

## Why has Nutrition Failed Us? Or Why has We Failed at Nutrition?

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Received May 15, 2019; Accepted June 27, 2019; Published October 10, 2019

We all know nutrition is undeniably important. In fact, doctors know it's the single most crucial element in all of health care. Every act, every thought, every emotion and every action is a reflection of the right nutrients being in the right place at the right time; and in the proper quantities; with the right pH; and correct medium viscosity and temperature. All of those things are controlled by biochemical reactions and those reactions are the essence of nutrition.

So, why is this most crucial of items also the single most consistently absent item from nearly all doctors' diagnostic and treatment considerations?

The answer is as astonishingly simple as it is complicated.

- Dental caries has radiographs.
- Cholesterol issues have blood tests.
- Periodontal disease has its clinical factors.
- Blood pressure has the sphygmomanometer.
- Nutrition has...nothing like that because it is so complicated. In fact, the study of nutrition is as complicated a subject as is the study of the cosmos. The details of the tiny are as challenging as the details of the grand. The only way to discuss and understand nutrition is to look at it from a macro point of view – but with science, wisdom and reality as the foundation of one's thinking.

We now have a way to determine a person's nutritional status. It used to be virtually impossible to do because even if one were taken into a sophisticated hospital and had a battery of expensive and time consuming tests performed, all one would get is a static picture of the patient that hour or that day or that week; and few hospitals can perform all of those tests.

A dentist can now accurately determine a patient's nutritional status without the need for any lab tests and deliver a repeatable evaluation of a parameter that is extremely critical in many ways. He can tell the patient's nutritional status in the past, currently and likely what it will be in the future.

Knowing a person's nutritional status is important because we never know when we will ask the body to heal.

We know that terrible things happen on the operating table: heart attacks, strokes, systems shut down and some people die in the OR. When asked what happened (assuming everyone did everything properly), the surgeon will tell us that *we don't know. All we know is that we stressed the body more than it could handle and we do not know that level beforehand.*

What exactly is stress? Stress translates biologically as the depletion of nutrients. We know the stress nutrients as Vitamin C, Vitamin E and the B-Complex. Of course it's much more complicated than that but we can agree that stress is the depletion of nutrients and when such depletion occurs, systems can no longer function as designed.

We (sort of) know well approximately 150 vitamins and different nutrients and also know that a single apple has over 8000 different nutrients. Assaying for them all is out of the question and even if we did that, the "needs graph" for each of us is widely variant even though we all need the same nutrients.

Now the dentist can tell if the patient is a high or low risk on the operating table and can do it swiftly and inexpensively with undeniable results. It is all based on *Quin'talano* (the essence of science): *Keen observation with a trained eye and deft interpretation with an educated mind.*

The most widely known instance of *Quin'talano* is the story of Dr. Alexander Fleming's discovery of penicillin.

The new oral examination is based on *Quin'talano* and is the reason dentists will experience a floodtide of referrals from the medical community.

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**Citation:** Gilbert JW. (2019) Why has Nutrition Failed Us? Or Why has We Failed at Nutrition? J Oral Health Dent, 2(3): 137-138.

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What surgeon, what hospital, what patient and family of the patient would not want to know the patient's nutritional status beforehand and hence know if the patient is a high or low surgical risk?

Now that we know a dentist can do this, there is no reason to not make use of this new diagnostic ability. In fact, should something untoward happen on the operating table and the surgeon is sued, the prosecuting attorney would ask why the patient was not referred to the dentist for this evaluation pre-operatively and there would be no good answer – except that few dentists currently know how to perform this new oral evaluation.

This new oral examination replaces the under-serving and narrow-scoped dental examination (which never really did hold up to scrutiny); adds only 2 min to whatever the dentist now does as an exam; and reveals a plethora of critical information about the patient never before evaluated. It is an impressive examination; impressive to the patient, to the staff and to the doctor as well.

There are 30 new items that are evaluated. The patient who displays 3 or 4 or 5 of the 30 is not telling us the same story as one who displays 21. Also, which ones and what combinations are important to the evaluation. No one has any of the thirty because no one is perfect. How far away from that perfect mark is the result of the doctor's experience and training in evaluating the findings.

Our first premise is that we do not believe that Nature makes design errors – certainly not on a wholesale basis – so the factory-installed equipment with which we were born should function fairly well; and if it doesn't, it is not a design error but a matter of not feeding those biologic systems what they need so they can perform as they were designed to perform; namely, keep us healthy and well.

It's a nutrition problem.

Also, we believe that if you see something you should not see (edema or bleeding without provocation, for example) or feel something you should not feel (pain or immobility, for example) it is an indication that body systems are not functioning as they should for if they were, you would not see or feel that. Something is wrong.

As I traveled around the country lecturing to audiences of doctors (dentists and dental hygienists), one of the things I would ask was a description of a healthy tongue. After some back-and-forth, it was decided that a healthy tongue had three basic characteristics: it was pink or pinkish; regularly elliptical, wider posteriorly than anteriorly; and the anterior 2/3 of the dorsum was homogeneous.

I then asked if anyone had ever seen a tongue that had a colored coating on it (brown, orange, green, yellow, white, etc.) and they all said yes; that they see it every day. When asked if that was part of their healthy picture, they all said no; we just told you it should be pink. When asked what they

did about it, they all said *nothing* (admitting that brushing the tongue did not get to the cause of the problem).

Isn't the doctor required to respond – at the doctor level – to those findings that are outside the parameters of health?

When asked if they ever saw a tongue with teeth marks – making the border a scalloped border, again, they all said yes; *that it was not part of their healthy picture and that they did nothing about it.*

And when asked about fissured (scrotal) tongue, they responded likewise but someone always shouted that it was benign because the textbook said so. And when asked what the vaunted text said about its etiology, they said it was unknown. So, how did they know it was benign?

The 30 items are all blatantly obvious yet are either ignored, looked right past or misinterpreted. No longer. It is time for dentists to behave as the doctors they have been given the wherewithal (and responsibility) to become.

And then, we enter that part of the new era in dentistry that is concerned with how to respond to these findings and do so at the doctor level. Ignoring them is not appropriate, not professional and not doing right by the patient who places faith and trust in the doctor.

That is the subject of Part Two.