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Children's Oral Pain

The seal of the American College of Dentists is a large, circular emblem. It features a central figure of a woman holding a scroll with text, flanked by two other figures. Below them is a large, stylized insect, possibly a fly or a bee, with its wings spread. The text "COLLEGE OF DENTISTS" is written in a large, serif font around the top and right sides of the seal. The Latin phrase "CURANDORUM HUMANITATIS CAUSA" is written in a smaller font around the bottom and left sides. The seal is rendered in a light, monochromatic style against the dark background of the cover.

Journal of the American College of Dentists

A Publication Presenting
Ideas, Advancements, and
Opinions in Dentistry

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Mission

THE *JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS* shall identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. All readers should be challenged by the *Journal* to remain informed, inquire actively, and participate in the formulation of public policy and personal leadership to advance the purposes and objectives of the College. The *Journal* is not a political vehicle and does not intentionally promote specific views at the expense of others. The views and opinions expressed herein do not necessarily represent those of the American College of Dentists or its Fellows.

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- A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
- B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;
- C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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FROM THE EDITOR

Hussies with Dental Degrees

Here are a few quotations that have appeared recently in the dental literature. “The average income of a dentist is around \$125,000 a year, ...and it is not nearly enough!” “It wasn’t until I really started making a good living at dentistry that I truly appreciated our great profession.” Or from another author, “It is my opinion, and always will be, that it is our moral obligation to provide for our families with the highest standard of living possible.”

These views are brazen, even in this .com, generation-X, “me” culture. There is nothing “unethical” about the kind of relationship with patients that is being proposed. It is an honest attempt to re-define the profession of dentistry and to give it a different ethical foundation.

The new definition of dentistry based on image would be driven by patients’ wants rather than their needs. This is a savvy marketing move since wants are unlimited and needs are not. On this new view, health becomes a secondary consideration in the definition of the profession. The goal is to preserve health while promoting image. There is serious talk these days about dentistry becoming an oral care profession rather than an oral health care profession. When servicing the public takes the place of serving it, it is acceptable to talk about money as the measure of success.

And big money is part of the image for some practitioners as well. “The im-

agists” I know are anything but hack, snake-oil salesmen. They are excellent technicians who ground their work in the biology of the oral complex. Professional wrestlers are superb athletes and impressive actors, but we feel the urge to put the word “wrestler” in quotes when describing them.

How should we refer to this new wave of money-centered, want-servicing practitioners? Quite literally, they are image technicians. Another term that can be useful is hussy, meaning both men and women. It is an old word that refers to those who undermine the ethics in a community by flaunting their assets. Our grandparents or even theirs often coupled the modifier “shameless” with this word, meaning that a hussy lacks the element of conscience necessary to see the impact of their behavior on people besides themselves.

Some hussies with dental degrees give outstanding continuing education courses and arrange to be picked up in chauffeur-driven, stretched limousines. In order to build the full impact, they stand in the door talking on their cell phones as the course participants leave. I have seen it and I confessed that it is a very powerful image.

But we need to look at the radiographs again; there are curves in these canals. Reread the quotations at the beginning of this editorial and ask yourself, “Who are these messages intended for?”

Can you imagine presenting this line to a teacher’s union local meeting, the AARP, or congressional representatives? Patients would doubtless find this offensive. In fact, the target of the hussy with a dental degree is another dentist. To understand the dynamics of dentists selling image to other dentists requires a re-examination of the motives of both the buyer and the seller. The oral health of Americans might possibly be part of this motive, but it is far from the dominant one.

I am worried about the “want-image-money” message of the hussies and its potential impact on the profession. The first of my four concerns is the question of self interest. Hussies show practitioners how they too can make money by reinterpreting patients’ dental concerns. The big names have stables of want-to-be gurus recruited from the most enthusiastic of their converts. This may be as American as business gets; but it is questionable practice in a profession. The whole thing resembles a pyramid scheme.

My second concern with image-based dentistry is that it trades on the historical reputation of a health care profession in order to promote something other than health. As an advertisement for a chain of tooth whitening centers on the West Coast announces on the radio, “There is a professional dentist at each center.” The word hussy originally was a colloquial term for housewife—certainly

an honorable calling. Dentistry must be very careful with its name to ensure that it accurately describes the way the profession intends to serve the public.

My third misgiving is about conscience—how do hussies rationalize what they propose? Faux ethics refers to following practices that blend self interest and high moral principles. Because the high principles are presented to the public and are consistent with practice, it is impossible to say for certain where the

(not want) for the customer. The trend in America is for business to incorporate some of the values professionals have supported for years. It is no time for the true professions to be dallying with commerce as a core value. I was present recently when one of the hussies spoke to dental students and explained his code of ethics. It consists of giving one's family everything they deserve. This advice was illustrated by the speaker's two infant sons dressed to the nines and posed

but no mention of standards of care, patient satisfaction, or functional and esthetic work. Baldrige insists on those things in the health category. When I checked the detail of the application I discovered that the practice was not applying as a health care provider but as a business.

Treatment that is not based in the oral health care needs of the public may be a legitimate business, practiced by well-meaning and hard-working individuals who are constantly improving their effectiveness in meeting the current fashion wants of a segment of the population. I admire their business acumen as much as I respect good business practice anywhere else I observe it. But is it a profession? Is it dentistry? To ensure that their advertising is not false and misleading I would suggest that a new name be developed. "Imageologist" or "cosmodontist" seem to express the true function. This is not a matter private to them. If they use the honorable name of dentist—one who places the patients' health care needs foremost—while championing different values, they damage the profession. Maybe, after all, they are just hussies with dental degrees.

David W. Chambers, EdM, MBA, PhD, FACD
Editor

There is serious talk these days about dentistry becoming an oral care profession rather than an oral health care profession.

true motives lie. Sensationalism on television is defended as "what the public wants." It is also a good way to sell advertising time. I would feel less nervous about want-based dentistry if the "profit" margins were the same in that area as they are throughout the profession and if the practitioners stopped referring to their practices as "high end."

My final concern about hussies with dental degrees is their shameless attempt to change the core values of the profession. The great prophet of manufacturing quality, G. Edwards Deming, defined quality for business as doing good

on a large motorcycle. If the heart of the new dentistry is image, that is the wrong image.

I am an examiner for the Malcolm Baldrige National Quality Award. This is a program administered through the National Institute of Standards and Technology and designed to promote performance excellence in each of three categories: health, education, and business. I recently reviewed an application from a health care provider. I grew increasingly nervous as I read the application and found goals such as "maximizing profit" and "empowering the staff,"

Dental Pain in Children: Its Existence and Consequences

Burton L. Edelstein, DDS, MPH, FACD

Abstract

The extent and seriousness of children's oral pain is documented from a variety of sources, including the popular press. Suggestions are offered for issues to be addressed.

Oral pain in children arises most commonly from cavities and much less often from trauma, abuse, periodontal disease, and lesions of the mucosal tissues. Dental caries is overwhelmingly common — affecting over half of all U.S. children by second grade (Healthy People 2000). Unlike other sources of oral pain, caries is common, persistent, progressive, and not self-limiting. Other painful presentations are either self-limiting (e.g., viral ulcers, soft tissue trauma), managed as a single episode (e.g., broken teeth, acute periodontal pathologies), or customarily managed by physicians (musculoskeletal conditions and tumors). For these reasons, this consideration of children's oral pain focuses on tooth decay.

Federal Data

Failure to document a public health problem often spells failure to attend to that problem, yet valid national data are often difficult to obtain. While the National Health Interview Survey reports that one in seven American adults have experienced dental pain over a six-

month period (Vargas, et al, 1989), there exists no published federal study of dental pain in children. A special analysis of National Health Interview Survey data conducted for this project revealed that 11.2% of U.S. children ages two through seventeen had a dental visit in the prior year because they "had pain or something was bothering them." Fully one in five children in poverty had a dental visit for dental pain or a related problem.

The accompanying chart shows that minority children, children of parents with low educational attainment, and children living in poverty had more symptom-related visits than did their peers. These findings relate only to children who successfully obtained a dental visit. Collection of data on all children, those who do and do not obtain care, was considered in planning for the fourth National Health and Nutrition Examination Survey (NHANES IV), but testing of a childhood dental pain measure proved statistically unreliable. Once again, policy makers will not have available national data on the existence of dental pain in young children.

Parental reports of unmet need suggest that dental problems are common. A multiyear review of the National Health Interview Survey (Newacheck, 2000) showed that one-in-five U.S. children have an unmet need for dental care — three times more children than have an unmet need for medical care and five times more than children with an unmet

need for vision care or prescription drugs.

State Data

State level data have been collected by some states through Maternal and Child Health and Medicaid authorities. For example, in Missouri 8% of Medicaid children's last dental visits were for emergency care (McCuniff et al, 1999). In California 47% of preschoolers in Head Start were found to have decay significant enough to suggest that they may be experiencing pain (Watahara, Murphy, & Isman, 1995). In Oregon 4% of Head Start children (Skeels & Clark, 1994) and in Washington 7% of Medicaid-eligible preschoolers (Washington State Department of Health, Community and Family Health, 1996) needed urgent care because of obvious pain or infection on the day of examination.

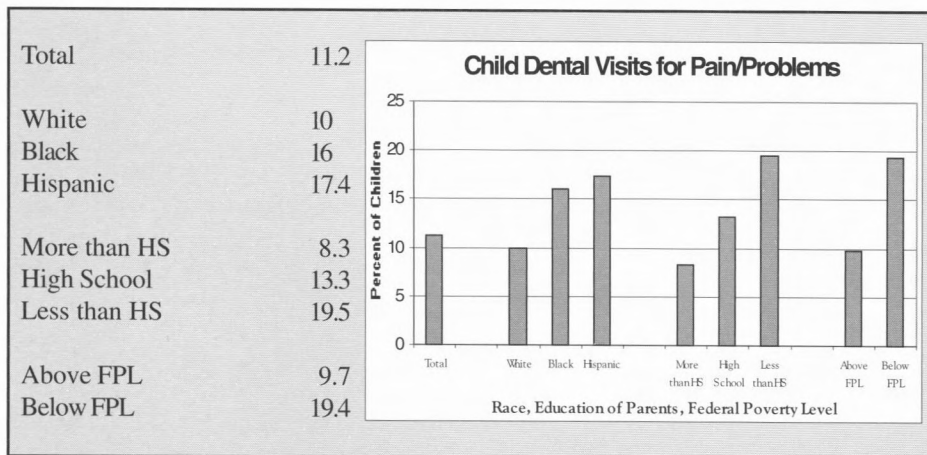
American Dental Association Data

American Dental Association reports on services rendered by dentists (American Dental Association, 1990) provide data



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The theme of children's oral pain was developed by the Milbank Foundations and the Mayday Foundation.



suggesting the magnitude of dental emergencies in children. From these data, pediatric dentists, who comprise only 2-3% of dental practitioners in the U.S., are calculated to provide urgent care services to more than five thousand children each workday. Among specialists, only oral surgeons and endodontists who manage pain for patients of all ages, have a higher caseload of emergency care patients. Comparable numbers for general dentists are not available.

Hospital Data

Many children who experience acute dental pain or infection from decayed teeth seek care in hospital emergency rooms rather than private dental offices. Half the children who presented to Pittsburgh Children's Hospital emergency room over a ten-year period with faces swollen from infection were suffering from nothing more than the consequences of cavities (Unkel et al, 1997). Dental emergencies at the University of Nevada School of Medicine emergency room account for 6% of visits among children younger than six years of age (Feldman, personal communication). Among children who presented to the Columbus (Ohio) Children's Hospital for toothaches, one-third had abscessed teeth and one-quarter had draining lesions (Wilson et al, 1997). For more than one in four the emergency visit to Children's Hospital of Seattle was their first "dental visit" (Sheller, Williams, & Lombardi, 1997). So acute is the demand for emergency dental services at

some children's hospitals that many have established separate mechanisms for managing these patients. For example, Columbus Children's Hospital has established a separate full-time emergency clinic and Seattle Children's Hospital has established a separate training elective on emergency care.

Dental Pain is Concentrated in Low Income Children

Taken as a whole, these reports suggest that acute dental pain of non-traumatic origin is more common among low income and very young children, children who typically fall outside the traditional dental delivery system but are generally covered by Medicaid or SCHIP. Indeed, a comparison of Medicaid enrolled children and their more affluent commer-

were also more often seen for more than one emergency visit within this five-month period compared to commercially insured children who were seen for only a single emergency visit (Amundson, 1999).

A case series at Columbus Children's Hospital provides a glimpse into the personal experience and consequences of toothaches among low income children presenting for pain relief. Of seventy-four children who presented as "walk-ins" for urgent dental care by one pediatric dental resident during a few weeks in 1998, 52% were reported by their parent to have suffered with the current toothache for a week or more before presenting to the hospital. The most common reasons given for electing treatment were pain, facial swelling, inability to eat, and need for pain control stronger than over-the-counter drugs could provide. Only 18% of parents sought care immediately upon the child demonstrating symptoms. Two-thirds of parents reported either no dentist-of-record or that the child's dentist was unable or unwilling to treat the immediate problem. In contrast, nearly 90% reported that their child had a regular source of medical care. Four in ten parents expected treatment by extraction yet more than half required immediate extraction. Parents were well aware that their children were experiencing other dental problems at the same time. Fully

Two-thirds of parents reported either no dentist-of-record or that the child's dentist was unable or unwilling to treat the immediate problem.

cially insured peers enrolled with Health Partners of Minneapolis showed that Medicaid children seek emergency dental care half again more often than higher income children. Of children seen in the first five months of 1999, 13.2% (179/1356) of Medicaid enrolled children and 9.4% (463/4934) of commercially insured children required urgent dental treatments. Medicaid enrolled children

75% of children required additional dental treatment according to both parents and the treating dentist.

Press Interest

Press reports are bringing this problem to the public. *The Denver Post* led its March article entitled, "Low Income Kids Lack Dental Care" with the statement, "Every day low-income children

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show up in the [Denver] Children's Hospital emergency room, faces swollen with infected teeth." *The New York Times* began its June article entitled, "Despite Medicaid Coverage, Dental Care is a Chronic Problem for Children of the Poor" with an anecdote about a two year old having her teeth extracted under general anesthesia.

Consequences of Dental Pain

Consequences of symptomatic dental disease are personal, familial, and societal. For roughly twenty million children, those who suffer 80% of tooth decay (Kaste et al, 1996), cavities are at best an inconvenient distraction and at worst a physical handicap. It is no longer unusual to see children smiling with a full set of unmarred teeth. But for an estimated four to five million children, chronic dental problems cause distractibility and other behavioral detriments, sleeplessness, acute pain from dental abscesses, disfigured smiles, dysfunctional speech, and difficulty eating. A seemingly conquered and innocuous disease, dental caries and its consequences in these children may be associated with poor educational and behavioral attainment and attendant problems of low self-esteem and social dysfunction. Chronically poor oral health is associated with failure-to-thrive in toddlers (Acs et al, 1992; Ayhan, Suskan, & Yildirim, 1996), compromised nutrition in children (Acs et al, 1992), and cardiac and obstetric dysfunctions as adults. Tooth decay, both treated and especially untreated, is disproportionately localized among low income children (Vargas, Crall, & Schneider, 1998) and is not declining in prevalence (Healthy People 2000). These findings contradict a 1990 *New York Times* report that NIH claims modern dental care "has virtually conquered dental disease in children."

Observing disadvantaged inner-city school children, social commentator Jonathan Kozol noted, "Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequences of wearing down the

stamina of children and defeating their ambitions (Kozol, 1991).

The impact of advanced dental disease on families is less well documented. There are a number of signs that a child's quality of life improves markedly following repair of extremely damaged dentition. Parents report that following dental repair for Early Childhood Caries (aka "Baby Bottle Tooth Decay") toddlers often regain or develop for the first

The financial burden from both direct and indirect costs may also significantly impact families.

time the capacity to play quietly, sleep through the night, complete a meal without fussing, and stop demonstrating distractible and irritable behaviors. These parents also comment on the improvement in their own life condition subsequent to the child's improved emotional disposition.

A pediatric dental educator located in Southern California describes a more extreme condition affecting families:

Many of our patients are children of illegal immigrants whose families live in overcrowded facilities where there is a premium on peace and quiet. The bottle is an easy way to keep a child quiet so that the family can rest after twelve to fourteen hours of work. Children are brought in after several days or weeks experiencing pain. They are brought in when parents can no longer stand the constant complaining. Some are so young that definitive treatment must be delayed until sedation or general anesthesia can be arranged. It is all complicated by the fact that many of these parents fear discovery and won't enroll their children in MediCal (California's Medicaid program.)

The financial burden from both direct and indirect costs may also significantly impact families. Children with ex-

treme dental needs, particularly young and special needs children, often require treatment under general anesthesia in the operating room. While Medicaid EPSDT is required to cover these expenses, many SCHIP and commercial plans do not, leaving families with exposure to high hospital, anesthesia, and physician costs. Indirect costs associated with lost work and school time, particularly for lower income families and single parents in welfare-to-work programs, can be extremely costly, threaten job stability, and diminish work and school performance.

Obtaining dental care when children are experiencing pain can be difficult, especially for patients without a usual source of dental care. Dental offices are generally tightly scheduled and geared to address only a limited number of "dental emergencies" in a given day or week. The high incidence of toothaches among Medicaid enrolled children places a stress on offices as they seek to address urgent need and work to assure follow up care. For example, in one large multi-provider pediatric dental office where 4,212 children were seen over a two-month period, eighty children presented for urgent care. Medicaid enrolled children represented only 13% of children seen but accounted for 71% of children requiring urgent care (Herter, 1999).

Societal costs emanate from these familial issues. HCFA estimates that between \$100 and \$400 million dollars are expended by Medicaid alone for direct hospitalization costs associated with treatment of early childhood caries (Schneider, personal communication). The societal and economic impacts of missed work and school days in children and adults are significant, with an estimated forty-one million restricted activity days due to dental problems based on the National Health Interview Survey (Gift, Recine, & Larach, 1992).

Policy Implications

Both public policy and clinical policy responses are required if we are to succeed in eliminating or more effectively ad-

addressing pediatric dental pain arising from caries. Public policy "fixes" require:

- Improvements in Medicaid and SCHIP programs so that they truly respond to the needs of children and their dentists and assure that dental care is readily available in the marketplace
- Attention by state and federal Maternal and Child Health programs and their associated Title V state block grants to address pediatric oral health
- Addressing dental workforce inadequacies in numbers of pediatric dentists and general dentists treating children as well as their geographic accessibility
- Development of an informational system that makes public insurance programs for children accountable to government and the public

Clinical policy improvements needed to address children's dental pain experience include:

- Refinement and widespread use of clinical guidelines that assure attention to children's oral health by all health practitioners who come in contact with young children
- Development of effective protocols for risk identification, oral health anticipatory guidance, early intervention, and disease suppression
- Maximizing opportunities to integrate oral health by effectively linking medical and dental care delivery systems so that oral care isn't given a second thought, an after thought, or no thought at all

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Ethics, Advocacy, and Oral Health of Children

Wendy Mouradian, MD

Abstract

The author describes a personal journey from providing primary care to children with cleft lip/palate to searching ethical aspect of health care policy. The implication of beneficence and non-maleficence, of autonomy and of four conceptions of justice on oral health care for children are traced. The dominant model of free-market, fee-for-service contains built-in disadvantages for the young and the poor.

This article describes my growing interest in and concern for children's oral health. This interest grew out of my experience in clinical care and administration of a large interdisciplinary craniofacial program, an experience that raised profound ethical issues for me, and eventually led to my current focus on ethics in health policy. This discussion reflects the evolution of my thinking from ethical dilemmas at the bedside to ethical issues in health policy.

Lessons from the Craniofacial Clinic

When I began working in the Craniofacial Clinic in 1992, I had not had much exposure to children's oral health issues. I

had little formal training in oral health in medical school, residency, or fellowship training. Although my father was a dentist, I did not consider dental issues to be "on my plate," and with the exception of fluoride and baby bottles, did not devote a lot of time to talking with mothers about oral health or examining teeth carefully.

Nor do I consider my experience unique. According to a recent national survey, pediatricians commonly face dental issues in their offices. Yet most report little or no training in the area and lack current knowledge needed for effective management of dental problems (Lewis, Grossman, Domoto, & Deyo, 2000).

