

# Dental Office Practices for Tobacco Users: Independent Practice and HMO Clinics

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**Abstract:** Surveys of independent dental practitioners and health maintenance organization (HMO) dentists and their adult male patients in Oregon found that cessation information and advice was being given to tobacco-using patients, especially smokeless tobacco users, and that the tobacco users surveyed expressed interest in obtaining help to quit. Oral health providers expressed an interest in further training in how to help their tobacco-using patients to quit. (*Am J Public Health* 1990; 80:1503-1505)

## Introduction

In 1985 it was estimated that over 12 million Americans ages 12 and older had used chewing tobacco or snuff (smokeless tobacco) in the past year<sup>1</sup>; among males who use smokeless, 43 percent used it almost daily.<sup>2</sup> Studies have shown correlations between smokeless tobacco use and gingivitis, gingival recession, leukoplakia, and oral cancers.<sup>3</sup>

In 1978, the House of Delegates of the American Dental Association (ADA) resolved that ADA members be encouraged "to undertake an educational effort to inform their patients of the systemic and oral health hazards of chewing tobacco and snuff." A 1964 ADA resolution had encouraged its members to advise their patients about the hazards of cigarette smoking.

Recent articles have reviewed dentists' involvement in smoking cessation counseling.<sup>4,5</sup> However, we are not aware of similar information about dentists' involvement with smokeless tobacco prevention. In this paper we report the results of two surveys of dentists, dental hygienists, and their adult male patients.

## Methods

### Independent Practice (IP) Survey

An explanatory letter was mailed to all practicing members of the Lane County Oregon Dental Society. Of the 114 dentists, 24 (21 percent) refused to participate and two were used as pilot offices. The study was conducted over a two-week period in 1988 during which time questionnaires were to be given to all male patients over 18 years of age visiting the dental office. Questionnaires were also completed by dentists and hygienists. The final questionnaire return rate for dentists was 83 percent (73/88). Data were also received from 65 hygienists and 806 adult male patients. Neither the

base population of hygienists nor the population of eligible male patients was known.

### HMO Survey

This study was conducted in the Kaiser Permanente Dental Care Program based in Portland, Oregon, which provided comprehensive dental care to 85,000 enrolled members. Seventy full-time dentists and 65 full-time dental hygienists were employed in seven fully staffed dental offices. The questionnaire return rate was 61 percent for dentists and 68 percent for hygienists.

Overall, 1,506 of age-eligible male patients (56 percent of the male patient population) completed the questionnaire. Observers making spot checks in the clinics noted that receptionists often failed to give the questionnaire to patients, but of those who did receive questionnaires more than 90 percent returned them to the reception desk as requested.

## Results

Table 1 presents tobacco use and attitudes toward provider advice from each sample.

Table 2 summarizes the reported interactions with smokeless tobacco users and smokers for dentists in both settings. Most offer some kind of information and cessation advice. All types of information and advice were given more often with smokeless tobacco-using patients than with smoking patients. However, only a minority of providers have cessation materials available in their offices. Dentists tend to be more optimistic and comfortable when advising about smokeless use than about cigarette smoking. The majority of dental professionals in both surveys were interested in learning about a smokeless tobacco cessation program. The data from hygienists generally paralleled those of dentists.

The majority of dentists report being pessimistic about the effectiveness of their advice or the likelihood of a patient attempting a cessation clinic program (Table 3). The majority of hygienists reported the need for further training and patient resistance to referral as the most important obstacles.

## Discussion

The results show that dentists and hygienists in both settings are concerned about patient tobacco use and inter-

TABLE 1—Male Patient Tobacco Use and Attitude toward Provider Advice

	Independent Practice (IP) N = 80%	HMO Clinics N = 1506
% Using smokeless	6	3.9
% Smoking	18	26.9
% Smoking and smokeless	1.4	0.7
Smokeless users interested in receiving cessation assistance	41	39
Smokeless users who would consider advice	27	33
Smokeless users reporting cessation advice	44	not asked

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**TABLE 2—Independent Practice and HMO Dentists Reported Interactions with Smokeless Tobacco Users and Smokers**

	IP Dentists (N = 73)		HMO Dentists (N = 43)	
	ST Users	Smokers	ST Users	Smokers
Advice and information usually given				
Discuss health hazards (%)	88	55	77	47
Discuss benefits of quitting (%)	62	51	42	35
Advised cut down use (%)	26	18	23	21
Advised quit cold turkey (%)	30	11	30	7
Prescribe nicotine gum (%)	8	5	2	5
No advice (%)	4	16	12	35
Perceived mean effectiveness of advice (7 pt scale)*	4	3	4	2
Feel comfortable in giving advice (7 pt scale)*	6	4	5	4
Have available information on quitting/health effects in office (%)	27	26	12	17

