



American Dental Association
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Comments of Dr. Amid Ismail, BDS, MPH, MBA, DrPH
to
**Joint Meeting of the Dental Products Panel of the Medical Devices Advisory
Committee of the Center for Devices and Radiological Health and the Peripheral
and Central Nervous System Drugs Advisory Committee of the Center for Drug
Evaluation and Research**

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Thank you, members of the panel, for allowing me to provide these comments today. My name is Dr. Amid Ismail. I am a professor of epidemiology and health services research at the School of Dentistry and School of Public Health, University of Michigan, Ann Arbor. I direct the NIH-funded Detroit Center for Research on Oral Health Disparities and lead the UM's Detroit Health Services Research Initiative. For the past four years, I have served as a volunteer member of the American Dental Association, Council on Scientific Affairs, and this year I am the Council chair.

I want to focus my comments today on two items: how the ADA develops its policies and positions on scientific matters; and how the choice of safe and effective restorative materials impacts access to dental care.

The Council on Scientific Affairs is charged by the ADA with responsibility for advising on the safety and effectiveness of dental materials, among its other duties. The Council fulfills this responsibility by keeping abreast of publications in the scientific literature, listening to the opinions of others in the scientific community and conducting its own periodic assessments of the scientific evidence. For example, the Council published a comprehensive review of the literature on amalgam safety in the April 1998 issue of the *Journal of the American Dental Association*.¹ Since then, the Council has updated its assessment whenever new information has appeared, most recently with the publication in the *Journal of the American Medical Association* of the long-anticipated studies known as the Children's Amalgam Trial.²

The Council is a body of independent, scientific experts and has no interest in the outcome of scientific debate other than to provide dentists with the best available scientific information on which to base their treatment decisions. Individuals who serve on the 17-member Council are chosen at large from among the ADA membership for their scientific expertise in a wide variety of fields affecting oral health. Like me, most members of the Council hold academic appointments and are involved in active research. This gives us the experience and expertise to read and assess the scientific evidence according to accepted standards of scientific rigor.

The Council is served by a professional staff that includes toxicologists, microbiologists, materials scientists and other research personnel, in addition to dentists. We have access to a panel of over 200 scientific consultants, covering all the clinical dental specialties as well as pharmacology, materials science, biostatistics and many other disciplines. One-fourth of the Council membership changes each year, ensuring that we have the benefit of fresh perspectives in our deliberations. Although we are a committee of the ADA, our scientific opinions are our own. Council statements and positions are submitted for publication in *JADA*, subject only to the constraints of the regular peer review process.

In the opinion of the Council, dental amalgam is a safe and effective restorative material. The current scientific evidence does not support an association between dental amalgam and any adverse health effect, except for the very small number of documented cases involving individuals who were allergic to one of its components. Dental amalgam is a valuable restorative option for dentists and their patients.

All dental patients deserve the right to choose the most appropriate course of treatment. Eliminating dental amalgam as a restorative option precludes a dentist from offering his or her patients what may be the best choice from a clinical perspective. Dental amalgams are generally the preferred material for large fillings in back teeth or in very deep fillings or fillings under the gum line. Alternatives are often less effective in these situations.

Amalgam is also the only dental restorative material that can be successfully placed in the wet environment of the oral cavity. This is especially critical when a dentist cannot create the dry field that is necessary for the successful placement of composite resin. Without the ease of use offered by dental amalgam, the dentist might be required to use other, more expensive methods to manage the patient, or the patient might choose tooth extraction over restoration of a tooth that could be made perfectly serviceable. Loss of natural dentition under such circumstances would rarely be necessary with dental amalgam.

The ADA's position is that all dental patients should be provided the full range of appropriate treatment options that are supported by the best scientific and experiential evidence available. Decisions on the most appropriate course of oral health treatment are best made by the dentist, in consultation with the patient, prior to treatment.

Dental caries (tooth decay) is the single most common chronic disease in humans. The Surgeon General reports that dental caries in children is five times more common than asthma and seven times more common than hay fever. Epidemiological evidence demonstrates that prevalence and severity of dental caries and restorative treatment needs are highest in low-income and special needs populations – those who qualify for Medicaid and the State Children's Health Insurance Program (SCHIP).

Access to quality dental care for all children, but especially poor children, is a vital element of overall health care and development. Unfortunately, children eligible for Medicaid and SCHIP are three to five times more likely to have untreated tooth decay. Only 20 to 30 percent of the children covered by Medicaid see a dentist annually, and an unknown, but much smaller, percentage receives comprehensive care. SCHIP extends dental benefits to millions more children, but the law does not require dental services. Access to dental care is a major crisis facing low-income Americans.

The ADA is concerned that efforts to eliminate use of dental amalgam will create unwarranted public anxiety, increase disparities, and eliminate viable treatment options. We strongly believe that all Americans are entitled to quality dental care. Those populations that have always received the least care deserve to have all of the dental care options available to them. We feel that eliminating these options will place Americans who are already underserved at an even greater disadvantage.

In conclusion, based on its review of the current scientific evidence, the ADA Council on Scientific Affairs supports the continued usefulness of dental amalgam as a safe and effective dental material. The overwhelming body of scientific evidence supports the safety of dental amalgam. It remains an important restorative option for all Americans. Thank you, again, for this opportunity to share our views.

¹ J Am Dent Assoc, Vol 129, No 4, 494-503 (1998).

² J Am Med Assoc, Vol 295, No 15, 1775-1783 and 1783-1792 (2006).