In the craniofacial setting I saw children with cleft lip/palate and other craniofacial conditions. Children with cleft lip/palate have an excellent outlook when all the many surgical, dental, pediatric, speech, and psychosocial issues relating to this condition are addressed. However, regular dental care and timely orthodontics are critical to these good outcomes. Children with more complex conditions may have severe orthodontic and dental problems in addition to hearing difficulties, increased intracranial pressure, ocular difficulties, and other medical complications (Gorlin, Cohen, & Levin, 1990). Treatment decisions are complicated by delicate timing considerations, trade-offs between physical fac-

tors and quality of life, and cost concerns. Treatment spans about two decades until facial growth and physical maturation are complete. I learned first hand why a long term, coordinated, interdisciplinary team is needed to optimize outcomes for these patients, why it is the standard of care in this field (American Cleft Palate-Craniofacial Association, 1993; Washington State Department of Health, 1997), and why dental providers are an integral part of craniofacial teams.

Complex Patients Raise Complex Issues: The interdisciplinary craniofacial team also provided an ideal setting for discussion of difficult treatment decisions and



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ethical dilemmas. Because of advances in surgical techniques, major craniofacial reconstructive surgery is now possible for children with complex craniofacial conditions. However it is often difficult to determine if such major surgeries are in the best interests of the child. The notion that "ethics is in some sense always about whether we ought to do what we can do" (Jonsen, 1990, p. 22), seemed apt for many of our team discussions. Balancing risk and benefits was especially problematic when the goals related to subjective quality of life improvements and when patients were infants or young children who could not decide for themselves. Who made these difficult decisions, and who would pay (Mouradian, 1995)? As director of the craniofacial program and pediatrician-case manager for our patients, I felt the weight of these daily dilemmas in clinical care.

To explore these issues more fully I began to study ethics in 1994 under the direction of Dr. Albert Jonsen, then chair of our Department of Medical History and Ethics at the University of Washington, eventually receiving a certificate in health care ethics.

Access to Oral Health Care: As my experience in craniofacial medicine and administration grew, other ethical issues began to emerge. While we could usually get costly surgeries approved, dental or orthodontic care was another matter — even if the success of the surgery or the habilitation of the child was dependent upon such oral care, as it is for children with cleft lip/palate.

At times we saw patients whose oral health had been mismanaged, or more typically just "unmanaged" by physicians who did not appreciate the importance of oral health. Such dental non-management complicated surgeries, increased costs of care, and compromised potential long-term outcomes for these patients. With over six thousand patient visits a year, we could easily draw such conclusions based on clinical observations.

Another observation I made was that my adolescent patients with cleft lip/

palate and other craniofacial conditions typically wanted their teeth straight and attractive. It was important to their self-esteem, and when adolescents neglected their oral hygiene it was often an indicator of other emotional or social problems. It was clear to me that their teeth and smiles mattered to them. However, accessing orthodontic care was often difficult.

And there was more. As I got to know our dentists and orthodontists better in the team environment, I began to hear about the many children who presented to dental clinic or the Emergency Room with urgent oral health needs — especially children from low income or minority backgrounds or from rural areas. Toddlers with rampant caries and pus draining and preschool children with dental abscesses and cellulitis were a regular part of the dental clinic in a large children's hospital. I was just becoming aware of the tip of the iceberg, and our experience does not appear to be unique. A survey of dental departments in tertiary care centers has found

- Balancing risks and benefits of complex surgical procedures for children
- Lack of coverage for medically necessary dental care
- Lack of appropriate knowledge of oral health issues on the part of physicians
- Profound oral health disparities in some high risk populations
- Importance of oral health to overall health and quality of life

All these gave me, as a physician, a new understanding of the importance of oral health, the need to integrate it into medical care, and the ethical dimensions of this care.

Integrating Oral Health: While the need to integrate oral health was especially clear to me in the care of children with craniofacial conditions, I also noted that other specialty clinics referred to the craniofacial team in order to get an

O f those poorest children guaranteed basic dental care through Medicaid, fewer than 1.5 actually receive it.

they are overwhelmed, with from four to twelve month wait for operating room time (Lewis & Nowak, personal communication). These departments typically serve as safety nets for poor children and those with special health care needs, and such service inadequacy disproportionately impacts them. Dental departments in tertiary care centers are threatened financially because of our failure to appreciate that the mouth is part of the body. Current definitions of medical necessity exclude dental-related care, and few employers provide dental coverage. Clearly in the oral health arena ethics is also about why we don't do what we can — and ought to do.

So these seemed to be the critical issues to me:

evaluation that integrated medical and dental perspectives. Children with developmental disabilities, heart disease, cancers, HIV-AIDS, and other immune deficiencies are all at increased risk for oral problems. Just assuring these children access to a dentist is not enough. These children need medically necessary dental care beyond the reach of the usual dental services. They often need hospitalization, general anesthetics, complex orthodontic treatment, access to pediatric dentists, and expertise of tertiary care centers. These children need medical providers who understand oral health issues and dental providers who work as part of the health care team. Like children with craniofacial conditions, these children need coordinated interdisciplinary team

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care that integrates medical and dental care. While team care is the standard of care for all special needs children (U.S. Department of Health and Human Services, 1987), because of the separation of

many lacked dental insurance, I was outraged. And among those poorest children guaranteed basic dental care through Medicaid, fewer than 1:5 actually receive it (U.S. Department of

other who has the knowledge, skill, and facilities needed to effect cure. It is inevitably a relationship of inequality in freedom and power in which the stronger is obliged to protect the interests of the weaker.

This is the core of professional ethics, and it always requires some degree of effacement of self-interest in favor of the patient. "Indeed," continuing to quote Pellegrino, "it is the fact of this effacement of self-interest that distinguishes a true profession from a business or craft." This requirement mitigates, if it does not eliminate, the conflict of interest that arises when caregivers are paid for their services.

According to Jonsen, some of the deepest questions we face in ethics arise from this paradoxical presence of self-interest and altruism in the tradition of medicine. The institution of medicine is built upon a "structural rift ... This moral paradox, like a geographic fault, penetrates the terrain of medicine ... No other social institution has such a paradox running through its very center. Moral conflicts shake every social institution, but in most of them the quakes are at the edges" (Jonsen, 1990, p. 7). To understand this rift Dr. Jonsen engages in some fascinating moral archaeology on the 2500-year tradition of medical ethics.

Beneficence and Non-Maleficence

The first great tradition came from the Greeks and stressed acting to benefit patients and above all doing no harm. But it lacked the appeal to compassion implicit in Pellegrino's discussion of the doctor-patient relationship.

Hippocratic medicine was a skill, its practitioners were craftsmen, and their objective was a good living. The etiquette that went by the name of ethics consisted of counsels of self-interest. There was nothing unethical or immoral in all this; self-interest can be an adequate moral principle when safeguarded by the precept "At least do no harm." Not until the second century A.D., when Stoic and Christian ideas had a whisper of influence, did even a hint of altruism appear (Jonsen, 1990, p. 9).

The obligation to help someone begins with the person's inability to help himself or herself.

medical and dental systems, oral health providers are rarely an integral part of the team. The integration of medical and dental services is especially critical for the population of children with special needs. (An exception to this is the University Affiliated Programs, providing leadership education in neurodevelopmental and related disabilities, funded by the Maternal and Child Health Bureau, where the requirement that such centers include dental providers as part of interdisciplinary team assessments has recently been reinstated.)

New scientific findings further corroborate the need to integrate medical and oral health perspectives. Recent data links maternal periodontitis with low birth weight (Offenbacher et al, 1996), and there is abundant evidence that caries is transmitted from mother to infant early in life (Tinanoff, 1997). Findings like these raise the possibility of targeting providers of obstetrical and pediatric care, as well as child care workers, WIC centers, well-baby clinics, etc., for education and oral health screening programs. New research agendas also increasingly can bridge the gap, given insights from modern genetics and molecular biology that molecules know no oral-systemic boundaries.

Ethics and Health Policy in Children's Access to Oral Health Care

Both the access issues and the importance of integrating oral health into overall health led me to focus more on ethics at the policy level. When I learned that more than ten million children lacked medical coverage, I was shocked; when I learned that more than two and a half times as

Health and Human Services, 1996). It became clear to me that what ever the delivery system, basic health benefits for children should include oral health care explicitly. The next part of this paper explores our common moral arguments that support provision of health care to all children and the impact of current policy choices on children's oral health care.

The ADA Code of Ethics (American Dental Association, 1998) emphasizes the importance of the ethical principles of beneficence, autonomy, and justice. These principles underlie medical care and apply equally to dental care. There are no morally relevant distinctions between the two professions. Drawing upon these principles it is possible to argue specifically that children should receive basic health care, and that such care should include oral health services.

First, we note that provision of health care is a moral act, and not an ordinary market exchange. It is a moral act because patients are vulnerable and seek out the help of doctors who have the special training and expertise to help them. Ed Pellegrino (1986, p. 34) puts it this way:

The commitment to the patient's welfare is the primary moral imperative in medical care. This commitment flows from the nature of illness and the promise of service made by individual physicians, and by the profession as a whole. That commitment has a basis in the empirical nature of the healing relationship in which a sick person — dependent, vulnerable, and exploitable — must seek out the help of an-

The Hippocratic tradition did lead to an emphasis upon competency, a requirement that was raised to a virtue in the Middle Ages.

An Ethic of Care: In the first centuries of the Christian era, the church adopted the care of the sick as a charitable obligation, adding the parable of the Good Samaritan to similar traditions in Jewish medicine. This parable, later used to exemplify the duties of the physician, reinforced an ethic of care — the need to care for the sick, whether friend or foe, even if at cost to oneself. These two broad ethical traditions, with their potential for conflict, created the stage for the structural rift.

Both traditions exist as the deep moral foundations of medicine. Medicine is a skill that is so rare that it can be sold at a great price. Acquired with effort, it promises great rewards — not only of income but also of prestige, reputation, and gratitude. In this the modern physician inherits the Greek tradition. ... At the same time medicine offers help desperately sought by persons often hard pressed to purchase it. They, and society, expect that the help will

play: respect for patient autonomy. Autonomy was never part of the Hippocratic task. Autonomy became increasingly important in this century partly because of cultural and political trends, but also because of technology. A critical insight from modern bioethics is that our ethical problems change as we change: new technologies create new ethical dilemmas. Innovative life-saving treatments brought hope to many, but created the potential for overuse of these therapies on the sick and dying. New surgical techniques opened the chance for miraculous cures — and mischief. Patients now have an explicit right to self-determination, and this is codified in a moral and legal doctrine of informed consent: all medical (and dental) care requires the informed consent of a competent patient. Thus a competent adult may refuse beneficial or even life-saving therapy, something an earlier paternalism would strongly resist (Jonsen, Siegler, & Winslade, 1998).

Respecting Children's Autonomy — The Best Interests Standard: This is not the case with children. Guardians, usually the parents, are the decision-makers, and they

A Societal Obligation to Care for Children: The legal and ethical precedents in medical decision making for minors speak powerfully to society's commitment to protecting children. Parents are given wide latitude in making decisions for their children — but legal limits are drawn when parents abuse or neglect their children, fail to provide them with an education, or subject them to religious practices that threaten their lives or safety. These statutes embody society's recognition of the vulnerability of children and their importance to society.

The same logic should be applied to health care. When the decision to procure health care for children is left to parental choice and ability to pay, many children will not receive health care. According to the U.S. Census Bureau's webpage, there are currently eleven million children without medical coverage, and some twenty-seven million are without dental insurance. Countless more are under insured or have problems accessing the services to which they are entitled. There is a tension between parental rights, and a societal interest in and obligation to protect children. This second tension — that is rarely made explicit — may undermine efforts to provide universal access to health care for children.

A societal obligation to ensure that all children have adequate health care can be argued from the principle of beneficence as well (Diekema, 1996). The obligation to help someone begins with the person's inability to help himself or herself. Children are vulnerable; they depend upon adults for care and nurture and for access to health, educational, and social services. Second, the obligation to help becomes more compelling when the need threatens the well being of the other person, as is true for matters of health. Children are in a position to benefit considerably from timely medical and dental care and preventive interventions, and to suffer disproportionately when those services are denied. Third, the obligation to help also depends upon one's ability to do so effectively. Our society has the resources for basic child

The legal and ethical precedents in medical decision making for minors speak powerfully to society's commitment to protecting children.

be forthcoming (Jonsen, 1990, p. 10).

Thus there is a fundamental conflict between our current view of health care as business and our belief that sick people should receive help from society when they need it. Our persistence in supporting the business model of medicine and dentistry, despite its failure to meet the needs of the poor and uninsured, is evidence of this fundamental, unresolved conflict and the tension it creates.

Respect for Autonomy

It was centuries before the next important bioethical principle would come into

play: respect for patient autonomy. Autonomy was never part of the Hippocratic task. Autonomy became increasingly important in this century partly because of cultural and political trends, but also because of technology. A critical insight from modern bioethics is that our ethical problems change as we change: new technologies create new ethical dilemmas. Innovative life-saving treatments brought hope to many, but created the potential for overuse of these therapies on the sick and dying. New surgical techniques opened the chance for miraculous cures — and mischief. Patients now have an explicit right to self-determination, and this is codified in a moral and legal doctrine of informed consent: all medical (and dental) care requires the informed consent of a competent patient. Thus a competent adult may refuse beneficial or even life-saving therapy, something an earlier paternalism would strongly resist (Jonsen, Siegler, & Winslade, 1998).

Respecting Children's Autonomy — The Best Interests Standard: This is not the case with children. Guardians, usually the parents, are the decision-makers, and they

health care. Finally, the obligation to help is the responsibility of all who can help.

critical roles adults play in their lives. The needs, circumstances, and values of

society must ensure that benefits and burdens are allocated irrespective of a person's position in the society. Such a system would best protect an individual's interests no matter what their ultimate position.

Inequalities, if they exist, must be arranged so as to benefit the worst off. In fact, society has an obligation to redress effects of the biologic and social lottery that create such inequalities. Examples of egalitarian approaches are in the Americans with Disabilities Act (Orentlicher, 1994), "affirmative action" social policies, and Medicaid programs that assist the poor.

Applying an egalitarian viewpoint to health care, Daniels (1985) has argued that health is so vital to equal opportunity that as a matter of justice, access to health care should be distributed to everyone as equally as possible. Dental disease is the most common, chronic condition of childhood, and lack of dental care in childhood and loss of permanent dentition can have life long consequences. For all these reasons, dental care should be part of any basic health care plan for children.

However, a pure egalitarian approach that accepts a societal obligation to redress inequalities from biologic or social lottery can also bankrupt a society, since there are many for whom enormous expenditures would still not restore their equality of opportunity, such as those with severe craniofacial conditions.

Utilitarian. A utilitarian approach moderates this tendency and considers "the greatest good for the greatest number of people" (Brock, 1982; Mill, 1863/1957). It is focused on populations rather than individuals and adopts a consequentialist approach. Cost-benefit driven approaches (Kaplan, 1993), QALYS, and outcome assessments reflect the utilitarian influence in public health and policy. Utilitarians favor preventive strategies and early interventions, and for this reason they generally favor services for children. Such approaches would favor dental health interventions such as water fluoridation and other prevention strategies (American Association of Public Health Dentistry et al, 1992).

There is inconsistency in our accepting responsibility for the elderly with the Medicare entitlement and our failure to do likewise for children.

It extends beyond parents and includes all who see the needs of children—health professionals, teachers, policy makers, and the public. There is inconsistency in our accepting responsibility for the elderly with the Medicare entitlement and our failure to do likewise for children.

Children Are Different: Evident in the preceding discussion is the fact that children are different from adults and that these differences are morally relevant (Mouradian, 1999a). These differences are always taken into account when we make medical decisions *in the best interests* of the individual child. Likewise a best interests standard should inform health policies: ultimately every policy reduces to what happens to a particular child at a particular time. A system of care in the best interests of the child will explicitly recognize how children are unique and use these differences as a guide to rational policy making (Jameson & Wehr, 1994; Stein, 1997). These differences include: (a) The vulnerability and dependency of children, (b) their incompetency in medical decision-making, (c) the importance of the environment children grow up in, (d) their constantly changing bodies and minds, (e) the epidemiology of childhood disease, and (f) children's position at the beginning of the life span.

Children's rates of biological, cognitive, and behavioral changes exceed those of any other stage in life, making them uniquely susceptible to a host of biological and social influences — prenatally and postnatally — including everything from environmental toxins to peer pressure. Environmental factors are important in all life stages, but are especially important for children because of their vulnerability and the

families and communities must be considered in our clinical decisions and policies. Children are subject to a large number of diverse and relatively rare chronic conditions that differ from adult pathology (with the notable exception of dental caries which is both chronic and common and exists in both age groups). Finally, there is maximal chance for education and disease prevention in childhood, and thus such interventions are important for economic as well as humanitarian reasons. It is critical that health policy makers understand the implications of these differences and children's developmental trajectories. These factors make clear the need for child-specific definitions of medical necessity.

Justice

The preceding arguments draw upon the principle of beneficence, the best interests standard, and the uniqueness of children to support special consideration for children in the delivery of health services. Our common notions of social justice also strongly support provision of medical and dental services to all children. Although different conceptions of justice exist in our pluralistic society, Kopelman and Palumbo (1997) have demonstrated that three major theories of justice support special consideration for children: egalitarian, utilitarian, and libertarian.

Egalitarian. The approach to justice that most closely addresses issues of disparities in access to health care and health outcomes is an egalitarian approach. According to Rawls (1971), any rational person not knowing his or her future would want to live in an egalitarian society, since arrangements in an egalitarian

Failure to provide such services increases costs of care and need for emergency room and hospital based services (Barsley, Sutherland, & McFarland, 1999; Mansky, Cohen, & Hooper, 1998; Unkel et al, 1997).

However, our quantitative utilitarianism requires some cautionary notes. Such an approach is highly rational and data driven, and it risks ignoring what clinical care has always known: that statistics gleaned from outcome studies do not perfectly predict individual patient outcomes. Also, our current approaches tend to ignore social determinants of health by focusing on intervention-oriented cost-benefit analyses (Wilkinson, 1996). Such an approach also ignores the uncertainties inherent in medicine, as well as the human and emotional elements of care. It does not allow for differences in patient outcomes that may relate to other variables such as quality relationships, including the physician-patient relationships. The current run to alternative medicine tells us that many of us believe our health can be benefited by elements more intangible than statistical analyses.

While it would be a mistake to leave behind all that science and rational analyses have to offer, we must subscribe to utilitarian approaches with caution. "Act utilitarian" approaches might also favor ignoring those few individuals with the most severe health problems, such as children with birth defects and developmental disabilities, in favor of cost savings for the majority. However, "rule utilitarians" would argue that there is more utility in a position that supports health care for all children than in one that singles out certain high cost children for exclusion based on cost efficiencies for the whole (Kopelman & Palumbo, 1997).

Libertarian. Our current health care system — especially the dental delivery system with its dependence on the small business model — largely reflects the libertarian position that health care should be rationed by ability to pay and personal choice (Kopelman & Palumbo, 1997). The dentist is one who through personal initiative and discipline has earned the right to offer dental services; patients have a right to seek care from

whomever they want and can afford (Nash, 1993). Social benefits are distributed on the basis of individual merit and contribution of effort, not on the basis of need or for the common good. Redistribution of income is unjust; per-

All dentists and physicians treating children should be aware of the special ethical and legal issues that arise when patients are minors.

sonal liberties and private property are the overriding values.

A libertarian approach accepts inequalities from social or biologic lottery as unfortunate, but not unjust (Kopelman & Palumbo, 1997). Charity is desirable, but not enforceable. This system of care disadvantages children, who are the poorest group by age and who cannot make their own choices. (The National Center for Children in Poverty webpage reports that 22% of children live in families subsisting below the federal poverty level, compared with about 10% of adults and elderly over 65 for 1997.) Yet libertarians may allow for a safety-net system for children whose parents cannot provide for them (Orentlicher, 1994).