\*1 = low, 7 = high

**TABLE 3—Major Obstacles to Treating Tobacco Use\***

Obstacles	Independent Practice		HMO	
	Dentist	Hygienist	Dentist	Hygienist
	%	%	%	%
I am pessimistic about people's ability to change	64	46	70	36
Patients resist referral to cessation clinics	56	52	56	61
I believe or patients believe intervention is not appropriate since tobacco use is a matter of personal choice	49	42	49	36
I have too little time	38	31	42	34
I need further training	37	55	33	52
There is lack of coordination between dentistry and tobacco cessation services	30	31	42	39
I have little confidence in effectiveness of available services	26	11	26	16
There are too few services to which patients can be referred	16	22	7	11

\*Respondents asked to choose four of the eight statements listed.

ested in providing cessation information and/or advice. Unfortunately, dental professionals receive little training and have few materials available that would facilitate such actions. Dentists appear more comfortable giving advice to smokeless tobacco users than to smokers. The relevance of chew and snuff use to oral health is the most parsimonious explanation for this finding. The difference between smokeless tobacco use rates in the IP and HMO patient populations may be due to demographic differences, sampling differences, or personnel differences.

The patients surveyed reported receptiveness to cessation advice and, in fact, expect it from a dental professional. Direct feedback from a dentist or hygienist on oral health status, such as visually pointing to tobacco-associated oral lesions, gingival recession, or tooth staining, can produce a "teachable moment" wherein patients are receptive to cessation advice. This receptivity to advice from dentists and hygienists is supported by data from an in-depth interview study of smokeless tobacco users.<sup>6</sup>

Studies of physicians' advice to smoking patients have

demonstrated modest but significant efficacy.<sup>7-9</sup> Recent reports indicate that dentists' direct advice also can have a significant effect.<sup>11-14</sup> Similar effects seem likely for smokeless tobacco. The obstacles to implementation include the need for specific cessation training for dentists and hygienists and self-help cessation materials for patients. Specific materials are now becoming available that will assist oral health professionals in getting more directly involved in advising patients who seek their help in order to quit the use of tobacco products.<sup>14</sup>

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## Evidence for Gonococcal Transmission within a Correctional System

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**Abstract:** In a study to examine sexually transmissible disease occurring within a large correctional system where sexual activity is prohibited, 27 male inmates acquired culture-proven gonorrhea from in-jail sexual activity during a three-month period. These results provide evidence to encourage inmate education about the acquired immunodeficiency syndrome (AIDS) and to support condom distribution programs in correctional facilities. (*Am J Public Health* 1990; 80:1505-1506.)

### Introduction

Studies reveal that up to 20 percent of male inmates engage in homosexual activity at some time during their imprisonment.<sup>1</sup> Research protocols which explore homosexual activity in jails and prisons generally use a subjective, questionnaire-type approach, asking prisoners whether they have participated in homosexual activity before or during incarceration.<sup>1-7</sup> Objective evidence for sexual activity occurring during imprisonment has been presented only in a few case reports which describe outbreaks of syphilis or gonorrhea occurring in prisoners incarcerated for prolonged periods.<sup>8,9</sup>

Sexual activity places inmates at risk for acquiring sexually transmitted diseases—including gonorrhea and the acquired immunodeficiency syndrome (AIDS). The risk of infection with the human immunodeficiency virus (HIV) among New York City prisoners during homosexual activity with other inmates is even higher than that of the general population, since studies have shown these inmates to have higher rates of HIV infection at admission to prison than the general population.<sup>10</sup>

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Sexual activity is prohibited in many correctional systems, including that of New York City. Thus, the provision of condoms to inmates often is deemed unnecessary and objectionable by correction officials, since condom distribution would imply that rules prohibiting sexual activity are not enforced, or are unenforceable.<sup>11</sup> Yet from a public health perspective, condom distribution to inmates is important to enable inmates to protect themselves from sexually transmitted diseases, including AIDS. This study was designed to answer the following question: is there **objective** evidence that sexual activity occurs **regularly** in a large jail system?

### Methods

In 1986, the correctional facilities of the New York City Department of Correction had a capacity to house over 12,500 inmates, and admitted more than 73,000 prisoners. The average daily census was almost always 100 percent or more of capacity. Most of the prisoners were detainees, staying for only a short period of time while awaiting trial or bail. Each prisoner received an admission history and physical examination which included collecting information concerning a history of gonorrhea, dysuria, or urethral discharge and performing a urinalysis. Any newly admitted inmate who became suspect for gonorrheal infection after admission screening was examined, cultured, and treated for gonorrhea if clinically indicated.

For the months of October, November, and December 1986, the names, prisoner identification numbers, and dates of positive culture for all male New York City inmates with culture-proven gonorrhea were collected. From the files of the New York City Department of Correction, the date of admission to the jail was obtained for these prisoners. If an admission date preceded the date of positive culture by more than one week, the inmate's chart was reviewed and pertinent data were collected. These data included: date symptomatic, collection date and source (urethral, anal, and/or throat) of the specimen, and history of previous gonorrheal infections and treatment received, if any.