosophy disregards changing dental occlusion and mal relationships as a form of effective treatment (based on conflicting opinions that TMD is both innocuous and unaffected by preventative therapy), while the latter believe in altering dysfunctional jaw relationships and mal-occlusal schemes (based on scientific objectively measured functional parameters) conservatively and reversibly when needed to effectively regain dental stability and functional postural health for our patients. Prior to altering any dental occlusion if and when needed to help reverse life-long masticatory debilitations and physical impairment, masticatory dysfunctions and eliminating central nervous system stresses and anxiety disorders, it seems clinically, logically and objectively reasonable that a bio-physiologic and scientific measured approach not be ruled out in today's advancing computerized digital age of healthcare.

I ask for your understanding and wisdom in your decision making regarding the ADA denial of the AAOP's application based on the failure to fulfill the ADA's established six requirements and not allow this organization to dictate their psychosocial agenda and standard of care on other dentists' freedom of practice.

Sincerely,

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Original document submitted October 1, 2019 by email to baumannca@ada.org. Letter as written from then-practice address (9061 West Post Rd., Las Vegas, NV 89148). Dr. Chan's current practice and Occlusion Connections educational center is located at 6170 W. Desert Inn Road, Las Vegas, NV 89146. Original .doc file metadata: created October 2, 2019 12:03 AM, last saved 2:36 AM, total editing time 1 hour 35 minutes, ten revisions. Reproduced verbatim for archival preservation.