Children's Access to Oral Health Services Under a Libertarian Model: Children's access to oral health services will be particularly affected by the current dental delivery system that rations care by fee-for-service/ability to pay and personal choice. Private practitioners operating on a small business model deliver the majority of dental care. Small businesses may be less able to absorb costs of non-paying patients and low Medicaid reimbursements or to engage in cost shifting. The lack of employer-based dental coverage and current definitions of medical necessity that exclude most dental-related conditions further decrease access to dental care (Conway, 1995). Since children are the poorest group by age, they would be expected to suffer disproportionately under a dental delivery system that rations by ability to pay.

Oral health services will also be disproportionately affected by a system of care that rations by personal choice. Because oral health is out of the mainstream of medical care, parents, medical providers, and the public do not always

appreciate its importance. Consequently oral health may be excluded from family budgets and from public health programs when resources are in short supply. Since children are unable to make choices for themselves, they will also suffer disproportionately in a system rationing by personal choice.

Thus it is not surprising that many children cannot access needed dental care in a system that approximates a free market (libertarian) model. The conflict between the professional's self-interest and a commitment to help those in need, evident throughout the health care system, is clearly seen in a delivery system that rations services by ability to pay with a "usual and customary rate" that is beyond the reach of many families or publicly allotted funds. Under such a philosophy, private charity must fill the gap and provide needed dental care for vulnerable children. In reality charitable outreach is not sufficient to meet the needs of a significant number of children.

Health Markets and Free Markets: It is often cited that the way to bring down costs is by increasing competition, relying on free market models. The "free market" strategy is appealing — since it has worked so well in so many areas and has contributed to our unprecedented prosperity. But it has not been a successful strategy in the health care system: many Americans lack health insurance while runaway costs still threaten to bankrupt us. Free market models cannot deliver affordable health care to all.

Insights as to why health care is such an inefficient market come from classic

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economic theory. Such classic economic theory was applied to health care markets by Kenneth Arrow (Arrow, 1963), and recently to pediatric care by Kopelman and Palumbo (1997). For efficient operation, markets require three things: (a) prices of goods must be determined in a competitive environment, i.e., by supply and demand; (b) all consumers must have access to all relevant information about the quality and utility of available items; and (c) all costs and benefits from transactions must accrue to the consumers and producers. The efficiency of markets varies directly with the degree to which these three necessary conditions are fulfilled. To the extent that these conditions fail, so does the efficiency justification for using market prices to determine how items are purchased and sold.

Our current health care system does not fulfill these requirements (Kopelman & Palumbo, 1997), as a few examples suffice to demonstrate. For example, when there are too many clinics, hospitals, and doctors — prices may not go down, but more procedures may be done, even aggressively marketed. Second, despite increase in consumer knowledge today, patients will never be fully informed about all the important aspects of the care they are purchasing. In addition, the need for individual health care is highly unpredictable, but indispensable when necessary. In this way health care needs differ from more predictable needs such as for food, clothing, and shelter, on the one hand, and expendable luxuries on the other. Finally, we are often not responsible for our health and illnesses, and costs and benefits may accrue to others beyond consumers and producers. We may get ill because we sit next to someone who is sick; or sustain injuries because a careless driver hits us. Likewise the costs and benefits of health care may accrue to systems outside of providers and consumers, such educational, social/welfare, and criminal justice systems.

The decision to rely on free market strategies for pricing of health care is not justified by economic considerations. Rather, it reflects an underlying commit-

Child-Specific Definitions of Medical Necessity

Children need a different kind of health care than adults (Jameson & Wehr 1994; Mouradian, 1999a, Stein 1997). Such child-specific definitions of medical necessity should include:

- Timely and appropriate medical and dental care
- Preventive care and anticipatory guidance that includes oral health
- Primary care medical and dental providers knowledgeable in the different conditions that afflict children and their interaction with development
- Attention to behavioral and developmental issues
- Attention to family circumstances and concerns and coordination with "wrap-around" services
- Access to tertiary care and pediatric specialists when needed
- Interdisciplinary team care for the child with a special health care need

ment to libertarian traditions, and makes clear just how deep is the conflict between our dual commitments to self-interest and compassionate care. Self-interest is not an adequate moral principle when those in need are denied beneficial health care. It is not an adequate moral principle when health care interventions can have harmful side effects. It is not an adequate moral principle if not balanced by a profession's commitment to individual patients and to the public as a whole.

Professional Ethics: Beyond protecting an individual patient's interests, it can be argued that dentists and other pediatric providers have a positive obligation to help ensure that all children have access to oral health care. First, in a general sense they have an obligation to act in the public good, in view of the public contribution to the funding of graduate medical education (Jecker, 1991), and an implicit contract to serve the public good. This obligation is not just an altruistic or gratuitous gesture on the part of professionals (Nash, 1984). Rather, this is required by the implicit "covenant" with

the public (May, 1977; 1984). Under this arrangement doctors are granted the right to "practice" on patients (licensure) and the right to self-governance. In return professionals makes a commitment to serve the public good and fulfill their obligations faithfully. Advocacy on behalf of the public's health can be construed to be part of that covenant. In addition, dentists and physicians serving children are in the best position to know what children require in the way of oral health care, and this special knowledge creates a special obligation to speak out on behalf of children's unmet health needs.

As the ADA Code of Ethics articulates, considerations of justice call for "the dental profession [to] actively seek allies throughout society on specific activities that will help improve access to care for all" (American Dental Association, 1998, p. 1).

Communitarian. This leads to the fourth approach to justice, a communitarian perspective, which regards principles of justice as pluralistic, deriving from diverse communities and values (Beauchamp & Childress, 1994; Chambers, 1996; 1999).

Such approaches emphasize the common good, communal customs, and cooperative virtues, and they avoid an emphasis upon abstract principles and individual rights. These positions emphasize the responsibility of the community to the individual and the individual to the community. A communitarian approach is found in this statement from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research (Quoted in Beauchamp and Childress, 1994):

The depth of a society's concern about health care can be seen as a measure of its sense of solidarity in the face of suffering and death. ... A society's commitment to health care reflects some of its most basic attitudes about what it means to be a member of the human community.

Although communitarian approaches are diverse, the emphasis upon caring for members of the community would require healthcare for children and might even prioritize them in circumstances of fiscal scarcity (Callahan, 1992). This approach would acknowledge that children are our most precious resource and the guarantee that society will have a future.

The Medicare entitlement for the elderly is a communitarian approach in a limited sense — a commitment to care for a part of our human community — but it is lopsided to one end of the spectrum where chronic illnesses and increasingly sophisticated and costly life prolonging technologies bite the majority of the health care budget. At the other end of the age spectrum, the good news is that health care for children costs relatively little — even basic care for all children, and a bigger investment up front would mean less costs down the line. That we fail to reach consensus on rational and compassionate policies to provide all children with health care may be a reflection of the tension between parental rights and societal obligations. Or it may just reflect that fact that children do not vote.

Summary and Conclusions

A rich tradition of medical ethics exists, and is as relevant to dentistry as it is to

medicine. All major theories of justice and arguments from beneficence support a societal commitment to provide basic health care for children. Such basic care should include needed oral health services. Child-specific definitions of medical care recognize the uniqueness of

workers, and society's interests in protecting itself by minimizing ambient illness. There are indeed many reasons why universal health care is in everyone's best interests (Churchill, 1994).

Articulation of important areas of moral agreement may help promote

In reality charitable outreach is not sufficient to meet the needs of a significant number of children.

children and provide a guide to policies "in the best interests" of the child. Professionals caring for children are in the best position to understand their health needs, and they have an obligation to advocate for improved access to health care for all children. There is a tension between parental rights and our societal obligations to children that complicates advocacy efforts. Children's oral health issues must be addressed in the context of their overall health and well being and the values of the society in which they live.

Our current health care system has been dominated by a fee-for-service libertarian approach that rations care by ability to pay and personal choice. This approach disadvantages children in particular and the provision of dental services in general. Although a free market approach to provision of health services is often advanced on economic grounds, analyses demonstrate that health markets do not fulfill criteria for market efficiency. A decision to maintain free market approaches in delivery of health care is a moral choice, not an economic one (Kopelman & Palumbo, 1997).

The current libertarian dental delivery system has impeded poor children's access to needed dental services. Safety nets or entitlements, in addition to charitable outreach, must supplement libertarian approaches. Since altruism has not been a sufficient motivating factor, appeals to self-interest may be more effective. These arguments would stress the cost effectiveness of early intervention and disease prevention, the economic benefits of children growing into healthy

universal health care for children. Although different philosophical positions will advance different solutions to the problems of children's access to health care, this consensus from a wide variety of ethical positions and arguments can lead us to a broad, non-partisan commitment to work on the problems until answers are found. Effective solutions will always be multidisciplinary and collaborative given our pluralism, the nature of children, differences between families and communities, and the wide variety of systems serving children. To the extent that these contextual issues are ignored, effective solutions to children's oral health problems cannot be created.

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Children's Oral Health Activities of the Department of Health and Human Services

Donald A. Schneider, DDS, MPH

Abstract

The federal government's primary roles are to promote oral health through public health interventions, finance care for low-income populations, assure oral health infrastructure and capacity, promote improvements in oral health services, and track the oral health of the American people. Examples of such initiatives are provided.

As described elsewhere in this issue, pain attributable to dental caries appears to be more incapacitating for the nation's children than is commonly perceived. Dental pain affects a child's ability to speak and creates distractions that may limit learning at critical periods in a child's development (Edelstein, 2000). Chronically poor oral health is linked with failure to thrive in toddlers and with compromised nutrition in young children (Acs, Lodoline, Kaminski, & Cisneros, 1992).

The reported concentration of dental pain among low income children is consistent with data describing the prevalence of dental caries and untreated decay. Children below 200% of poverty

have substantially more dental disease, and more untreated dental disease, than those above the 200% poverty level. Mexican-American and African-American children are about twice as likely to experience caries, and have higher levels of untreated caries than their non-Hispanic white counterparts (Vargas, Crall, & Schneider, 1998). The National Institute of Dental and Craniofacial Research (NIDCR) reports that 80% of tooth decay is experienced in only 25% of children (Kaste et al, 1996), with the most untreated disease occurring in those of low income. In certain populations, such as American Indian and Alaskan Native children, early childhood caries has been found to be an especially significant public health problem (Bruerd & Jones, 1996). High rates of dental caries also have been reported for Head Start children.

In April 2000, the General Accounting Office (GAO), the investigative arm of Congress, issued a report on oral health which reviewed dental health status and utilization data from four national health surveys and a survey of State Medicaid agencies (U.S. General Accounting Office, 2000). The report confirms that dental disease continues to be a chronic problem among many low-income and vulnerable children and adults, and that disparities

between low-income and more affluent populations exist despite coverage of dental services under Medicaid and the State Children's Health Insurance Program (SCHIP).

The disparities in oral health status and dental access between those of low income and their better-off counterparts are of major concern to the Department of Health and Human Services (DHHS). The DHHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes eleven operating divisions that manage more than three hundred programs covering a wide number of activities, including activities with potential for reducing dental pain.



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Summary of Recent Initiatives Sponsored by the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA)

- **Medicaid Concerns:** The agencies sought to highlight Medicaid dental program concerns and pediatric oral health as significant public problems by convening, in 1998, a major national conference on pediatric oral health that involved policy makers, care providers, government, and advocates. This conference stimulated creation of the HRSA-HCFA Oral Health Initiative and stimulated widespread policy activity within the professions and government (Spisak & Holt, 1998). A year later, HRSA and HCFA actively participated in a follow up conference on Medicaid/SCHIP dental issues sponsored by the American Dental Association (American Dental Association, 1999).
- **State Summits:** Supporting state dental "summits" that provide the opportunity for state level players to meet on a face-to-face basis to develop state-specific strategies and implementation plans to overcome existing dental access barriers.
- **Communication and Technical Assistance:** Establishing a range of electronic and face-to-face communications opportunities for state dental program managers to share common concerns and learn from one another about evaluating and revising dental programs .
- **Building Expertise:** To assure that states have ready access to authoritative information on Medicaid/SCHIP dental programs, HCFA has identified and trained a point person in each of the DHHS regional offices around the country. In conjunction with a HRSA public health dentist and an Academy of Pediatric Dentistry-appointed dental practitioner, regional teams support state efforts to improve publicly funded insurance programs for low income children.
- **Exploring Ways of Reducing Disease in Low-Income Children:** Initiating a multi-agency demonstration project which seeks to demonstrate that innovative management of early dental decay in young children can improve health while reducing treatment costs.
- **Accountability:** Revising the EPSDT/State reporting system, effective April 1, 2000, to clarify the types of services delivered to children and help assure that comprehensive care is provided and developing, with the National Committee for Quality Assurance, more refined performance measures to help assure that Medicaid dental managed care programs are accountable for service delivery.
- **Policy Review:** Revising the AEPSDT/Medicaid Dental Guide to reflect current dental practice and supplement policy guidance provided in HCFA's State Medicaid Manual and engaging a HCFA "Technical Advisory Group" to address technical problems within the Medicaid program.
- **Toolbox:** Developing an Internet based "state toolbox" (<http://www.hrsa.gov/oralhealth>) designed to provide information to states, Medicaid officials, advocates, dental societies, and other stakeholders interested in stimulating Medicaid reform or improving Medicaid dental performance. The state toolbox will include: (a) actuarial models for states seeking to plan financing of dental care for children under Medicaid and SCHIP; (b) interactive geographic mapping software to assist states in planning/targeting their needs for and distribution of dental resources; and (c) workforce models to help address a state's questions about general and dental health manpower needs and distribution.
- **State Dental Officials:** HRSA is assisting states in establishing or rebuilding their state health agency dental public health programs by detailing federal dentists to states.
- **Service Delivery:** Expanding HRSA's Community and Migrant Health Center dental programs by targeting communities that treat low-income and disadvantaged populations, including migrant, homeless, and at-risk minority populations.
- **HRSA's National Health Service Corps Scholarships:** Reinvigorating the dental NHSC Scholarship program in order to increase the number of minority and culturally competent providers who work in underserved communities.
- **Community Development and Sealant Grants:** HRSA is funding programs that help localities integrate oral health services with other services being provided for high risk children, including provision of sealants through school programs that also link children to comprehensive dental care.
- **Policy Center:** Establishing an oral health policy center to facilitate analysis and dissemination of information about oral health and to enhance communication between HRSA's Maternal and Child Health Bureau and various governmental, professional, and private organizations.

DHHS Oral Health Directions

In addressing oral health disparities, two important documents will provide the department and the nation with a clear road map for activities over the next decade. The first document is the recently

additional work required to assure that disadvantaged populations achieve the same health improvements as the general population. Eleven of seventeen oral health objectives relate directly or indi-

the department's response to the April 2000 GAO report on oral health. A selected number of these initiatives are summarized.

The DHHS includes eleven operating divisions that manage more than three hundred programs covering a wide number of activities, including activities with potential for reducing dental pain.

released *Report of the Surgeon General on Oral Health in America*. In her introduction, Donna E. Shalala, secretary, DHHS, notes that the "report addresses the inequities and disparities that affect those least able to muster the resources to achieve optimal health." The report concludes by offering a framework for further action, emphasizing the need to build partnerships and facilitate collaborations that will enhance education, service, and research and eliminate barriers to care.

Although the entire human life span is addressed in the Surgeon General's report, special emphasis has been placed by DHHS on children's oral health and access to dental services. To better address children's needs, the Surgeon General convened a Workshop on Children and Oral Health on March 19-20, 2000 and a major national conference on children's oral health issues on June 12-13, 2000. The results of both the workshop and conference, when compiled and published, will help to inform the department and the public as to appropriate responses necessary if all children are to have improved oral health.

The department also has just released a second document directing attention towards oral health disparities: *Healthy People 2010*. This report includes health and oral health objectives to be achieved by the nation over the next decade. Like the Surgeon General's report, *Healthy People* applauds the substantial gains accrued in oral health, while spotlighting the

rectly to children's health status and access.

The department's Office of the Secretary is seeking to engage the nonfederal sector in joining with the department in addressing oral health issues. On June 28, 2000, the Office of the Secretary convened an Oral Health Leadership Meeting, bringing together representatives of foundations, businesses, the health professions, academe, the public, and state governments. The purpose of the meeting was to raise awareness of disparities in oral health status and in dental care, charge the nonfederal sector to play a key role in problem solving, and encourage the formation of an ongoing, nonfederal Oral Health Working Group which will develop new strategies to advance oral health. Additionally, the Office of the Secretary plans to sponsor a Federal Partnership Workshop on Children and Oral Health to foster intra-agency and inter-departmental cooperation in eliminating oral health disparities among children.

Operating Division Initiatives

While the Surgeon General's activities and *Healthy People 2010* are critically important initiatives, the department, through its operating divisions, has been developing additional programmatic efforts to address oral health disparities. Those recent initiatives, both under way and planned, as well as inter-division collaborative strategies, are described in detail in

The Administration for Children and Families (ACF)

ACF is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities, including the Head Start program. In 1999, a partnership for oral health was formed between the Head Start program, the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB), the Health Care Financing Administration (HCFA), and the Department of Agriculture's Supplemental Food Program for Women, Infants, and Children (WIC).

This partnership commissioned three scientific papers about current evidence-based oral health practices and guidelines related to nutrition and oral health, prevention of caries, and access to care for young children. These papers were the focus of a September 1999 Head Start and Partners Forum on Oral Health which brought together Head Start staff and parents, representatives from sponsoring agencies, and child advocacy groups. The ACF is planning a national oral health education campaign that will disseminate to Head Start programs and families key information presented at the forum. ACF plans to encourage states to further study access to care, establish oral health coalition round tables to address local access problems, and replicate the forum at regional and state levels.

Agency for Healthcare Research and Quality (AHRQ)

AHRQ was established in 1989 as the Agency for Health Care Policy and Research. AHRQ is the lead DHHS agency for supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHRQ's programs bring practical, science-based information to health practitioners, consumers, and health care purchasers. AHRQ, in conjunction with

Children's Oral Pain

the National Institute for Dental and Craniofacial Research, currently supports a dental evidence-based practice center which considers dental care issues such as caries management. AHRQ also will be working with NIDCR to explore opportunities for expanding the field of dental health services research, continuing the dental scholar program with the American Dental Education Association, and expanding training opportunities through National Research Service Award programs. Through its grants programs, AHRQ also will be conducting and promoting oral health services research that can address issues that underlie the oral health disparities that result in dental pain in children.

Centers for Disease Control and Prevention (CDC)

CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC monitors the nation's oral health by conducting periodic assessments of oral health status, trends in oral diseases and access to oral health services, and by evaluating prevention and control interventions. CDC collects, analyzes, and disseminates data related to oral health through several national and state-based mechanisms such as the National Health and Nutrition Examination Survey. These studies pertain directly to children's experience of dental pain by pinpointing high risk populations so that public resources and programs can be well targeted to reach those with greatest need. Other CDC activities that can address high risk child populations include:

- **Prevention:** Increasing access to preventive dental services, such as dental sealants, through school-based or school-linked approaches.
- **Fluoridation:** Improving access to optimally maintained community water fluoridation.
- **Purchasing Specifications:** Developing Medicaid managed care purchasing specifications and contract language to help states assure that children covered by Medicaid managed care are

offered the full range of dental services mandated by Medicaid.

- **Special Populations:** Funding demonstration projects and research focused on special populations including a variety of data collection and analyses, health communication, and intervention projects.

Health Care Financing Administration (HCFA) and Health Resources and Services Administration (HRSA) Joint Activities

HCFA is responsible for the administration of Medicaid, SCHIP, and Medicare. Comprehensive dental services for low-income children are a required component of Medicaid through its Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service. Although dental services are optional in SCHIP, all but one of fifty-six states and territories include or plan to include substantial dental benefits for most eligible children. HRSA, the federal access agency, directs national health programs that seek to improve the health of the nation by assuring quality health care to underserved, vulnerable, and special-needs populations, and by promoting appropriate health professions workforce capacity and practice.

Given their conjoined interest in access, HCFA and HRSA have established a joint Oral Health Initiative (OHI) directed at resolving barriers to oral health access in Medicaid and SCHIP. The initiative recognizes that care delivery cannot be addressed independently of care financing. HCFA's Medicaid and SCHIP programs are administered by states within broad federal guidelines. HRSA's programs are similarly delivered within states and communities. Both HCFA and HRSA therefore believe that solutions to oral health disparities are best generated at local and state levels. The agencies seek to provide resources, guidance, and technical assistance necessary to enable states and localities to better address their local oral health concerns. These OHI activities have been conducted jointly by the two agencies or one of the agencies

has taken the lead role with the other participating as a key collaborator. Some activities are shown in the side bar.

