Letters

JADA welcomes letters from readers on articles that have been published in an issue of JADA within the previous 2 months. Accepted letters will be forwarded to the article's authors for comment. By sending a letter to the editor, the letter writers acknowledge and agree that the letter and all rights of the letter writers in the letter become the property of JADA. Letter writers must disclose any personal or professional affiliations or conflicts of interest so readers can take that into account when assessing the letter writers' opinions. The views expressed are those of the letter writers and do not necessarily reflect the opinion or official policy of the ADA.

JADA reserves the right to edit all letters into a publishable format (up to 550 words and 5 citations and no illustrations) and requires all letters to be signed. You may submit a letter via Editorial Manager by going to https://www.editorialmanager.com/jada/default.aspx (clicking the "Register" link on the Editorial Manager home page and follow the step-by-step process to create an account if needed).

STANDARDS AND INFORMATICS

In response to the excellent Editorial in the January issue of JADA (Wright JT. Transforming Dentistry with Technology. *JADA*. 2022;153[1]:1-2) regarding the desirability of medical-dental electronic health record (EHR) interoperability, I would like to point out some ongoing American Dental Association (ADA) standards and informatics activities that promote medical-dental EHR interoperability.

The ADA is the secretariat for the American National Standards Institute (ANSI)-accredited Standards Committee on Dental Informatics (SCDI). The ADA SCDI has, for over 20 years, worked on the development of standards and technical reports dealing with all aspects of EHRs through a voluntary consensus process involving all interested stakeholders, including providers, vendors, payers, professional associations, regulators, and academics. Many of these ADA/ANSI documents directly address interoperability among dental and medical EHR systems.[1]

In addition, the ADA has collaborative leadership partnerships with numerous accredited standards-development organizations.

The ADA has an agreement with HL7 International for development of standards that share joint branding and intellectual property rights. Many of these ADA-HL7 standards are directed specifically toward medical-dental interoperability, including specifications for a common EHR architecture, the HL7 Electronic Health Record Dental Health Functional Profile,[2] and for implementation guides to share messaging content specifications via technologies using HL7 Clinical Document Architecture[3] and HL7 Fast Healthcare Interoperability Resources.[4]

ADA leads on the development and implementation of the dental aspects of interoperable diagnostic terminologies, including collaboration with the International Health Terminology Standards Development Organisation for SNOMED CT and SNODENT terminologies.[5] The ADA also serves as chair for the International Health Terminology Standards Development Organisation Dentistry Clinical Reference Group.

For the interoperable exchange of dental images, the ADA has, since 2000, recommended the implementation in dentistry of Digital Imaging and Communication in Medicine (DICOM), the medical standard for imaging. The ADA is the secretariat for DICOM Working Group—22 Dentistry and is a member of the DICOM Standards Committee.[6]

I mention these examples of some ADA initiatives to highlight the emphasis that the ADA has placed, and continues to place, on standards and informatics activities intended to foster interoperable dental and medical records. As the noteworthy push for interoperability of EHRs moves forward, ADA initiatives should serve as a foundation for more complex future initiatives, thus avoiding needless duplication and allowing for advancement for medical-dental information exchange more quickly and efficiently. ■

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SCIENTIFIC ILLITERACY

The December *JADA* commentary titled "COVID-19 and Scientific Illiteracy, a Syndemic" (Glick M, Wolff MS, Carrasco-Labra A. *JADA*. 152[12]:967-968) has a glaring omission and even crudity to it. To start with the crudity. The statement "Negative attitudes and distrust have been shown to be associated with belonging to ethnic minority groups, lower levels of education, and lack of regular access to health services often due to low incomes" reeks, at the least, of snobbery and elitism. I would say while these people, as the authors define them, may not be as smart as the authors in quantitative science, I would have just as much, if not more, confidence in their common sense and ethical or moral values than in those of a high-income, highly educated, powerful elitist.

The omission is that the authors make no compelling reference to ethics or morality and the wayward ways science has taken from the 20th into the 21st centuries. As Richard Feynman pointed out, scientific knowledge does not come with a set of instructions to do either good or bad.[1] And when in the hands of powerful political, media, and corporate groups, it has trampled and does trample individuals' human and constitutional rights and dignity.

The authors also mention communication. Well, the low-income groups, low-education groups, or ethnic groups the authors mention are quite astute in questioning and being skeptical of the "science agendas" of the media, politicians, and corporations. Perhaps the authors, if they dare, should speak the same way of these powerful groups as the individuals referenced. These groups are masters at coercing people to increase ratings, votes, and sales.

I recommend the authors tell these groups to communicate health matters in the way a health professional does every day in their office settings—one-on-one with a low-income, low-education, or minority ethnic person as the authors categorized them. That is, not as a rating point or as an election vote or as a sale but as a human being with all the rights and dignity they deserve. And for that brief time, they are treated as the most important person in the universe to that professional—a person, not a member of some group defined by academics, politicians, the media, or corporations.

Carl Sagan once said "extraordinary" claims require "extraordinary" proof.[2] And lately, the average person senses when "science and health" are in the hands of the media, politicians, and corporations and that the "extraordinary" invasion of their individual privacy, rights, dignity, and lives requires "extraordinary" proof of decency and respect if there is to be communication. Again, all I sense communicating in the authors' commentary is a crude snobbery toward people who are in my office and life every day.

Particularly, I am arguing here for an "extraordinary" respect to all, whatever income, ethnic group, or education and whether they agree with us or not, and for a more serious look at the extraordinary way science is used and abused by large groups that we may agree or disagree with. ■

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1. Feynman RP. *The Pleasure of Finding Things Out*. Perseus Publishing; 1999, 142.
2. Sagan C. *The Demon-Haunted World: Science as a Candle in the Dark*. Random House; 1995.