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Opinion

Person-Centered Care Minding the Gap While Exploring the Grand Canyon

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Introduction

Today was a day of serendipity. I received an email to submit an opinion piece to this esteemed journal. It was also the day I was asked to provide a "curbside" consult for a patient being provided care by a third-year dental student at a University dental school. This case seemed to highlight some of the gaps that still exist in healthcare systems and the challenges that must be addressed, if person-centered care is to become a reality.

Person-Centered Care

One definition of person-centered care is that it is "a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing, and monitoring care to make sure it meets their needs. This means putting people and their families at the center of decisions and seeing them as experts, working alongside professionals to get the best outcome [1]." This differs from patient-centered care, where the patient-centered care system focuses on the diseases the person is diagnosed with and their treatment, rather than on the broader health and well-being of the person.

Gaps in the System

The patient was seen today for a periodontal therapy appointment, where the patient had explained there was a six-month history of discomfort with eating spicy foods and bleeding with toothbrushing. Upon further questioning, the patient explained that during the past six months there had been three separate dental visits where dental restorative work had been completed. While the patient had made the dentists aware of their oral mucosal pain, the dentists had deferred diagnosis and treatment to the patient's physician. Of course, the physician referred the patient to their dentist for their oral soreness...

My colleagues in oral medicine have long had the following saying, "If your dentist tells you to see a doctor and your doctor tells you to see a dentist, you should see someone in oral medicine". Unfortunately, many patients spend far too long inside that gap, exploring the "Grand Canyon", bouncing between different providers, spending time, money and their patience, without much relief. This gap in care is often a source of a significant diagnostic delay (unpublished data from one Oral Medicine service puts the mean time between patient reports of symptom onset and a consultation for the same condition that is within the scope of an Oral Medicine dentist, at 31.5 months) and a significant burden. Given the length of time before receiving effective care, the number of visits to providers and the disability weights for orofacial pain [2], there is a significant and measurable amount of suffering, albeit for a relatively small number of people.

Gaps in Education

The patient's medical history was unremarkable, but for two factors. The first was that the patient had started seeing a dermatologist around 5 months ago, because of hair loss. The second factor was that the patient was subsequently prescribed Ozetla (apremilast) around three months before today's visit. According to the patient, this prescription was to help with hair

loss. Otherwise, the patient denied any other health diagnoses, and denied any history of other skin lesions, genitourinary, or gastrointestinal symptoms.

The arbitrary separation of medicine and dentistry produces profound logistical problems. The systems that perpetuate this bizarre situation where the mouth and jaws are separated from the rest of the body, should have ceased many years ago. I'm reminded of the era pre-biopsychosocial model, described by Engel in 1978, where biomedicine had led to the situation where psychological and social disorders were not thought to be within the realm of Medicine [3]. Within the U.S.A., the American Medical Association advocates for "care led by physicians", yet 10% of Medical Schools that participated in a 2009 survey reported no portion of the curriculum covered oral health, and nearly 70% of the other schools had less than 5 hours of oral health topics in their four year curriculum [4]. Granted, this data is from over 15 years ago and many physicians might receive some education about the oral health of their patients as part of residency and fellowship training. But a situation where oral health training is optional within medical training and yet care is led by physicians, is bound to lead to diagnostic and care challenges for patients with oral and craniofacial disorders.

Gaps in Communication

On head and neck examination, there was no lymphadenopathy, or signs of swelling or infection. The patient had no fever and their blood pressure and pulse were 127/83 and 73, respectively. The skin of the face and neck appeared normal, as did the vermillion border of the lips. Intra-orally, there was erythema and edema affecting the upper attached gingiva. White striae and erythema were visible bilaterally on the buccal mucosa. There was a 4mm circular ulceration in the left buccal vestibule, adjacent to tooth #18. The dorsum of the tongue had areas of ulceration, with multiple adjacent white plaques, with minimal erythema. The ventral and lateral aspects of the tongue appeared normal. A differential diagnosis included erosive lichen planus, with Beçhet's disease (based mostly on the Ozetla prescription) or lichen sclerosus (based upon the hair loss) also included.

What I really wanted was to review the notes of the dermatologist the patient had seen, to understand what blood tests had been ordered and better understand what diagnosis the Ozetla prescription was being used to treat. In an ideal world, I could have reviewed all this information with the patient, chairside. Instead, I was faced with trying to navigate a sub-optimal situation with separate and non-communicative electronic health records and provide some palliative care for the patient, while more information was gathered. Ironically, the Dermatologist worked for the same University as I do. At least communication between us should be somewhat easier. I should be grateful for the small graces.

The Solution

What would an ideal patient care system look like for this, or any patient with simultaneous oral and systemic problems? Having providers that could evaluate both hair loss and oral cavity symptoms would be ideal. In some parts of the world (e.g. Italy), Oral Medicine complaints are often managed by Dermatologists. But assuming that the logistical challenges of international travel are too much to solve for this individual patient, how could care be provided for this patient, in the current system within the USA? One possible solution would be that as soon as an oral cavity complaint is described, the patient should be provided with a consultation. Not just a referral, but an actual consultation appointment. Perhaps this could be an initial "triage' evaluation by a dentist, who might best be able to guide the patient to the appropriate specialists (Oral Medicine, or a clinical Oral Pathologist). Why does this care path not exist? What would it take to have a consultation appointment available for any patient arriving at a medical provider appointment with an oral cavity complaint? Change.

When I was asked to submit this opinion for this journal, I considered the patient's unfinished journey. Obviously, both "the system" and I, have not provided the care the patient desired, despite "care" being delivered several times. For the sake of our patients, we need to work together with our physician colleagues to solve these undeniable problems. Perhaps healthcare-itis can be successfully treated.

Acknowledgement

None.

Conflict of Interest

No Conflict of Interest.

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