Indian Health Service

IHS is the principal federal health care provider and health advocate for American Indians and Alaska Natives. Its goal is to assure that comprehensive, culturally acceptable health services are available and accessible to target populations. In 1999, the director of IHS developed an oral health strategy to increase access to essential treatment and preventive oral health services and improve native peoples' oral health status. Recent ongoing and planned activities include building the IHS dentists cadre, assessing the oral health of Native Americans, increasing availability of fluoridated water, developing oral health support centers, targeting early childhood caries, and creating a national coalition effort to support and promote oral health services for Native Americans.

National Institutes of Health/ National Institute of Dental and Craniofacial Research (NIH/NIDCR)

NIDCR supports a wide range of basic, translational, clinical, and epidemiologic research designed to document and understand the factors involved in the existing disparities in oral health, as well as to support the development, testings, and evaluation of interventions to reduce oral health disparities. Selected activities supported by the NIDCR include:

- **Disparity Research:** Supporting grants such as the "Centers for Research to Reduce Oral Health Disparities" that are directed toward understanding the reasons for health disparities and addressing minority oral health issues through both research and research training.
- **Data Resources:** Initiating a data resource center with a five-year goal of generating a catalog of existing databases relevant to oral health, acquiring pertinent databases, and establishing

Internet access to these databases for research.

- Clinical Management: Convening workshops to assess the state-of-the-science for specific diseases, including the "Workshop on Developing Criteria for Diagnosing Early Childhood Caries," in April 1999 and sponsoring, in 2001, a "Consensus Development Conference on Diagnosis and Management of Dental Caries Throughout Life."
- Developing a national oral health curriculum designed to teach six-to-eight-year-old children essential concepts of oral health.

low-income, minority, special needs, and otherwise vulnerable children, programs must be continually evaluated for effectiveness and revised as better options and new knowledge becomes available. Such evaluations are often difficult to accomplish. State-level data on oral health status and access may be lacking, the length of time between action and results may be insufficient to assess affects, and implementation of multiple, concurrent innovations at the local, state, and federal levels make it difficult to

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The department's Office of the Secretary is seeking to engage the nonfederal sector in joining with the department in addressing oral health issues.

Discussion

The activities summarized in this paper are not intended as a complete inventory of the dental programs and projects for which the DHHS is responsible, nor do they represent the full range of day-to-day oral health program functions carried out in the department. Rather, they are offered as a snapshot of activities that the DHHS has created in response to continuing concerns about children's oral health, their access to dental care, and the elimination of their dental pain. As is evident from a review of these programs, the federal government's primary roles are to promote oral health through public health interventions, finance care for low-income populations, assure oral health infrastructure and capacity, promote improvements in oral health services, and track the oral health of the American people.

It is difficult to know the extent to which the programs noted here are resulting in improved oral health outcomes and access. Of forty-four state Medicaid agencies responding to a 1999 survey, almost all report undertaking multiple, recent activities intended to improve dental access for Medicaid beneficiaries (Nagy, 2000). For the department's efforts to be successful, however, especially in regard to

tease out the impact of a single variable, thereby hindering elucidation of "best program practices" and delaying science transfer. Enhanced data collection and evaluative health services research are among the most vital elements for assuring progress in this area.

As noted in the Surgeon General's report, if America is not just to reduce, but to eliminate oral health disparities and dental pain, it will require "the collective and complementary talents of public health agencies, private industry, social service organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens." Through oral health programs across its various agencies, the federal government plays a critical role in bringing the plight of underserved children to the attention of the public and addressing their needs so that children need no longer suffer the pain of preventable disease.

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How Federal and State Policy Can Alleviate Children's Oral Pain

Raymond Rawson, DDS, FACD, and Daniel M. Fox, PhD

Abstract

The issues faced by state-managed dental programs for children are complex. A voluntary group of senior legislators and officials from the executive branches of more than forty states has studied the problem and developed a four-level plan. The program has been modeled against existing cost and idealization data and appears to offer an effective alternative to current plans.

Although millions of children are eligible for dental care through Medicaid, this program has not secured their oral health. The officials implementing the new State Children's Health Insurance Program (SCHIP), enacted by the U.S. Congress in 1997, seemed likely to replicate the Medicaid experience. Therefore, one of us (Rawson), who is a dentist and dental educator as well as a state legislator, called this deficiency to the attention of the Reforming States Group (RSG), a voluntary association of senior legislators and executive branch officials from more than forty states. The RSG leadership agreed to convene a work group of dentist-legislators from several states,

other legislators, and experts on dental care for children to explore how both Medicaid and SCHIP could serve the oral health needs of children in low-in-

tempting to understand the elements contributing to this epidemic problem and to determine what would realistically be required to adequately treat twenty

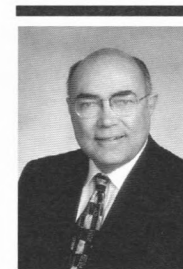
Many dentists see Medicaid and SCHIP patients as having more difficult dental problems.

come families in ways that were cost-effective and sensitive to the norms and standards of the dental profession.

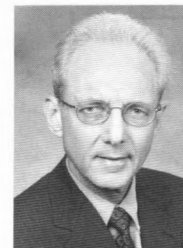
The work group realized that it needed to communicate to policy makers the seriousness of the problem it was considering. Dental caries is the most prevalent chronic childhood disease. A full 50% of first-grade children and 80% of 17-year olds suffer from this disease. Most disturbingly, 80% of tooth decay is found in 20% of the population. It is estimated that there are 41 million restricted-activity days every year in the United States due to pain and infection caused by dental caries. In addition, children miss 52 million school hours each year in the United States for the same reason.

Prior to considering possible solutions to these enormous problems, the work group spent significant time at-

tempting to understand the elements contributing to this epidemic problem and to determine what would realistically be required to adequately treat twenty million poor children in the United States.



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Copies of the Reforming State Group report on children's oral health can be obtained from the Fund at 645 Madison Avenue, New York, NY 10022 mf@milbank.org

The reasons for lack of access are complex and varied. It has been suggested that there is a low reimbursement rate at the heart of the problem. Low reimbursement that also requires complicated paper work reinforces many dentists' distrust for government and its programs. Other factors contributing to the problem were poor education of patients, disruptive behavior by children, and a high "fail to show" rate.

Moreover, dentists have competing pressures that make them unsympathetic to the socioeconomic reasons that children fail to keep appointments. They un-

derstandably consider it expensive to schedule their time for appointments, and then not have children to treat. In addition, many dentists perceive that they are more likely to be sued by Medicaid and indigent patients. In sum, many dentists see Medicaid and SCHIP patients as having more difficult dental problems: which they do, many of them having never been seen by a dentist.

derstandably consider it expensive to schedule their time for appointments, and then not have children to treat. In addition, many dentists perceive that they are more likely to be sued by Medicaid and indigent patients. In sum, many dentists see Medicaid and SCHIP patients as having more difficult dental problems: which they do, many of them having never been seen by a dentist.

Pain is a signal that we are going to damage these children's nutrition, education--indeed their development as productive human beings.

derstandably consider it expensive to schedule their time for appointments, and then not have children to treat. In addition, many dentists perceive that they are more likely to be sued by Medicaid and indigent patients. In sum, many dentists see Medicaid and SCHIP patients as having more difficult dental problems: which they do, many of them having never been seen by a dentist.

The members of the work group judged Rawson's first-hand experience in Nevada as a stark example, if a somewhat extreme one, of the national problem. In 1997, the Nevada legislature found that only six dentists in the whole state provided dental care to children eligible for Medicaid. Probably less than 20% of all eligible children received any services at all. The legislature found this situation unacceptable and adjusted the pricing on major diagnostic groups to allow adequate payment to those dentists willing to accept Medicaid patients. As a result of those efforts, the number of dentists willing to treat Medicaid patients increased to approximately 20% of the licensed dentists in the state.

Unfortunately, the number of children being treated is still below 30%. Nevada legislators and their staff estimated that 60% of the money spent on

and mimics private insurance programs in all of its substantial features. The model program was designed with variability factors so that costs could be controlled through four levels of dental treatment needs.

The RSG, with assistance from the Milbank Memorial Fund, a national foundation that has worked in health policy since 1905, engaged the firm of PricewaterhouseCoopers (PC), to perform an actuarial study to validate the presumptions of the model program. PC developed an interactive model based on the experiences of over a billion treatment claims in the California Medicaid (called DentiCal) program, where dental fees had been raised under court order to approximately 60% of what was usual and customary. This model was then compared to data from HEDIS and from Medicaid dental services in Oregon. The RSG found from this analysis there is evidence that well-designed plans can assure coverage of value for a price that would require an expenditure (through insurance or other mechanism) by the state and federal government in collaboration of approximately \$14 per child per month.

The CHIP dental program in western Pennsylvania also provided corrobora-

rating evidence. This program is modeled on commercial dental insurance. The program has increased to 64% the number of eligible children treated and increased to 86% the number of children with a regular source of dental care.

Michigan's MICHild Dental Plan, which provides up to \$600 per child per year, also offered encouraging evidence in point. Officials of that state report that 85% of Michigan dentists participate in the plan; 95% of children enrolled in the plan have their dental needs met.

The plan described by the RSG reasoned that there should be a stratification of care in four levels:

- Level I provides for diagnostic and preventative services, and requires no pre-authorization for enrolled patients.
- Level II provides for basic restorative care up to \$400 in treatment cost and also does not require pre-authorization for enrolled patients. This would provide care for 80% of children without any hassle, and consume 25% of the available treatment dollars.
- Level III provides advanced restorative treatment between \$400 and \$1,000. This would provide care for 15% of children and consume 45% of the available treatment dollars. By requiring pre-authorization, it prevents potential over-utilization while allowing children with more serious dental problems access to the care they need.
- Level IV provides for catastrophic care above \$1,000. It would provide treatment for 5% of children and consume 30% of available treatment dollars. Work in Level IV should be performed by specialists, with whom the plan would contract, thus saving some expenditure through a discount for volume.

As noted above, the actuaries concluded that the cost of care in this four-level plan would be \$14 per child per

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month (PCPM) plus administrative costs. Moreover, the actuarial study produced a spreadsheet where some treatment vari-

care and 62% for restorative and palliative care.

There is evidence that well-designed plans can assure coverage of value for a price...of approximately \$14 per child per month.

ables can be changed (but not the division of care into four levels) and the price effects analyzed. If a state feels preventative treatments are more important (or that the plan is more generous than it can afford), it can analyze the cost of proposed changes. With state and plan administration expenses included, the total cost for the program is \$17 per child per month. Typically, state and federal governments share the expense at a 40:60 ratio. For budgeting purposes, states should assume that the plan would cost less than \$1 million each year for every 10,000 children.

For contrast, here are current examples of state expenditures:

- Connecticut currently spends \$7.13 per member per month (PMPM), with 38% of its treatment dollars expended for diagnostic and preventative

- Massachusetts spends \$6.08 PMPM with 49% of its treatment dollars expended for diagnostic and preventative care, and 51% for restorative and palliative care.
- Vermont spends \$6.45 PMPM with 38% of its treatment dollars expended for diagnostic and preventative care, 54% for restorative and palliative care, and 8% for orthodontic care.
- Nevada has recently authorized \$10.50 PMPM for dental treatment. Their plan will be administered through a capitated system organized by the new dental school.

Members of the RSG work group have been invited to describe and discuss this plan for organizing and financing dental care for children in low-income families all over the country. The Ameri-

can Dental Association featured the plan at a meeting of state dental leaders in the summer of 1999. About six months later, public affairs staff of many state dental societies began to advocate the plan, with the approval of the ADA.

More important, the dentist legislators in the RSG work group have been invited by their colleague legislators to discuss the plan in legislative hearings or officially sponsored meetings in various states: including, to date, Connecticut, Massachusetts, North Carolina, and Wisconsin. RSG visitors to Vermont learned that in his "state of the state" address, Governor Dean had reported that, "One sixth-grader, on his first dental visit ever, had six teeth pulled and was forced to miss a few days of school. When Principal Sue Maguire stopped by to visit the boy, he told her, "I never knew what it felt like not to be in pain..'"

Untreated dental disease in children is a nationwide problem. We have thrown significant resources at it, but ineffectively and inefficiently. We treat emergencies, sometimes; we prevent hardly ever; we do routine dental work on a random basis. As a result, millions of children are in pain and at severe risk of pain. Pain is the most obvious symptom; a signal that we are going to damage these children's nutrition, education—indeed their development as productive human beings.

How Foundations Can Help Fill the Gap in Oral Health

Malcolm V. Williams, MPP, and Lauren LeRoy, PhD

Abstract

Private philanthropy through foundations is in an excellent position to assist in meeting the needs of the nation's dentally underserved through stimulating initiatives and pilot projects and gathering and disseminating information. This report presents examples of this work in the areas of direct delivery of services, outreach and education, and water fluoridation.

Despite significant improvements in oral health since the 1960s, millions of Americans still suffer from preventable oral diseases ranging from caries to cancer. As the recently released *Oral Health in America: A Report of the Surgeon General* illustrates, dental caries is the most common chronic childhood disease, a significant number of elderly adults are edentulous or have severe periodontal disease, and thousands of Americans are diagnosed with and die from oral cancers each year. Moreover, oral health problems are more severe among low-income persons and racial and ethnic minorities.

While oral health has been relatively low on the list of public health priorities, there is growing recognition that it is a critical health issue. Diseases of the mouth can affect the ability to speak, chew, and swallow—a particular concern for growing children and frail seniors. Mouth diseases can also cause extreme pain, result in lost work and school days, and contribute to low self-esteem.

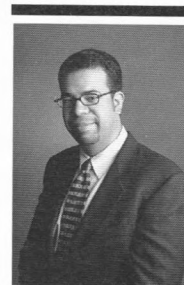
Unlike many other conditions, oral disease affects everyone, at every age. The size and complexity of the problem, combined with the relative lack of programs to address it, leaves the door wide open for both public and private initiatives. Rising to the challenge are many health foundations throughout the nation who — with their flexibility, resources, and community knowledge — recognize a unique opportunity to improve the nation's oral health, in a variety of ways.

The Problem and the Philanthropic Response

An important factor affecting oral health status is the lack of access to oral health services, particularly among minorities and low-income persons. Not only are oral health services poorly insured, but few dental providers serve the poor, and

many community-based preventive programs are often unavailable to substantial portions of the underserved. Additionally, millions of Americans do not have access to water containing enough fluoride to protect their teeth.

These factors have led to an increased awareness among foundations and the development of creative approaches to address oral health concerns. By their very nature, health foundations and corporate giving programs are particularly well-suited to help tackle this problem



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on the local, regional, and national levels. Their traditional missions have been to improve health, especially that of vulnerable groups and populations, and they are familiar with the needs of their local communities and constituencies. Most importantly, perhaps, they have at their disposal a number of tools for addressing different dimensions of the problem and the built-in flexibility to do so. In addition to their primary role of grantmaking, foundations can conduct policy analysis, collect and analyze data, commission studies and reports, convene meetings and forums, and launch public education programs and campaigns.

Grantmakers in Health (GIH) is working with the growing number of foundations that have begun to focus on the problems and importance of oral health. As an educational organization serving trustees and staff of foundations and corporate giving programs working in the health field, GIH draws attention to such emerging health issues and then helps foundations find their niches.

GIH also brings together grantmakers, policymakers, and other experts to showcase successful grantmaking models and to explore the special role foundations can play in improving access to oral health services. From this unique vantage point, we have identified some innovative programs that illustrate the depth and breadth of foundations' many responses.

Private Programs that Work

Because of the variances in asset size, geographic focus, mission, and community needs, each foundation or corporate giving program approaches the oral health problem differently. Some foundations focus on children and fund strategies to prevent the occurrence of dental diseases; others focus on the oral health of older adults. Among the strategies employed to date are:

- Funding of direct delivery of oral health services
- Education and outreach programs designed to promote personal oral hygiene
- Water fluoridation systems

- Multifaceted approaches that encompass more than one strategy

Direct Delivery of Services

Providing direct delivery of services to populations in need is one way foundations have contributed to the oral health of their communities. The California Endowment, for example, provided a grant to *Dientes! Community Dental Clinic* to expand its successful pilot program which provides free preventive oral health care to children of low-income families in Watsonville and the Pajaro Valley of California. Working with the Healthy Start Program, *Dientes!* currently provides free dental screenings and preventive visits to children at school sites, many of the children being sons and daughters of migrant workers, and typically lacking access to comprehensive medical and dental services.

With this grant, *Dientes!* will be able to both expand its services to children and increase the number of schools in the program. In addition to free screenings, services will include sealants, fluoride treatments, cleanings, and classroom dental education to children. The program will also add a preventive team to help serve the additional schools. With the added team, dental staff will increase time spent at each school as well as increase the number of children served. The program will also prepare local residents for careers in the dental field by offering training opportunities in the school's dental program and at the *Dientes!* clinic.

Also in California, John Muir/Mt. Diablo Community Health Benefit Corporation in Contra Costa County provided a grant to Parkside Elementary School to support a program of dental care and education for children, many of whom speak only Spanish, who have been identified with dental problems. Community dentists volunteer to attend to the needs of low-income and uninsured children, providing cleaning, repair, and extraction services. The grant allows the program to continue providing care to children and their parents, and to hire

a dental hygienist who will provide most of the cleaning services.

Other funders are committed to addressing oral health needs among the elderly. The Jenkins Foundation of Richmond, Virginia, for example, provided a grant to the Virginia Foundation of Dentistry for the Handicapped to provide free comprehensive dental care to elderly and disabled indigent patients. The Retirement Research Foundation provided a grant to Nova University, in Fort Lauderdale, Florida, toward a dental services program to serve nonmobile geriatric patients in retirement communities and to provide special training for dental students and professionals.

The Moses Cone-Wesley Long Community Health Foundation provided a grant to Access Dental Care to improve dental care for elderly residents of nursing homes, assisted living facilities, and group homes in nine communities in North Carolina. Under the program, two dentists, a dental hygienist, and a dental assistant will serve twenty facilities, providing twenty-four-hour emergency coverage, and helping facility staff deliver daily preventive oral hygiene. Partners in the project include the Piedmont Triad Area Agency on Aging, Guilford County Health Department, Guilford County Dental Society, and Greensboro Area Health Education Center.

Outreach and Education

Other foundations focus on providing education about the importance of preventive oral care. Through *Communities First*, The California Endowment funded the Comprehensive Health Center (CHC) to meet the challenge of improving dental health status for minority families in southeastern San Diego. Lay health workers, predominantly African-American and Latino, are trained to disseminate information and to encourage residents to make appointments for regular check-ups. CHC will partner with *Colaborativo SABER* to develop a unique dental health curriculum that is culturally relevant to African-American families, patterned after its effective Spanish cur-

riculum. Both will be used in the CHC dental health program.

The California Endowment also funded a rural oral health outreach project. Mono County Dental Task Force — a coordinated effort among local nonprofit, private, and public agencies — was awarded a grant to start up the Sierra Park Family Dental Clinic at Mammoth Hospital to educate local children and families about the importance of oral hygiene and to provide annual dental screenings in Mono County schools (K-12).

Other approaches to improve education include those of the Kansas Health Foundation and the Northwest Health Foundation. The Kansas Health Foundation supported a program to provide information about hygiene, nutrition, safety, dental health, and health and wellness screenings to students in kindergarten through third grade. The Northwest Health Foundation provided a grant to the Oregon Health Division to support the design of educational materials about early childhood cavities and effective prevention strategies and the distribution of these materials to targeted primary health care and dental providers.

Water Fluoridation

Access to fluoridated water is another important component of oral health. The per capita cost of water fluoridation over an entire lifetime can be less than the cost of one dental filling, making fluoridation a cost-effective although still controversial method of preventing dental disease. Several foundations have awarded grants for the development of fluoridation systems for their communities. The Kansas Health Foundation, for example, provided a grant to develop a partnership with the United Methodist Health Ministry Fund to provide technical assistance to communities in Kansas considering using fluoridation in their water systems. The Sierra Health Foundation and the St. Luke's Health Initiatives have also funded water fluoridation projects.

Multi-Faceted Approaches

Many foundations combine several approaches to improving oral health. Anthem Blue Cross and Blue Shield Foundation, a corporate foundation based in Colorado, for example, funds the *Shining Smiles Initiative*. *Shining Smiles* focuses on educating the public and policymakers on children's dental health issues, developing educational exhibits for children, disseminating commissioned papers on the subject, and creating a mobile dental clinic.

The Josiah Macy, Jr. Foundation funded a consortium of three dental schools (University of Connecticut, Columbia University, and University of Michigan) to assess the feasibility of teaching dental students and residents in a community setting instead of the traditional venue of the dental school clinic. The three schools hope to enlist senior dental practitioners from the community to serve as mentors and provide settings where training can take place. As an

children's access to care by simplifying the interaction between dentists and public agencies as well as by increasing the reimbursement to providers. For this project, a model dental insurance plan for children eligible for CHIP was devised and made available over the Internet. Officials and dentists in any state can use the model to change assumptions about reimbursement and the number of eligible children to calculate the approximate cost of the model plan for their state.

Sierra Health Foundation funds *bright SMILES*, an initiative started in 1998, which makes \$500,000 available to improve access to oral health services in twenty-six Northern California counties. In 1999, the California Endowment contributed \$1 million to the program, expanding its reach to six additional counties. Funding from *bright SMILES* is supporting dental sealants, fluoridation, prevention of early childhood cavities, school-based dental exams, primary

By their very nature, health foundations and corporate giving programs are particularly well-suited to help tackle this problem on the local, regional, and national levels.

added benefit, students will learn practice management as part of their training. By working in underserved areas, students can practice in a setting where patients frequently have serious dental problems, rather than in the more affluent clinic populations in whom caries and tooth loss have become increasingly rare.

The Milbank Memorial Fund, a foundation that supports research and policy analysis, copublished a report, *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments*, with the Reforming States Group (RSG) on a new approach to policy for state financing of dental care. The new approach attempts to improve

dental services, dentist recruitment, capital equipment, and clinic renovation.

The United Methodist Health Ministry Fund funds *Healthy Teeth for Kansans* which is a \$1.25 million campaign to prevent dental disease in Kansas through support of sealants for children, community water system fluoridation, and improved access to Medicaid dental services for children. The fund also provided a grant to the University of Kansas Health Services Research Group to study the reasons so few children on Medicaid in Kansas receive dental care each year. The study surveyed dentists, beneficiaries, advocates, and policymakers and developed recommendations for ways to improve Medicaid children's access to den-

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tal services. Over the last fifteen years, The Washington Dental Service has contributed millions of dollars to community projects, education programs, and research activities focused on oral health. For example, *The Cavity Free Kids* program is dedicated to eliminating tooth decay in children from infancy through elementary school age in Washington state. Through innovative projects and strategic partnerships, *Cavity Free Kids*

insurance (Arizona's Medicaid program) but the AHCCS dental benefit does not cover basic prevention and treatment for adults.

Finally, St. Luke's funded a public-private collaboration to undertake a public education campaign focused on fostering preventive oral health habits among children. Partners include: City of Phoenix Education and Youth Services, Phoenix Coyotes Goals for Kids Foun-

Foundations can conduct policy analysis, collect and analyze data, commission studies and reports, convene meetings and forums, and launch public education programs and campaigns.

links with oral health coalitions, dental care providers, and community organizations.

Based in Phoenix, Arizona, St. Luke's Health Initiatives has focused on oral health care under a broader access-to-care initiative. One of the priorities is to improve the oral health of Maricopa County residents by using community-based prevention, public and professional education, and innovative financing incentives.

The need for subsidized dental insurance was identified in St. Luke's community health needs assessment. In response, St. Luke's is also sponsoring a dental insurance pilot program conducted in partnership with the Arizona Department of Economic Security (DES), the Maricopa County Department of Public Health Services (DHS), and Delta Dental, a private insurer. DES staff determine eligibility, PHS staff provide overall program administration, Delta Dental put together a special insurance package, and St. Luke's pays for the program and an extensive evaluation. This pilot targets families living in Maricopa County who receive subsidized child care. Some of these families may be eligible for coverage by AHCCS

dation, Arizona Department of Health Services (Office of Oral Health), and Delta Dental. The campaign ran from April 1999 through July 2000 and included fun-filled and educational events to increase awareness among children and families about the importance of brushing and flossing, eating right, using mouth guards, and getting regular dental checkups.

Integrating Oral Health with Overall Health

Some foundations are integrating oral health services into their other health grantmaking programs. In 1998, the W. K. Kellogg Foundation launched *Community Voices*, a national initiative to improve health care access and quality in thirteen cities. The five-year program is intended to help ensure the survival of safety-net providers, to strengthen community support services, and to help educate the public and policymakers on the importance of improving health care to the underserved, through communications, research, and technical assistance. The Kellogg Foundation requires each of the learning laboratories to integrate oral health services into their other activities.

In California, the Sierra Health Foundation has integrated oral health issues into a broader range of programs, providing support to The Dental Health foundation for a series of dental health seminars to educate members of community collaboratives, funded under the Foundation's Community Partnerships for Healthy Children. These seminars address children's dental health and best practices, provide training on networking with existing dental health resources, and share information on current collaborative dental health projects. These community coalitions have learned to assess local needs and set long-term priorities, plan strategies that leverage local resources, rely on members of the community to be part of the solution, and measure results and use what is learned to further fine-tune their efforts.

The Future

Oral Health in America: A Report of the Surgeon General has drawn national attention to the importance of oral health to overall health, and sparked interest in both the public and private sector in tackling this issue. It identifies a number of steps to improve oral health:

- Change public, policymaker, and provider perceptions about oral health so it becomes an accepted component of general health
- Enhance research and accelerate building the science base
- Build an effective health infrastructure that meets the oral health needs of all Americans
- Remove barriers between people and oral health services
- Use public-private partnerships to improve oral health for those who disproportionately suffer from oral diseases

While the Surgeon General's report broadens the challenge to public and private entities alike, it lays out a wonderful framework for foundations to help improve the oral health of current and future generations.

Dental Pain and Systemic Health and Wellbeing of Children

Paul S. Casamassimo, DDS, FACD

Abstract

This report presents evidence from a variety of sources which suggests that the full impact of dental pain among children may not yet be understood and may extend to health status generally and to social and other indicators of wellbeing.

To date, authors have reported lower than normal weights for children afflicted with severe dental caries (Acs et al 1992). In our own research, we have noted variability in physical development of children when compared to norms for age.

velop normally. This work brings to the forefront two concepts that have profound importance for dentists treating children. The first is that dental pain from dental caries is a systemic illness and its treatment in early extensive forms

Parents waited on average a week before seeking care for a dental caries emergency.

The dental literature is buzzing today with systemic and oral health relationships. The associations of periodontal disease with heart disease and prematurity of offspring have received the most visibility (Beck et al, 1996; Dasanayake, 1998). Blood levels of lead and dental caries also piqued interest recently and the possibility of relationships with other poor childhood outcomes raised (Moss, 1999). The association of dental infection with sub-acute bacterial endocarditis is perhaps the best known oral-systemic relationship (Dajani, 1997). Dental pain in children, as the result of dental caries, may prove to be the most significant of all of these connections, when we begin to look more closely at the early childhood effects of untreated chronic pain and prolonged infection.

In our findings, weights were not consistently lower and some children were grossly overweight. When a thorough look at chronic dental pain in children is accomplished, it is likely that we will see a variety of patterns, including a child who (1) is malnourished and underweight, (2) cannot eat a balanced diet and who subsists on sweetened liquids, (3) appears normal in weight, but whose diet provides inadequate nutrition for optimum growth, and (4) whose growth and development is secondarily affected by chronic pain and its effects on catecholamines and regulation of growth hormone.

The oft-cited work of Acs and colleagues (1992) has become the classic associating dental caries with failure to de-

constitutes medical necessity. The second is that dental pain predicts a constellation of childhood woes that may predict poor global outcomes for children afflicted.

To deal with a disease that can alter the physical development of a child brings the dentist into the world of

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medical necessity. Dental treatment assumes a higher level of importance, fulfilling the adage that "general health includes oral health." The dentist becomes

- Chronic pain elevates catecholamines to the point at which growth and develop-

Dental pain from dental caries is a systemic illness and its treatment in early extensive forms constitutes medical necessity.

involved in a far more serious aspect of a child's life. What we do know is that for some children, significant dental caries predicts lower weight. We also know that dental pain results in missed school days (U.S. Department of Health and Human Services, 2000). What remains to be shown is that dental pain has a profound and perhaps irreversible impact on a child's development.

It is unknown whether dental pain affects developmental status and in what ways, but it is clear that the disease of dental caries is localized in the poor and in minorities (U.S. Department of Health and Human Services, 2000). These are groups also traditionally left behind in scholastic performance. Could it be that dental caries and the pain associated has a relationship with school performance? The relationship between health and readiness to learn is well established. With half of Ohio's elementary school-children experiencing dental caries, it is not unrealistic to expect that for many of these children, dental pain impairs learning (Ohio Department of Health, 1995).

The possible pathways for such a mechanism are easy to hypothesize:

- Chronic tooth pain leads to a diet rich in carbohydrate rather than protein and impairs what would otherwise be significant neural growth in the preschool years.
- Chronic pain leads to inability to concentrate at home due to pain, sleepless nights followed by sleepy days, and the inability to concentrate in school.

ment are affected through endocrine feedback mechanisms.

While these mechanisms remain untested, it is hard to dissociate the localization of poor oral health from other global markers of poor childhood outcomes. Single parents, poverty, lack of insurance, and minority status have all been associated with poor childhood outcomes (The Annie E. Casey Foundation, 1999). Similarly, poor oral health has been associated with many of these markers (U.S. Department of Health and Human Services, 2000). Future research will determine the meaning of such relationships, but they are provocative.

Consider still another aspect of the downward spiral. Very recent animal research from the National Institutes of Health suggests that animals who received painful trauma of medical procedures as newborns were much more sensitive to pain later in life (Recer, 2000). In humans, clinical correlates exist. When children are under-sedated for painful procedures, their pain threshold is lowered in the future. Will the same children who suffer dental pain in the early years

policy implications of such a phenomenon are profound. Can we ever expect general dentists, already marginally trained in pediatric dentistry in our dental schools (American Dental Association, 1999), to be able to manage these children?

As we continue to move down the spiral, consider the potential effects of pain and untreated caries on diet and physical health, immune function, and protein intake. Other work performed at Columbus Children's Hospital showed parents waited on average a week before seeking care for a dental caries emergency, suggesting that these children were chronically affected. Currently, we have over five hundred children, overwhelmingly of preschool age, waiting to be treated under general anesthesia, in spite of running two operating rooms a day, every day, at the hospital and referring patients to the Ohio State University College of Dentistry where we operate a similar service two days per week. The point of these numbers is to project that thousands of children live in this country with chronic dental pain and its collective effect on health is unknown. Today, a child can be treated in an operating room under general anesthesia for chronic otitis media, with the rationale that hearing and subsequent development will be affected. The same service to a child with severe dental caries is often denied reimbursement. I would offer that chronic dental pain holds the same medical necessity and will ultimately be shown to have a similar effect

To deal with a disease that can alter the physical development of a child brings the dentist into the world of medical necessity.

of life become the dental care avoiders and dental phobics of the future? Does early dental pain then also predict poor patient behavior during treatment? The

on a child's health, development, and ability to learn.

It is beyond the range of this report to continue speculation on the cascading

physical, emotional, and psychological effects of dental pain. Our own data point out high use of over the counter medications. This year, we experienced a case of a hospital admission for acetaminophen intoxication as the result of dental pain. This is not a unique problem (Kearns, 2000). We also have no idea of the psychological effect of

dental pain in children will be shown to have the same magnitude of impact that our country recognized in World War II, with dental caries being a major factor in health of recruits and thus in the security and wellbeing of the nation.

The Mayday and Milbank Foundations have identified the tip of the iceberg. The National Institute of Dental and Craniofacial Re-

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We have no idea of the effect of untreated pain on family relationships, trust, security, and safety.

chronic pain on motivation, although some authors have hinted at its effect (Kozol, 1991). Finally, we have no idea of the effect of untreated pain on family relationships, trust, security, and safety. Consider the child, first with unremitting dental pain to which a parent cannot or will not respond, and then who finally is treated with a painful extraction of an abscessed tooth with the parent unable to offer assistance. What this pattern does to healthy attachment and bonding remains to be demonstrated. Unfortunately, this occurs hundreds of times a day in this country and for many children, is a way of life.

Dental pain will no doubt be shown to have profound effects on the populations so affected. The research remains to be done. On a daily basis, at our hospital, we see case examples of the devastation of childhood by dental caries and its attendant pain (Wilson, 1997). I have no doubt that in years to come,

search has begun to fund centers to address disparities and pediatric oral health issues. Perhaps the day will come when dental pain in children is not just unknown to the majority of the dental profession, society, and policy makers, but is truly unknown.

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The Mayday Fund

Fenella Rouse

The Mayday Fund's mission and entire program focus is the alleviation of the incidence, degree, and consequences of human physical pain. Mayday was established in 1993 and funded from the estate of Shirley Steinman Katzenbach to continue her interest in infusing social and, in particular, medical causes with sensitivity to the issues of human suffering.

Pain in America ranges from pediatric migraine (endured by 7% of American children), to the pain often associated with the illnesses that cause death (still undertreated in 50% of people who are dying, although the vast majority of those cases could be easily brought under control), to back pain suffered in differing degrees, some incapacitating, by millions of Americans. Other forms of chronic pain strike millions more and result in untold numbers of productive days lost.

Mayday's trustees have long held an interest in helping to alleviate pain experienced by children. Working with young people serves a number of purposes: we hope to help raise a generation that will be better informed about the beneficial use of medication. Although the situation is improving, too many adults in America still often believe, mistakenly, that taking medication will lead to addiction. Addiction, in fact, is extremely rare and never a reason not to take properly prescribed medication. But there is another special reason for treating children's pain: pain, when felt by a child, interferes with the child's development. Clearly, a child with persistent, recurring headaches is less able to do well in school, make friends, or interact with family. Children whose early experience with doctors includes painful treatments, become resistant to and fearful of medical

treatment, whatever its form. And children, too, are particularly adept at using the distraction, relaxation, and hypnotic techniques that can relieve many types of pain.

project (<http://edc.org/painlink>). Our project with the Milbank Memorial Fund is another example of a partnered program. Helping to alleviate children's den-

Helping to alleviate children's dental pain is just the sort of program in which we want to be involved.

For these reasons, Mayday supports a number of projects to relieve childhood pain. A recent sample includes a grant to Rainbow Babies and Children's Hospital in Cleveland, Ohio, to support teaching for primary care doctors about treating headaches; a grant to Lancaster Health Care Alliance in Lancaster, Pennsylvania, to establish the Mayday Headache Clinic; a grant to Hugs Children's Hospice in Vancouver, Canada, to make a documentary video of young people describing how the pain control techniques they learned thirteen years earlier have stood them in good stead at different times in their lives. The Mayday Fund has also established more long-term working relationships with partner organizations intended to extend their work in training and supporting programs for health care providers. Examples include the City of Hope in Durate, California, which is distributing effective educational material (<http://mayday.coh.org>); the American Society of Law, Medicine and Ethics which supports a legal scholars program for focused investigation of topics on pain; and the Education Development Center in Newtown, Massachusetts, which provides free technical assistance to more than twenty health care institutions each year through the EDC Mayday / PainLink

tal pain is just the sort of program in which we want to be involved.

In May 1998, representatives from nineteen advocacy organizations, all concerned in one way or another with the treatment of pain, came together at our invitation to meet and talk. As far as we know, this is the first time that a group of this size and composition has gathered to share ideas and discuss collaboration to improve the treatment of pain in America. We hope that some useful connections were made and that joint activities will take place in the future as a result of contacts made and ideas exchanged.

We hope that everyone who reads this will have ideas about how Mayday can improve its program and will communicate those ideas to us. Please contact us by e-mail or go to our page at www.painandhealth.org. And we thank all those who take part in Mayday programs and who whose work makes a reality of our wish to help in the fight to reduce physical pain.

Ms. Rouse is Executive Director of the Mayday Fund, c/o UBS Trust Company, 10 East 50th Street., 15th floor, New York, NY 10022. Maydyfnd@aol.com

Issues in Dental Ethics

Professional Ethics in Dentistry Network

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Doctors, Patients, and Transitions

This installment of our “journal-within-a-journal” includes essays, reactions, and commentary about a vexing issue: What happens to patients when a practice changes hands, and what happens to the relationships between participating dentists? Michael Weisenfeld describes the positive scenario when things go pretty much as planned. Then he describes three potentially ugly variations. He uses marriage, divorce, and the children as a metaphor. He points out a problem that lurks in even the best of situations: Since dentists don’t talk much with each other about bad outcomes, they don’t possess the necessary interaction skills. They avoid such discussions, and things deteriorate. Then, rather than using face-to-face negotiation and problem solving, they bring in third parties like attorneys, insurance companies, or state boards. At that point, nobody wins (except the attorney). Weisenfeld advocates “open and respectful conversa-

tion and negotiation.” No matter how these things get resolved, they involve tricky ethical matters, even between nice people acting in good faith.

Hasegawa and Mathews examine what happens when a purchasing dentist doesn’t like what he or she sees in the mouths of the inherited patients. They review the theoretical models available to make sense out of bad outcomes or bad work. Then they make a startling point: If your work is 99.95% error-free, and you see ten patients per day and work four days per week for fifty weeks each year, you will make fewer than one mistake each month, but ten mistakes per year. Over a ten year period, that’s one hundred errors. (For an interesting read about the way that the airline industry thinks about this problem relative to the way that the medical community views error, check out Lucian Leape’s classic article in the *Journal of the American Medical Association* of December, 1994, 272 (23), 1851-1857 titled “Error in Medicine”).

Don Patthoff jumps on the marriage metaphor and writes that we are generally aware of the *covenant* (an unbreakable promise or commitment) that exists between doctor and patient. But, he points out, we would be far better off treating our collegial relationships in that same way, rather than viewing them from a competitive-legalistic perspective. Without a deeper professional commitment, he observes, “the slick will win and the suckers will lose” when practices change hands in a commercially competitive milieu.

Hasegawa & Mathews as well as Patthoff allude to the inappropriateness of comparisons between the world of “regular” commerce in a market economy and the dental practice. The basic assumptions between parties are different. When you go to a store, everyone understands the competitive arrangements. Buyers try to get as much product as they can while giving up the least possible amount of

their hard-earned money. Sellers, conversely, try to get the highest price for the least product. This model creates problems in health care, mostly because the "buyer" (the patient) is not in a fair competitive position relative to the doctor's knowledge and the urgency of the situation. Plus, there is more at stake than a sweater, a carpet, or even a new car. Dentists engage in a relationship of *care* with their patients. There is a fiduciary duty. These articles explore the complex interaction between the doctor-patient relationship and the new doctor-doctor relationship under various special circumstances.

Mert Asku, a dentist and an attorney, reviews the legal swamp awaiting those who buy and sell a dental practice. Frankly, his essay frightened me. The marriage metaphor shifted to the nightmare scenario.

Each of these well-written articles comes to roughly the same conclusion. All parties, patients included, are better off

when dentists are willing and able to communicate face-to-face about difficult, but inevitable, matters. I agree. I think we need to periodically renew our commitment to direct communication. Don't talk to third parties, behind someone's back. Don't grouse to yourself and get all worked up about how bad they are. As part of a practice transition or sale, create a mechanism for future directness. Then, when the feathers hit the fan, rehearse what you are going to say, take a deep breath, and go see that (weird) other person. Be prepared to listen, and be prepared to hear a point of view that may surprise you. Seek the win-win.

I can't let this opportunity go by without an advertisement. Consider hiring a psychologist to help with the communication process. We are trained and practiced in the skills needed to help others understand each other and get along. It is often surprisingly easy for a third party psychologist type to help out, and it can save everyone a lot of money and grief.

We hope you enjoy these articles. We welcome your ideas and invite you to join our group. Submissions to "Issues in Dental Ethics" and correspondence about joining PEDNET (Professional Ethics in Dentistry Network) may be sent to:

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The best way to reach me is by e-mail bpeltier@uop.edu at the University of the Pacific School of Dentistry.

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Breaking Up is Hard to Do

Michael D. L. Weisenfeld, DDS, MPA, FACD

Abstract

A complex set of ethical and legal issues results when a dentist discovers what he or she believes to be substandard treatment rendered by a former owner, associate, partner, or employee of the practice. Some scenarios and their ethical issues are presented.

The life cycle of a dental practice with multiple dentists has some similarities to a marriage. Often such a practice can last and prosper. But sometimes the association fails, just as some marriages end in divorce. In addition, as in marriages that fail, money can become an important issue in the dissolution of the relationship, especially regarding the dentists' relationships to their patients.

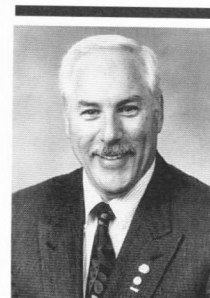
When a marriage dissolves, the future custody of the children is often at issue and financial aspects of custody issues can often predominate. In the dissolution of a joint practice, the practice's patients are often at issue. This relates not only to questions about how patients learn about the dissolution of the practice and make their decisions about where to receive their dental care in the future — matters that are ethically complex in their own right. It can also involve patients making claims for

retreatment or other remediation for treatment received prior to the dissolution. Such issues can arise whether the breakup involves partners, dentists who are employees, dentists who are independent contractors, or even if a practice is sold to a different dentist. These issues are particularly difficult to resolve, not to mention expensive, in part because they are so ethically complex. They merge the ethical challenges of dissolving a joint practice with the already complex ethical issues that arise whenever patients have bad outcomes. This is especially true when bad outcomes lead to suspicions or allegations, from any source, of bad work. (It is the subtlety and complexity of these issues that made Chapter Nine, "Bad Outcomes and Bad Work," the longest chapter in Ozar and Sokol's *Dental Ethics at Chairsides*.)

In addition, I have found that, unfortunately, these problems often spill over into the legal arena or become entangled with issues of insurance or professional regulation as one or another of the parties seeks a way to fund retreatment or sometimes simply seeks a way to "get" the other party. The three scenarios of joint practices whose dissolution has gone bad that will be presented below involve three different ways that such situations can move beyond being ethical disagreements and become complicated, bitter, and often more expensive disputes.

Doing It Right

First, however, it is worth asking what such situations look like when they work out well. If patients of a now dissolved joint practice seek retreatment or remediation for treatment done when the practice was intact, what do the dentists involved need in order to work the matter out without recourse to the law, insurance companies, or boards of licensure? The first characteristic of such a situation must be a commitment on the part of each dentist *not* to quickly seek assistance from the law or other third parties. Dentists need to work it out by talking and negotiating with each other. This can be very challenging because practices that dissolve often leave negative residual feelings on both sides. Re-establishing communication on an important and delicate matter and negotiating openly as peers (especially if they were not peers in the now-dissolved relationship) can be very difficult. It is worth asking how often a dentist turns to a third party to aid his or her cause in



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such a matter principally to avoid the difficulties of negotiating as peer-to-peer with the other dentist. As will become clear, it is also worth asking how often

bad work among dentists generally. Consequently, many dentists face these ethical challenges without an articulate understanding of what they themselves

Substantial sums of money are often needed to fund retreatment of patients, even if offering retreatment is more of a good business decision than an ethical requirement.

these difficulties are serious enough to ethically justify recourse to the third party.

A second characteristic of dentists who succeed in working out such a situation together is that they come to agreement about three sets of factual judgments regarding the complaining patient's prior treatment. Such agreement may occur in a straightforward fashion, or it may only occur through careful compromise. However, without it, coming to a joint resolution of the patients' complaints will be most difficult. These three sets of judgments are:

1. What was the patient's presenting condition, what treatments and other interventions were offered to the patient, and which of these were recommended to the patient by the dentist?

2. What treatments and other interventions were undertaken for the patient and what was their quality? Was the quality good or superior, or was it just within or below the standard of care in some determinate respect?

3. What was the patient told to expect from the work done, both prior to the work and after it was completed?

Thirdly, even if the dentists agree about these factual matters, if they can not come to a shared view of how to ethically deal with a particular patient's compliance, then they still might find themselves at odds. One of the chief hindrances to open negotiation about such situations when joint practices dissolve is that there is so little open discussion of the ethics of bad outcomes and

believe ought to be done, much less any skill in discussing this with others who might disagree with them.

To mention the simplest case, is there an ethical obligation to retreat a patient who has experienced a bad outcome that is no one's fault and is within the range of risk factors explained to the patient before treatment? Or is retreating under these circumstances ethically optional, whether or not it makes good business sense to do? Why or why not? How do these obligations change, if at all, if the dentist believes he or she might have made a minor error in doing the treatment? A major error? What if a dentist has a concern about another dentist's treatment? What *must* be said to the patient, if anything? What *may* be said? What *may not* be said? And under what varying circumstances, if any, do proper answers to these questions change? The absence of open discussion of these ethical questions within the dental community makes the establishment of respectful communication and open negotiation between dentists from a now-dissolved practice even more difficult when the issue at hand is a patient's complaint arising from a bad outcome and possible bad work.

Examples of Breakdown

Here are three examples of situations, each one based upon an actual case, in which such communication and negotiation did not happen.

Scenario 1. An owner dentist hires an employee dentist. The employee is paid a daily salary (minimal) and a percentage of production (30%) after meeting a daily minimum threshold. The owner of the practice receives the bulk of the payments for the services provided to patients by the employee dentist, which are billed in the name of the practice. The relationship lasts eighteen months. After the employee dentist leaves, some of the employee dentist's patients register complaints about their care. The owner dentist examines the patients and concludes that the treatments done by the employee were substandard and need to be redone.

Suppose next that, having redone the treatments to the patients' satisfaction, the owner dentist decides to seek legal advice and through his attorney decides to bring a malpractice claim against the ex-employee dentist alleging negligent treatment for multiple patients. He demands aggregate policy limits (\$600,000) to compensate for damages, namely the costs of the retreatments plus alleged damage to the reputation of the owner dentist's practice.

As you examine the ethical issues raised by this scenario, consider these questions:

- Was the method of resolving the dispute ethically appropriate? If not, what might have been done differently?
- Does an owner dentist have an obligation to supervise his or her employee dentists? If so, is there an obligation to discuss that and other criteria for employment before the employee begins work. Also, if supervisory obligations are present but not fulfilled, do they lessen the responsibility of employee dentists for low quality work?
- Who should decide if treatment by the employee dentist was acceptable? Is it ethically satisfactory that the owner-

dentist made the judgment after the fact that the treatment by the employee dentist was substandard?

- Who should pay for any needed retreatment in this case? Does the answer to this question depend on whether the employee dentist's treatment was in fact below standard? Should the owner dentist be paid again for the retreatments?
- Is there ethical justification in making a claim against the malpractice insurance? If so, should the claim be made by the owner dentist or by former patients?
- If, in fact, there was gross or repeated negligence, is there a role for the state board of dental examiners?

As you examine the ethical issues raised by this scenario, consider these questions:

- What is the dispute in this case: poor treatment or the value of the practice sale?
- Was the method of resolving the dispute ethically appropriate? Assuming the purchasing dentist's judgments are sincere, is there ethical justification for the purchasing dentist to report the case to the state board? Is the state board of licensing an appropriate venue for dispute resolution?
- Do dentists who are selling practices have an obligation to permit purchasing dentists to observe the quality of their work? If not, how ought

services. The contractor dentists are expected to use the laboratory selected by the owner for fabrication of crowns and other prosthetic appliances.

After one of the contractor dentist leaves, the owner asserts that many of the contractor dentist's patients were negligently treated and need retreatment at substantial cost. The owner dentist does not wish to absorb the cost and suggests to those patients that they sue the contractor dentist. The malpractice insurer now faces multiple lawsuits originated by patients, but instigated by the owner dentist. The owner dentist informs the carrier (who also insures his practice) of what he has done after the fact. The contractor dentist asserts in defense that the owner had vicarious liability, since the contractor dentist was the owner's agent, and that the owner also forced use of a substandard laboratory.

As you examine the ethical issues raised by this scenario, consider these questions:

- Was the method of resolving the dispute ethically appropriate? If not, what might have been done differently?
- Does an owner dentist have an obligation to supervise his or her contractor dentists and, if so, does that obligation, if not fulfilled, lessen the responsibility of contractor dentists for low quality work?
- If retreatment is ethically owed to patients (as opposed to being ethically optional), who has the greater responsibility to pay for retreatment, the owner of the practice or the treating dentist under contract to the owner? Does the answer to this question depend at all on relative percentages of the collected fees received by the owner and the contracting dentist? Is the exact split of the original fee (40/60) relevant to their proper shares of the cost of retreatment or is it irrelevant?
- Is it ethical for the owner in this case, assuming the owner's

There is so little open discussion of the ethics of bad outcomes and bad work among dentists generally.

Scenario 2. A dentist sells his practice to a younger dentist. The contract allows for payment over time. The selling dentist wants to leave his practice completely, but is not yet ready for full retirement. Therefore he practices part-time in another location. Some time after the transaction, the purchasing dentist makes a complaint to the state board of dentistry, alleging negligent treatment by the selling dentist of some thirty-seven patients who either have returned with complaints or been found to have substandard work on subsequent appointments. At the same time, the purchasing dentist stops making payments for the purchase of the practice, asserting that the sale was based on a false evaluation of the worth due to the need for retreatment of many patients. The allegations of the purchasing dentist also place the license of the selling dentist in jeopardy, due to the multiplicity of patient files under investigation by the state board.

subsequent questions about the quality of a selling dentist's work be resolved?

- Who should pay for any needed retreatment in this case, and does the answer to this question depend on whether the selling dentist's treatment was in fact below standard?
- If retreatment is in fact needed by the selling dentist's former patients, is the purchasing dentist's claim that the practice was improperly valued ethically supportable? If so, is the purchasing dentist's stoppage of payment ethically justifiable?

Scenario 3. The dentist owner of a large group practice hires a number of independent contractor dentists. Patients are supplied to the contractor dentists by the practice and remain with the practice as the contractor dentists come and go. The contractor dentists are paid 40% of fees collected by the practice for their

judgments about the quality of the contracting dentist's work are sincere, to suggest to patients that they should sue the former

to feel that the dentist who did the treatment is fully responsible if the treatment

simply an assertion by one party that negligent dentistry was done. As indicated above, the resolution of cases like this without recourse to third parties, which is almost always divisive and expensive and is often insensitive to patients' most important needs as well, depends on a commitment of both dentists to respectful conversation and negotiation.

All of the cases discussed also involve contracts between the dentists, either employment or sales. Unfortunately, the contracts have no funding for enforcement. If there were some sort of funding such as a self insured retention fund or some money in escrow to pay for the failures which come to light after the breakup, the problems noted above could be better managed. If the contract for the dissolution of the practice included a method of mediation that was negotiated from the start, all would be better off. While there is malpractice insurance that will cover negligent acts, it is surely best to try to resolve these disputes without the involvement of the malpractice insurance carrier. When a dentist initiates a lawsuit through a patient, the main beneficiary becomes the patient's lawyer. Ultimately, using the tort system to resolve these disputes will drive up the cost of insurance to all dentists.

The dental community needs to address much more frankly the difficult ethical issues raised by the variety of joint practice relationships now common, and to include in this conversation as well the particular ethical issues that arise *afterwards*, when these relationships have dissolved.

In the dissolution of a joint practice, the practice's patients are often at issue.

contractor dentist who had been working for the owner?

Personal Reflections

I have encountered a number of situations like the three described in these scenarios. These situations have three common threads: (1) There is little or no effort to establish lines of communication and negotiation between the dentists; (2) the dentists now caring for the patients feel wronged by the dentist who has left their care; (3) substantial sums of money are often needed to fund retreatment of the patients, even if offering retreatment is more of a good business decision than an ethical requirement.

It seems clear that, above all, it is ethically necessary to see that patients are properly cared for. If there truly is a need to retreat a given situation, that should be done. If it is appropriate to charge for the retreatment and the patient accepts its appropriateness, that can reduce the financial burden to the responsible dentists. But that is not always the case because the patient has already paid for a service and it may not be appropriate to charge a second time. In practice, then, there is often no way to lessen the monetary impact of such cases. With respect to feeling wronged by a former colleague, it is very easy for the dentist who is now caring for the patient

should fail, regardless of the legal and employment relations in the original treating situation. This leads to the conclusion that payment for needed retreatment should come from him or her. But dentists practicing together in differing legal and employment relations may bear differing measures of responsibility for the outcomes of the practice, particularly if owner dentists place specific conditions on how employee dentists or contractor dentists are to practice. It is also relevant if payment is first to the office, not the treating dentist, and only a percentage of the bill is paid to the treating dentist. Much more understanding of the ethics of various legal and employment relations between dentists is needed, as is much more frank conversation by dentists in these relationships about both their present situation and the various futures to which their present relationship might lead.

This takes us back to the first of the common threads: open and respectful conversation and negotiation. To focus on the most dramatic absence of collaboration, each of these scenarios leaves the determination of negligence in the hands of only one of the parties. Who should determine negligence in the examples above? Certainly, the dentist who has inherited these patients is not unbiased. In each of these cases, there was no effort at collaborative evaluation,

Human Error or Substandard Care: Where Do We Draw the Line?

Thomas K. Hasegawa, Jr., DDS, MA, FACD, and Merrill Matthews, Jr., PhD

Abstract

Undesirable outcomes can reflect differing levels of culpability on a dentist's part. At one extreme are pure accidents or unexpected side effects from practices that are within the standard of care. Sometimes there are justifiable differences of opinion among qualified practitioners. Dentists are liable for their poor judgments and especially for wanton disregard of professional standards. One must look to the pattern of unwanted results for a full understanding of substandard care. An owner dentist has some obligation to establish what standards of care for the practice are maintained among all dentists, including employees.

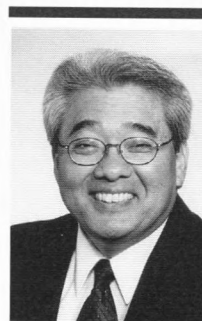
Patients expect to receive competent care from their dentists. When there is an adverse outcome, as there is in every practice, it is incumbent upon dentists to attempt to understand the cause of the problem and, if possible, prevent or at least be prepared for the same in the future. To the patient who endures the adverse outcome, concerns may arise: Was this outcome the result of poor work? After all, the correlation between bad

work and bad worker is common in other areas of our lives when a service fails, such as the car whose transmission has been replaced three times.

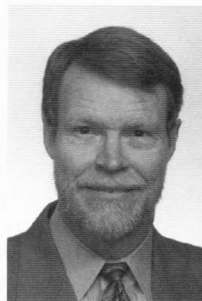
One of the reasons for involving the patient in treatment decisions and obtaining informed consent is precisely because of the risks involved in patient care, including the risks of the unknown, even when the health care provider does an excellent job. The patient then has the opportunity to glimpse the complexities of disease and healing and health before consenting to care.

But while there may be similarities between repairing a broken transmission and restoring a diseased tooth, the analogy quickly breaks down when there is a question of poor work. For it is one thing to have a bad transmission job and another to have compromised oral function due to substandard care. Because dentists are human, they will make mistakes—even the best of them. Is it reasonable to expect that dentists provide competent care 100% of the time? What is an acceptable amount of human error or substandard care (if any)? The scenario we are considering challenges us to examine these questions in regards to a specific practice arrangement of an owner-dentist who is concerned about

the quality of work of a former employee-dentist. Three aspects of this scenario will be considered, including: (1) What are the obligations of both owner-dentists and employee-dentists to patients? (2) Is there an acceptable level of human error or substandard care? and (3) When does substandard care become intolerable?



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*Obligations of Owner/
Employee-Dentists to Patients*

The scenario presents a fairly common arrangement between an owner-dentist and an employee-dentist. In this case, however, a concern has been raised about substandard care provided by the ex-employee-dentist. The first question that arises is what duty or obligation does the owner-dentist assume for the quality of patient care provided by an employee-dentist? How would the obligation of the owner-dentist to oversee patient care vary for an employee-dentist versus an equal partner?

Under an equal-partnership arrangement, the responsibility for patient care would normally reside with each partner. But is that true of the owner-dentist/employee-dentist relationship? A lot will depend on the circumstances present in each individual case. It might be helpful

hiring a dentist with poor clinical skills by carefully screening potential employee-dentists; confirming letters of recommendation, curricula vitae, practice experience, continuing education activities; and by contacting trusted clinicians who may know the quality of the clinician's work. Based on this knowledge, an owner might choose to be involved with cases at the beginning of employment so that some diligence may be attributed to assuring quality. The length and depth of this involvement may vary with the practice experience of the employee-dentist along with the owner's expectations. A clinician with two years of experience may engender more oversight by an owner-dentist than a clinician with ten years of comprehensive patient care experience in a well-respected practice.

Had an employee-dentist been working for eighteen months, as specified in

man error or a pattern of substandard care? The philosopher Morreim (1993) provides a methodology for delineating bad outcomes from bad work using five levels of adverse outcomes. The five levels are also sensitive to additional factors such as whether the adverse outcome is the result of a clinician's incompetence, impairment, or unethical behavior. In regard to physicians, Morreim states: "An *impaired* physician is unable to practice medicine with reasonable skill and safety by reason of physical or mental illness. He or she may be hindered by waning eyesight, dementia, or substance abuse. The *incompetent* physician, on the other hand, is not ill, but ignorant or unskillful, while the *unethical* physician knowingly and willingly violates fundamental norms of conduct toward others, especially his or her own patients."

Under this methodology, the first level of adverse outcome is the complete accident, independent of any human decision or action, such as a power failure in the office or a dental equipment failure. An example of an adverse outcome at this level may be the patient who suffers a first-degree burn on the lip due to a handpiece overheating. The patient may not notice the heat due to numbness of the lip, and the clinician may not immediately notice the heat due to the insulation provided by the gloves worn during the procedure. This first level of adverse outcome does not seem relevant to the scenario.

In the second level, a clinician's well-justified decision unexpectedly turns out badly. For example, a clinician contemplating a surgical extraction of an impacted third molar may decide to provide endocarditis prophylaxis using the standard AHA guidelines, as the patient has a medical condition of mitral valve prolapse with regurgitation. If that patient, with no history of previous allergy to penicillin, suffers an anaphylactic reaction upon taking the prescribed regimen, it does not reflect negatively on the clinician, even if the outcome is bad. Is this level of adverse outcome relevant to the scenario? Probably not. But it is at least possible that some of the complaints are

Owner-dentists are obligated to ensure that patients are receiving quality care by employee-dentists.

to view the relationship on a continuum, with the partnership arrangement at one end and the owner-dentist/employee dentist at the other end. Under the owner-dentist/employee-dentist relationship, the employee-dentist works for the practice. Indeed, checks are made out to the practice, not the dentist. As a result, the owner-dentist may have an obligation both to the patients and to the employee-dentist to make reasonable checks on the work—at least until the owner-dentist is satisfied that the new dentist is providing quality care.

Just as in any employee relationship, it is the responsibility of the owner to make sure that the work is done properly, and it is the owner who may reward exceptional performance or dismiss an employee for substandard work. This process could begin as early as the decision to hire an employee-dentist in order to expand services to the practice. The owner can minimize the chances of

the scenario, the owner-dentist should know something about the character and quality of the employee-dentist's practice. Certain trends may alert the owner-dentist to possible problems, such as the number of complaints about quality of care, the number of patients leaving the practice, the number of laboratory cases that are redone, and the number of patients who refuse to pay for treatment.

However, at such time that the owner-dentist feels confident that the employee-dentist is practicing at the standard of care, he or she may reduce the oversight, in essence, moving to the right on our continuum, as a relationship of mutual trust and respect develops.

*When Does Human Error
Become Substandard Care?*

Claims of substandard care by some patients in an employee-dentist's practice are the central concern in the case study. Are these claims isolated instances of hu-

of this sort. Without more information it is hard to know for sure. Suffice it to say that one or more of the complaints may not be a result of bad patient care.

The third level is concerned with the reality that good clinicians may disagree about a recommended treatment based on their individual practice experiences and expertise. This disagreement focuses attention on what Sadowsky (1979) has called the moral dilemma of the multiple prescription in dentistry. That is, there may be multiple treatment alternatives with varying claims for quality, durability, comfort, esthetics, and costs for a specific clinical condition. For example, a conservative MOD restoration for a mandibular first molar may be restored in amalgam, gold, porcelain, or acrylic resin. Good clinicians will provide competent care choosing among these varying materials and techniques. Clinicians, then, may adopt and promote a pattern of practice which is distinguishable by the choosing among a myriad of alternatives including these materials and techniques (Ozar & Sokol, 1994). Practices are often identified by descriptors such as "implant," "reconstructive," "emergency," "preventive," "esthetic," "family," and so on. When good clinicians disagree this may not be a matter of what is "right" or "wrong," but rather what are the qualities of the recommendations, and how do they match the expectations and goals for the patient. A disagreement may be interpreted by a patient as "bad work" if the clinician is not careful about discerning what is communicated to the patient. The ADA Code offers the view that "a difference of opinion as to preferred treatment should not be communicated

complete removable partial dentures, while the employee-dentist makes this choice only in more extreme cases. The patient then may have two competing

over the year and a half, on average, 10 patients per day, four days a week for a total of 72 weeks. That would yield approximately 2,880 patient care visits.

Good clinicians may disagree about a recommended treatment based on their individual practice experiences and expertise.

philosophies in the same office, which may contribute to the patient complaints presented in this scenario.

At level four the clinician exercises poor, although not outrageously bad, judgment or skill. For example, a dentist may have started an extraction procedure without carefully reviewing the pre-operative periapical radiographs and then encounter complications of root fracture. On careful evaluation, the radiographs could reveal the possibility of an apical dilaceration that may have alerted the dentist and patient to certain anticipated complications, such as the need to section the tooth or the possibility of a fractured root. Or, on recall, the dentist forgets to record a change in the patient's medical history regarding antibiotic allergies and nearly prescribes the same at a subsequent appointment.

The level four type of adverse outcome may be relevant to an owner-dentist regarding the substandard care provided by the employee-dentist. Should patients expect that human error never exists? Is one or two acts indicative of incompetent care? Where do we draw the line between normal human error and substandard care? And does or should the line shift with different

Now suppose that a clinician's work 99.5% of the time is error free? In the scenario if you take 0.5% you could assert that 14 complaints of poor judgment are not unreasonable considering the total number of patient visits. Viewing the complaints over the course of eighteen months, that is less than one per month. The focal point for the scenario is the statement "after the dentist leaves, *some* of the employee dentist's patients complain." Is "some" in this scenario equal to 14 or fewer complaints? Also, what are the patterns of poor judgment? That is, what if all of the complaints are about overextended denture flanges? Or on the other hand, what if there is a distribution of concerns such as 5 crowns with light interproximal contacts resulting in some food impaction, 5 amalgams with overhangs that occasionally shred floss, and 4 denture patients with overextended flanges causing tissue soreness? In these instances the question remains: is there a pattern of errors that mark incompetence? And then the more discreet question, is the error a difference of individual standards for contacts, gingival margins of amalgams, or the proper extent of a denture flange as opposed to a grossly deficient contact, overhang, or extension? Or is it that the patients expected brighter smiles with the office bleaching, or demanded longer teeth for their dentures, and were these expectations unrealistic? Or is it again, a level of disagreement between two clinicians? Is the determination of substandard work by the owner dentist, substandard for most of the profession, or is the expectation higher than what

/ *s there a pattern of errors that mark incompetence?*

to the patient in a manner which would imply mistreatment." In this scenario, the employee and owner-dentist may have differences in their individual patterns of practice. For example, an owner-dentist may insist on implant support for most

people. A clinician with two years of practice experience can be expected to make more errors than a seasoned clinician. But how many is too many?

For example, suppose in the scenario at hand that the employee-dentist treated

may be expected by a reasonable clinician?

In one regard the scenario provides some relief since all patient care deemed substandard has been corrected to the patient's satisfaction by the owner-dentist. The ADA Code is useful here also as it is an obligation of the owner dentist in this scenario to seek justice or fairness for the employee dentist by assuring that claims of substandard care by patients are justifiable. The decision facing the owner-dentist is whether the claims of substandard care are isolated instances of human error or a pattern of substandard care that raises the concern that the ex-employee dentist is incompetent, impaired, or unethical.

When Substandard Care Becomes Intolerable

Adverse outcomes at the fifth level are egregious violations of the expected quality of care. The clinician at this level extracts the wrong tooth, crowns teeth without justification, disregards standard endocarditis prophylaxis protocols, or fails to diagnose periodontal disease. All

four examples elevate the concern from a pattern of substandard care to gross errors in judgment and skill. In this regard the ADA Code requires of its members that "Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faculty treatment by other dentists." If the employee-dentist in the scenario is a member of the ADA, the owner-dentist could take the concern to the local dental societies' ethics or judiciary committee. If the clinician is not a member of the ADA, an alternative would be to make a report directly to the State Board of Dental Examiners. In the scenario the owner-dentist chose to take a legal action against the ex-employee dentist to recover costs for retreatment plus the alleged damage to the reputation of the owner dentist's practice.

Conclusion

Owner-dentists are obligated to assure that patients are receiving quality care by employee-dentists. By diligent screening

procedures and judicious oversight of patient care in the office the owner-dentist may lower the risk of claims of substandard care by patients of employee-dentists. In any case, the owner-dentist does have an obligation to the employee-dentist to be just and fair when complaints of substandard care arise. When complaints arise as in this scenario, it is incumbent on the owner to discern whether they are isolated instances of poor judgment or human error, a pattern of substandard care or incompetent practice, or egregious or gross violations of standards of care. These types of decisions are some of the most difficult a dentist must face and define the integrity of the profession.

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Problems in Practice Relationships from the Covenant Perspective

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Abstract

The relationships among dentists with other dentists and with their patients resemble the relationship in a marriage. These can be based on contract or covenant or both. In contracts, parties seek to maximize their benefits subject to social norms; in covenants, parties seek to maximize mutual benefit. The relationship between dentists must be seen in the context of the covenant that exists with their patients. Available remedies include arbitration, mediation, ethical deliberation, and pre-contractual agreements.

Michael Weisenfeld's article, "Breaking Up Is Hard To Do," raises ethical issues rarely discussed at the level needed if the dental profession is to meet the challenges raised by the continuing developments of market and organizational strategies. His opening comparison of dental practice relationships to those experienced in marriage is striking. He then offers three scenarios where the fairness of those relationships is, at the very least, questionable when the break up occurs. In the end the interaction of the principals seems closer to the battlefield than to the loving household.

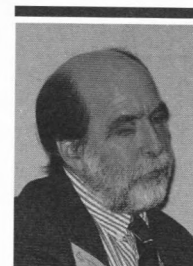
When I was a kid, my dad told me that "nothing is fair in love and war." I tried to figure out what he meant. As I grew up, I looked for the ways in which fairness and war are incompatible. I also gradually began to think that the concept of the incompatibility between fairness and love was wrongheaded.

It was only later in life that I learned that Shakespeare's actual phrase was, "*everything* is fair in love and war," a statement of relativism if ever there was one. By that time, I was already warped and saw that if we only look at what people really do in the world, Shakespeare's observation would seem to be accurate. If, however, we look at truth in its broadest sense, then the meaning of fairness in relationships is something more—much more. The first point then, is that there is a big difference between "nothing" and "everything" being fair.

With these things in mind, at first glance the comparison of a dental practice relationship to a marriage seems useful and fair. However, when a broader understanding about fairness is applied, the analogy seems deficient for several reasons. The most obvious one is the legal-contractual perspective. Three cases are presented for comparison with three different relationships: employer-employee, buyer-seller relationship, and con-

tract-for-services. These three scenarios are as different as comparisons of rape, prostitution, and a shotgun marriage. All involve distasteful interactions, but the nature of the relationships makes a lot of difference. Furthermore, as a group, these relationships seem grossly different from those of a healthy marriage, where the meaning of love can be fully discovered and nurtured as a very real but mysterious truth.

Weisenfeld points out that all three of the failed dentist-to-dentist relationships are faced with issues involving both money and patient care. Arguably, from the standpoint of dentistry's obligations to the public, the most important concern is the commitment to patients. It is this commitment that forms the basis for any special relationship between dentists and their profession. Focusing primarily on money and failure in these cases is like focusing on sex and failure to help get at the ultimate meaning of mar-



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riage. In both situations the nature of the primary relationship—professional commitment or love—is denigrated.

Covenants and Contracts

Covenants and contracts can be illuminated by returning to the marriage analogy and applying it in a different way. There are two major and very different understandings of the marriage relationship. Marriage is viewed by some as a faith covenant and by others as a legal contractual relationship. Although the word “covenant” is also used in law, as in the term “restrictive covenant,” its meaning in law is very different. A faith covenant, because of its basic nature, is an unbreakable promise. On the other hand, a legal covenant, because it is a negotiated contract, is a breakable “promise.”

Couples who enter their marriages under a faith covenant, then, approach their problems very differently from those who see it as a contract. Similarly, those dentists who include the idea of a faith covenant in their understanding of a practice relationship will see things very differently from those who see it only as a contractual relationship. How one answers the questions raised at the end of each scenario will depend on whether one thinks that relationships with patients should be viewed as covenants or as contracts.

For those who view marriage as a covenant, marriage occurs within a community and helps to shape that community. Those who enter marriage with this understanding do not see divorce as a solution to problems in a marriage. Marriage is then about giving to others and learning to forgive rather than the assignment of accountability and blame.

Popular wisdom often presents marriage as simply a voluntary contract between two free and consenting persons and divorce as simply the voluntary termination of this contract. The impact on the children and on the community that must support the social consequences of the divorce are contractual details, sometimes stipulated in advance, more often negotiated when the contract “fails.”

For dental practitioners whose relationship to their patients is a covenant-like promise, a professing, a commitment to care for them, a joint practice is

dentist-to-dentist relationship in joint practice situations. Because dentists are bound together in the same kind of covenant to the same patients, their rela-

Above all, dentists in shared practices should be explicit with one another in their commitment to deal ethically with patients they share.

first of all a mutual sharing of this professional commitment to a group of patients. If there is a breakup, for whatever reason, the dentists’ commitments to their patients would require, without question, that the practitioners’ obligations to their patients be fulfilled. If this means they need to negotiate with peers, to swallow hurt feelings, or to risk some monetary loss, then, because of their commitments to those patients, they are obligated to do so. This is where the analogy to marriage is informative in reminding us that as professionals we make covenants with our patients.

We also make contracts with our dental colleagues when we decide to work in the same physical place or share the same help and materials. We can only do this with other dentists because we have made a covenant with our profession, and our profession has made a covenant with society.

It is fair to ask, then, if dentists in joint practice can have a merely legal contract with one another — without the perspective of a covenant — and appropriately ask questions about these scenarios in exclusively legal and business terms. The answer is that if dentists’ relationships with their patients were only contractual relationships, then dentists’ relationships to one another could hardly be more than this. But dentistry is a profession, and our commitment to our patients have implications for every aspect of dental practice, including joint practice relationships of whatever legal-contractual sort.

For this reason, it is not possible to have only a legal-contractual relationship with a dentist with whom we share patients. The covenant understanding of marriage does not directly relate to the

relationships cannot be understood only as a legal contract about monetary matters.

Remedies

The reality is that the benefits of multiple-dentist relationships bring with them certain costs, both financial and interpersonal. To take these benefits while trying to dump the financial liabilities on to patients, other dentists, and the public through the courts, insurance companies, or licensing boards is professionally irresponsible. A partnership insurance plan that all partners can purchase before entering a joint practice relationship—like a prenuptial agreement — may help. But my observation is that the slick will win and the suckers will lose. The “stuck” dentist is, after all, responsible for analyzing the risks of the relationship beforehand and for recognizing that a dentist’s professional commitments to patients may subsequently mean addressing the consequences of a broken relationship. Oftentimes, just treating the patients right, solving their individual problems, and moving on is better use of one’s energy than fighting, blaming, and trying to avoid the consequences that are partially the result of a decision the “stuck” partner made when first entering the doomed relationship.

Above all, dentists in share practices should be explicit with one another in their commitment to deal ethically with patients they share, whatever that takes, from start to finish, and thereafter if necessary. But how can dentists be explicit when there are at least three kinds of relationships being mixed and meshed? How can they do this when some of these relationships are defined by rea-

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sons, feelings, and forces that are beyond what law can do?

The first, and primary relationship is our common promise to our patients. The fiduciary doctor-patient relationship has its foundation in the trust of the pub-

lic. Patients, because of anxiety, illness, and lack of expertise are vulnerable, and we, as dentists, are obligated not to take advantage of this vulnerability. Fairness is determined by holding dentists accountable to professional standards.

We can only (form joint practices) because we have made a covenant with our profession and our profession has made a covenant with society.

can use any agreed-upon arbitrary method for making decisions. A third party decides who wins, not who is right or wrong. The decision tends to be based on what has happened in the past.

are promises to be worked out only undermine the trust needed to negotiate the unknowns in any relationship. Their very presence also undermines the real nature of what the profession is. Dental partners are, first of all, accountable to all of their patients whose voices are more than likely left out of the deals. This accountability goes beyond the size of the distal margin on the upper second left molar, and involves the efficient use of our resources for managing our relationships with our staffs, our colleagues, and our other needs in life. To focus only on the technical styles and qualities of care can lead to superficial cries about standards that are then waved about as legal swords.

Mediation is based upon the future not the past. It does not concern itself with who is right or wrong. It is different from adjudication and arbitration because of its focus on the future, its non-interest in evidence, and also because the participants, rather than a third party, form the settlement agreements. The mediation process is not perfect, however. It sometimes resembles the behavior of computers that need to be shut down and restarted for no apparent reason. Neither the consultant nor anyone else, for example, can accurately predict or assess the losses of a practice based on unwanted outcomes or bad dentistry.

The second relationship is our negotiated business dealings with our colleagues. We are buyers and sellers who tend to look at fairness in terms of profits and losses based on the market value of our practices. If for example, a consultant in practice transition becomes an agent for a dentist and tries to get the best deal for him or her at the expense of another dentist, the other dentist will do the same. A battle is waged that results in a winner and a loser.

The third relationship is organizational and pertains to the management of everyday decisions, and occasionally to momentous decisions.

It is obvious then, that each professional dental relationship is as unique as is every marriage relationship. In some respects it is more complex in that we are more on stage as public citizens, business people, and providers of care. Just as the internal life of marriage cannot be managed by law, neither can the internal life of dental partnerships. Decision-making in these caring relationships should be collaborative efforts, not adversarial battles.

Arbitration and mediation are sometimes employed as alternatives to law and war. Arbitration is a modification of adjudication. It is so-named because it

Ethical deliberation can also be used to resolve disputes. It is not just an agreement that is based on what each party feels or thinks is acceptable. Rather it is a process of discernment and growth where the decisions of each party are tested against articulated ethical norms based on an honest search for truth, freely using both faith and reason. Prayer has also been used in order to better reveal the nature of faith covenants.

Will prenuptial agreements work? In terms of business ethics: maybe. In terms of covenants, organizational trust, and professional standards: no. An unbreakable faith covenant is not the same as a contract "promise" that is designed to be broken. Pre-contractual agreements about a business partnership that

do we want to live at war or in love?

Although the scenarios may not be conducive to straightforward answers, there are definite boundaries. These boundaries can limit the forms of our business, organizational, and professional relationships. Each form of these relationships should be explicitly articulated from the very beginning to the very end. Dentists are not married to each other, but as a profession they are married to patients. Fairness in both profession and marriage is a covenant of love that knows no bounds. When it is limited to a view that forces it to be seen only as a contract about how the spoils of battle will be distributed, it misses the true nature of what both marriages and dental partnerships can be about. If it is true that we become what we practice, it is fair to ask, do we want to live at war or in love?

Dental Associateships and Purchase Agreements: When "I Do" Becomes "I Don't"

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Abstract

The American legal system is based on generally prevailing notions of fairness. A high degree of risk exists when dentists make unilateral interpretations of what is fair apart from existing norms. In particular, dentists must understand the nature of indemnity insurance, contract law, and the definition, rights, and obligations of independent contractors.

A marriage, like a business partnership, is an example of an organizational institution with implications to both those belonging to the institution and to those interacting with members of that particular organizational institution. Dental practices organized as partnerships, limited partnerships, and corporations are entities with legal lives of their own. The professional organization often employs, in addition to the owner dentists, support staff, dental assistants, dental hygienists, and perhaps enters into contracts with others including accountants,

legal counsel, janitorial staff, landscaping contractors, and associate dentists.

The relationship between the associating dentist without ownership rights and the owner differs greatly from a marriage. Despite these differences, the success rate of association agreements often resembles the statistical success rates of marriages. While there are numerous ethical and legal implications of entering into organizational agreements, the nature of the agreement that brings together an associating dentist and a dental practice carries with it specific legal implications which could differ from perceived ethical implications. However different legal and ethical principles might appear to be, legal principles are, in part, a reflection of societal ethical beliefs and as such, the courts attempt to reach decisions congruent with these concepts of justice, equity, and fairness.

While the legal concepts most important to the issues raised in Weisenfeld's article involve basic concepts of contractual obligations, issues of agency, and employee liability doctrine, these legal implications are sometimes understated and misunderstood. In addition, dentists have numerous professional responsibilities related to providing competent pa-

tient care and it is clear that professional dental organizations place great emphasis on the obligation to provide competent care, even when the dentist is faced with contractual obligations that could affect the dentist's decision-making process. It is the duty of the dentist as a professional to provide competent patient care while preserving patient autonomy.

It must be obvious that clinically acceptable lower quality care is still within the spectrum of clinical acceptability, and while the ethical dentist always strives to provide the best possible care under the circumstances, issues resulting in malpractice claims have unfortunately become quite common. Weisenfeld's article surrounds issues relating to the standard



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of care and the definition of this term. Malpractice requires two basic elements: first, the issue must have a definable minimum standard of care for a particular procedure, and second, there must have been a failure to meet that

employees when such acts are performed during the normal course of business. As an employee, the courts will presume that the owner dentist will exert control over the associate dentist with regard to material elements affecting the

reasonable care in the selection of associates practicing as employees. What evidence suggests that the owner dentist exercised such reasonable care as required in this case?

From a legal perspective in a fee-for-service indemnity plan, the patient would have financial responsibility for needed retreatment when an insurance contract only provides indemnity for care after a certain minimum period of time.

minimum standard of care. Beyond arguing the facts of a particular case and whether a breach in the standard of care occurred, there are other clear defenses to claims of malpractice, and these would include the respectable minority exception, clinical innovation, and contributory fault of the patient.

The issues of malpractice, as described in Weisenfeld's scenarios, have implications impacting both the patient and the accused dentist. The dentist accused of substandard care risks economic loss and potential harm to his or her professional reputation. In each instance, the dentists as professionals must understand and respect the implications associated with accusations of malpractice. Nonetheless, the dentists should strive to meet the needs of the patients under their care, keeping in mind that in addition to the legal avenues for dispute resolution, peer review and private mediation are possible alternate options to dispute resolution.

Whether the associate dentist is an independent contractor or employee might have little bearing on whether the owner dentist faces at least some ethical or legal responsibility for the alleged inferior quality workmanship performed by the associate dentist. However, as an employee, the associate dentist is, in a legal sense, a "servant" of the practice owner dentist employer. The legal concept of *respondent superior* establishes legal liability on an employer for the negligent acts of

quality of the services rendered to patients of the practice. Furthermore, barring unusual factual circumstances, courts would in most cases hold the owner dentist, as an employer, responsible for assuring the quality of the work performed by employees of the practice.

First Scenario

In the first scenario, the owner dentist is hoping to recover economic damages as the result of alleged failure of the associate dentist to meet the minimum standard of care. The owner seeks to recover the aggregate policy limits of the associate dentist even though the owner dentist has clear legal and ethical responsibilities as an employer. The owner shared in the revenue generated from the services rendered by the associate. From a legal and ethical perspective, regardless of the implications of being an employer, should the owner dentist have standing to collect the full amount of the practice fees for the alleged substandard care, when the owner shared in the revenue generated by the associate dentist? This question will be one of several issues facing the attorney providing counsel to the owner dentist.

There are several other questions that will arise in this case:

- Under the doctrine of corporate responsibility, the owner dentist will have certain responsibilities and duties to the patients of the practice to exercise

- Given the relationship between the owner dentist and associate employee dentist, and barring unusual intentional negligent actions, should an owner dentist have access to the courts to use legal means to recover damages from an employee associate for damages resulting from perhaps the owner dentist's own failure to provide adequate supervision of the associate dentist?
- Legal resolution will allow injured parties to collect for costs associated with care failing to meet the minimum standard. What evidence does the owner dentist have from independent third parties indicating that services rendered to patients under the care of the associate employee dentist failed to meet the minimum standard of care?
- Legal standing, the right to bring suit based on some direct loss sustained as a result of the action of another, is a requirement for litigation. It would appear that the legal standing of the owner dentist would be insufficient to advance a claim against the associate. If not, what legal standing does the owner dentist have in bringing a legal malpractice claim based on the alleged substandard treatment provided to patients receiving care in the practice?

From a legal perspective in a fee-for-service indemnity plan, the patient would have financial responsibility for needed retreatment when an insurance contract only provides indemnity for care after a certain minimum period of time. This includes needed care for conditions that are unquestionably the patient's responsibility. The reason most practices assume the risk of replacement is based in the lan-

guage of preferred provider agreements signed by many dental practices and on the ethics of the individual dentist. The decision to retreat in scenario one is being made with the sole judgement of the owner dentist based on patient complaints. Whether the associate dentist employee in fact provided substandard care must be reviewed by an independent third party, and this review must consider the limitations of the associate dentist's employer-employee relationship.

Weisenfeld also raises several questions regarding the role of malpractice insurance in providing compensation to the owner dentists. Professional liability/malpractice insurance is similar to many other types of insurance. The purpose of the insurance policy is to protect the practitioner from unpredicted losses. However, patients receiving care from an insured practitioner also receive benefit as well. The patients receive protection knowing that should a negligent act result in damages as a result of receiving dental care, the patient is able to receive economic compensation for the costs associated with the negligent acts regardless of the economic solvency of the practitioner. The practitioner is protected from unanticipated losses from failures to meet the standard of care and the economic loss associated with harm resulting from such events. Since the insurance provides indemnity for negligence of the policyholder, it is quite unneces-

Second Scenario

In the second scenario, Weisenfeld examines contracts involving the sale of dental practices and the implications of alleged substandard care provided to patients by the owner dentist. The purchasing dentist is

The issue of retreatment could have been addressed as part of the associateship agreement.

attempting to rescind the terms of the sales contract based on the complaints and personal findings of thirty-seven patients. The legal justification upon which the purchasing dentist would want to rescind the agreement is diminished value because of material misrepresentation at the time of the contract or material defects in the practice affecting the value where such defects were known to the seller. From a legal perspective, guarantees or representations regarding the outcome of clinical care between a doctor and a patient are in general unenforceable unless accompanied by a statement in writing. While this is the case, the ethical practitioner will in general have realistic representations of the expected outcome, and in general is advised to avoid making guarantees.

Again, it must be clear that low quality clinically acceptable care, in general, cannot be the basis for a legal claim of

prevail until such time as legal remedies are available. The purchasing dentist entered into as legal agreement with the selling dentist, and while this agreement also carries with it ethical obligations, the legal ramifications of breaching a contract

could be severe. The sales contract is a memorialization of all of the terms and conditions regarding the sales of the dental practice. The Statute of Frauds, a legal concept, will in general, prevent the introduction of terms that are not spelled out in the contract. There are several questions that will be brought forth during legal representation including:

- What would a reasonably prudent purchaser of a dental practice investigate prior to purchasing a practice to ascertain the quality of care rendered by the selling dentist? In this instance, did the purchasing dentist take reasonable care to ascertain the quality of care rendered to patients? Also, would it be reasonable to expect that the purchasing dentist should have had, from a legal perspective, notice of the need to provide retreatment for allegedly negligent care?
- With accusations of negligent care, the purchasing dentist must be able to provide evidence of the alleged negligent care to a third party for proper review. What opportunity does the selling dentist have to defend against the claims of alleged substandard care?
- From a legal perspective, the practice purchaser will become encumbered with the legal obligations of the selling dentist related to the practice. Were there other legal obligations that affected the practice value that

Barring unusual factual circumstances, courts would in most cases hold the owner dentist, as an employer, responsible for assuming the quality of the work performed by employees of the practice.

sary for the owner dentist in the first scenario to make a claim against the associate dentist's insurance policy. Any claim the owner dentist would have is most appropriately directed at the associate dentist.

any kind. An exception might be the selling dentist making claims to indicate that the practice possessed patients with higher than average quality expectations and such an atmosphere of high quality becoming part of the intangible practice assets. Regardless of the present circumstances, the terms of the contract must

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the selling dentist had a duty to bring forward and failed to bring forward during the sales transaction?

- As a practicing professional, the purchasing dentist also would

Low quality clinically acceptable care, in general, cannot be the basis for a legal claim of any kind.

have ethical obligations to consult with the selling dentist regarding these concerns and attempt to provide timely and acceptable remedies to the affected patients. What steps did the purchasing dentist take to address these concerns with the selling dentist?

The purchasing dentist has an ethical responsibility to provide care to the patients regardless of the personal financial implications associated with the purchase agreement. The purchase agreement must prevail until such time legal remedies are sought to rescind the agreement. From a legal perspective, monies could be deposited into an escrow account until resolution of the dispute. The seller should be well advised to avoid unilateral action, which would result in suspension of payments to the purchaser. The purchasing dentist's legal counsel should be vigilant in protecting the rights of the purchasing dentist, and perhaps contracts drafted for the sales of dental practices should include specific formula agreed to in advance where the purchaser can seek remuneration for needed unanticipated retreatments for which the purchasing dentist cannot invoice the patient.

An interesting variation on the theme of Weisenfeld's second scenario would substitute defective porcelain crowns resulting from suspected substandard laboratory fabrication in place of the alleged selling dentist's substandard care. In this instance, the defective product resulting in retreatment is more remotely related to the selling dentist's treatment.

In this case, would the purchasing dentist be more forgiving to laboratory failures than to failures resulting from the alleged substandard care of the selling dentist? These types of failures have the same financial implications. However, the fail-

ures attributable to laboratory error might have less of a stigma associated with them and therefore the purchasing dentist might be more willing to include the selling dentist in resolution of this dilemma. Given this perspective, the purchasing dentist might reconsider taking an adversarial position against the selling dentist and perhaps should first approach a collaborative solution to the issues. As an intermediary, if needed, the attorney in the role of counselor could assist in reaching an agreeable course of action with the goal of preserving ethical patient care.

Third Scenario

Independent Contractor?

In determining whether an independent contractor or employee relationship exists when determining liability, there are several considerations including:

1. The extent of control exerted by the owner dentist over the associate dentist
2. Method of payment—production versus hourly
3. Whether the associate subcontracts as appropriate without direction from the owner dentist
4. Whether the parties created an expectation of employer/employee or independent contractor

In scenario three, one would argue that the facts presented raise issues of independent contractor status where the owner dentist maintains control of critical aspects of the patient care process. Legal concepts regarding independent contractors originated from litigation in-

volving skilled tradesman and the liabilities associated with careless workmen resulting in suits against property owners. The independent contractor concept arose to protect property owners who exercised little right of control as to the manner of completion of the contracted work. See sidebar.

It is the degree of control exerted by the owner dentist that will define the ultimate legal standing of the associate dentist as an independent contractor or employee in the third scenario depicted in Weisenfeld's article. The questions that could arise in each of these instances include:

- What degree of control did the owner dentist exert over the associate dentist with regard to working hours, length of appointments, selection of materials and instruments used in the procedures, providing of support staff to conduct procedures, etc?
- What degree of duty did the owner dentist have to select competent associate dentists and duty to periodically monitor and review their competency?

- Is the owner dentist accepting indemnification of retreatments by retaining 60% of the fees collected which includes the costs of overhead, with overhead including those instances where retreatment is indicated?

the patient, and furthermore, what is the ethical dilemma associated with "ownership" of patients of the practice?

is as valuable as well-communicated informed consent, which should be a familiar part of providing ethical patient care. Issues of responsibility and profes-

ing dentists and the right to practice following termination of the association agreement or following the sale of a dental practice. Such restrictive covenants often restrict the seller or associate from re-establishing a practice within a certain number of miles from the practice from which the dentist separated for a certain number of years. An ironic note: legal employment agreements restricting the rights of partners or associates (attorneys) to practice after termination of the relationship are prohibited under the ABA Model Rules of Professional Conduct. Such agreements restricting the rights of partners or associates to practice law after leaving a firm limit professional autonomy and limit the freedom of clients to choose legal representation. These issues of professional autonomy and patient autonomy are an apparent non-issue in medicine and dentistry, as the courts and respective professions continue to sustain such agreements. Regardless of this issue, ethical decision-making must focus on the patient and must preserve the intention of the profession to serve the best interests of the patient. If it should be clear that the dispute resolution process between colleagues cannot be allowed to compromise patient care, then disputes between professionals cannot be allowed to place individual patients into the center of the dispute. While disputes between professionals might be the subject of courtroom drama, planning, communication, and mutual understanding are much more effective.

The purchase agreement must prevail until such time as legal remedies are sought to rescind the agreement.

- Were the patients aware of the associate dentist's independent contractor status or did the practice "hold out" the associates as members of the practice indistinguishable from the owner dentists? Apparent agency is a legal concept that would arise when the practice causes the patients to believe that the independent contractor associates are agents/employees of the practice. In this case, the question is, what does the reasonable patient believe based on the business practices of the dentist group? Were the associate dentists an "apparent agent" of the practice and were patients given the perception that the practice employed many dentists?

The issue of retreatment could have been addressed as part of the associateship agreement. A well-drafted and well-communicated associateship agreement

is simple when all parties understand the terms of any agreement and the implications associated with such professional transactions.

While sometimes unclear, the legal principles in the United States are intended to reflect ethical values and principles of fairness and justice. Involvement of the legal profession in dispute resolution is a reflection of the complicated nature of professional transactions and the implications of poor negotiation. However, with regard to issues of malpractice and substandard care, it is a member of the dental profession who establishes the standard of care, the failure to meet that standard, and the proximate cause of damages to the alleged failure to meet that standard. The legal profession becomes involved to facilitate the process when the parties involved in the dispute feel they are unable to resolve their differences in opinion.

As a final note, it is interesting that each scenario Weisenfeld describes also raises another common dilemma involv-



Promises

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Abstract

Sometimes language is used to describe things and sometimes it makes things happen. The four conditions required (person, context, words, and effect) for performance language are presented. It is argued that diagnosis is a performance and not a description and has traditionally been undervalued by dentists. Discursive ethics is based on a special class of performance language—the promise.

The dental profession has become increasingly concerned over the truthfulness of claims. Perhaps at no time in our history—and certainly not since the beginning of this century—have the practitioner and the public been subjected to such a variety of treatable diseases, so many products and processes, so much diversity in practice and payment patterns. More people than ever are making claims through more channels, and they seem to conflict with each other and what was said just a few months before. We have only begun to address the problems of truth claims.

Dentists and patients have to be concerned with another powerful group of statements that is not based on being true or false. These are words that do something. “You are under arrest,” “I would like you to join the professional team in my office,” “I now pronounce you husband and wife,” “I will sell my practice for \$400,000,” “The insurance request is denied.”

Casey struck out in the bottom of the ninth. That is a fact, and anyone in Mudville who saw the game would say so. But what about that second, called strike? What was it when the ball just crossed the plate but before the umpire made his famous gesture? The answer is, as umpires everywhere will insist, it was nothing. The pitch is what the umpire says it is.

In just the same way, the verdict is what the jury declares; guests are made welcome on the date mentioned on the dinner invitation; dentists are competent to practice if the state board says they are; and patients have periodontal disease if the dentist diagnoses it. Sentences that describe conditions of the world and are subject to being true or false are called descriptive sentences. Sentences that do work, those that confer status,

create relationship, or engender expectations are called performance language.

Rules For Doing Things With Words

There are four conditions that must be met in order to do things just by saying so. When any are missing, performance language miscarries or the situation becomes ambiguous. There is also a fifth condition, common to many performatives but not essential.

The Right Person. A parent or legal guardian can give informed consent for a minor or incapacitated patient. A state board can revoke a dentist’s license, and an insurance consultant can authorize payment on behalf of patients. But patients cannot revoke a license or authorize payment; a board cannot give informed consent or authorize payment; and the consultant cannot give consent for treatment or discipline a dentist. In very formal situations such as weddings or graduations, expected language often includes words to the effect “by the authority vested in me...”

The Right Circumstances. Dental licenses can only be disciplined or revoked following prescribed procedures conducted in a prescribed manner. None,



to my knowledge, have been revoked in a bar or elevator in recent years. Sea captains are occasionally authorized to perform marriages, but only at sea. Conditions supporting doing things with words often extend to interpretation of the appropriateness of the circumstances, the mood of those present, and even the way something is said. A jury of twelve reasonable men and women is occasionally called on to decide whether a person was joking, coerced, or otherwise acting out of character when making a promise.

The Right Words. In order to accomplish something with words, the right person in the right circumstances has to use the right words. It is something like a magical incantation. The normal formula is “I *verb object* (where the object normally refers to another person or to something about another person). “I accept your offer to become a partner in the dental practice,” “I submit this treatment plan for preauthorization on behalf of the named patient,” “By my signature on this disclosure form I signify that there is no conflict of interest between the manuscript as submitted for publication and any commercial interest I may have in products or procedure described.” Sometimes performance language appears to evade this requirement by using professional jargon. An example might be “You have periodontal disease.” But it is always possible to restate a true performative into the conventional form, as in “By virtue of my training and license, I diagnose a treatable periodontal condition in your mouth.”

The Right Effect. The intent of using words to do something is always to transform someone. “You are fired, out, married, guilty, exonerated, in arrears, etc.” These statements have the effect of changing the status of the person referred to. Sometimes performance language changes both the speaker and the listener. “Because of certain circumstances, I find it necessary to discharge you as a patient” or “I agree to the conditions of the memorandum of understanding for hospital privileges” change

both the person speaking and the person to whom the speech is addressed.

Ceremony and Symbols. The four requirements just listed pretty much define what is necessary for doing things with words. There is, however, a fifth element that is often present and, because it is so special, is distinctly associated with performance language. Very formal and high language is often used to call attention to the fact that something is being done rather than merely being described. Special locations are reserved (such as the Temple for Mormon marriages) or special costumes are worn (judges’ robes or academic regalia). Often gifts are exchanged as a visual sign of an anticipated transformation (such as wedding rings or buying a round of drinks after a business deal is concluded). The show and ceremony are not essential to doing things with words, but they are a way of drawing attention to the fact that words are being used here in a special way.

Diagnosis

A case can be made that diagnosis is an undervalued service in dentistry and that it is undervalued because of the mistaken belief that it is merely description.

by a license to diagnose. The diagnosis is made in a dental setting and is based on traditionally recognized tests and examination procedures. The diagnosis follows a formula of the dentist naming a condition present in the patient, normally using professional nomenclature. But most importantly, a dental diagnosis alters the person who is diagnosed. It is something more than accurately describing the signs and symptoms; it is creating a treatable condition. Regardless of how well a dentist performs a therapeutic intervention, he or she is open to malpractice action or censure if the therapy is not based on an accurate diagnosis. From an insurance point of view, patients are ineligible to receive reimbursement under the conditions of their pre-paid benefits unless an appropriate diagnosis has been made.

Because diagnosis has often been confused with description (words that tell about things) instead of being performance language (words that do things), there is a tendency to devalue it compared to the physical interventions of doing things to patients. The same confusion is less likely to occur among physicians. They normally bill patients a

There is one universal kind of action statement that requires no approval or authority from anyone else. That is a statement that is binding on the person who makes it for some future action – a promise.

The alternative presented here is that diagnosis is the essential foundation for all professional work and that diagnosis is performance language. Diagnosis meets all of the necessary conditions. Only certain individuals are qualified to do it, it takes place in specific circumstances, a formal language is used, and it significantly alters the person to whom the diagnosis is addressed. A hygienist or assistant can see white spots on enamel and accurately record pocket depths, but neither has the training nor the authority

fee commensurate with the value added by the diagnosis and then allow follow-up by nurses and technicians who provide services at a lesser fee, presumably because these add less value. Those dentists who advertised discounted or even free diagnosis raise some concern about the worth of their diagnoses and undermine the value of diagnosis generally throughout the profession. There is a significant difference between a dentist’s diagnosis and a free estimate for getting one’s roof repaired.



The story had been told before but bears repeating in this context. An old

doing the speaking. It creates a relationship among them.

Sentences that do work – those that confer status, create relationships, or engender expectations – are called performance language.

gentlemen ran the power plant in a small New England community for years until his retirement. Several months into the watch of his replacement the plant failed and the town was in darkness for hours. Nothing the new man did revived the system. In desperation he phoned the fellow who had kept the plant in operation for so many years and the old guy promptly restored the power simply by kicking one of the pieces of equipment. He provided a bill to the city fathers of \$408. When questioned about the high cost of such an easy solution, the old-timer itemized his work as follows: “Kicking \$8; knowing where to kick \$400.”

Promises

Philosophers such as J. L. Austin have proposed various classifications and analyses of performance language. There is one category of words that do things that merits special attention. These are promises. The first criterion for performance language is that a person of special status must be authorized to make the statement that causes an action. There is one universal kind of action statement that requires no approval or authority from anyone else. That is a statement that is binding on the person who makes it for some future action—a promise. Each of us is qualified (subject to certain exclusions for age, competence, and capacity to perform) to create relationships with others that commit us to predictable behavior in the future. Almost any circumstance is appropriate and the formal language (“I promise you ...”) applies. In the case of promises, performance language alters both the person to whom spoken and the person

One of Steven Covey’s seven habits of highly effective people is putting first things first. Covey defines discipline as keeping the promises we make to ourselves. It is obvious that promising has the capacity to change people. One of these capacities is to create trust. This is an essential condition for human interaction—the ability to go about our own business on the assumption that others will do theirs consistently and as promised. Without such trust, life would be brutish, superstitious, and primitive. Consider the simple act of signing one’s name on a piece of paper at the end of a pleasant dinner (normally without reading anything more than the total charge) and then several weeks later signing a check to the credit card company that covers, among other things, the cost of the dinner. The check is a warrant authorizing another, unknown person to adjust your assets. All of these transactions are based on promises, and in a society that keeps such promises, life is richer and more fulfilling. Contrast this with the barter arrangement between strangers in primitive societies or with

by remeasuring. The same sort of truth test does not apply to performance language, such as diagnosis. Two professionals can agree on the descriptive language that supports the diagnosis and still disagree on the diagnosis. Although performance language is subject to disagreement, there are elaborate mechanisms that govern how disputes are resolved. Normally this involves appeal to other professionals who are qualified to make their own performance language statements. A marriage, for example, is not dissolved by people agreeing that they no longer love each other. Only certain bodies are recognized as having authority to overturn performance language announcements such as revoking a dental license or disputing a diagnosis in a malpractice suit. If disputes over performance language could be resolved by appeal to the facts, lawyers would be an unnecessary class of professionals.

There is a school of ethics, known as discursive ethics, that places promises in a central role. In fact, a discursive ethicist would say that beneficence is a promise to do one’s best to benefit others; nonmaleficence is a promise to avoid harm (either intentionally or unintentionally through performing work one is not qualified to undertake); veracity is a promise not to mislead others; etc. None of these are principles in the abstract sense—all of them are actions performed with words that have the effect of changing the particular person who makes the promises and those who receive the promises.

A case can be made that diagnosis is an undervalued service in dentistry and that it is undervalued because of the mistaken belief that it is merely description.

the failure of the Russian economy and its tax and banking systems.

Descriptions are subject to being right or wrong and can be verified by reference to the facts. If a pocket depth reading is charted as four millimeters, this description can be verified or repudiated

For a discursive ethicist, veracity and autonomy has special meaning. For one such as Jürgen Habermas, veracity—freedom from misleading others—is more than an ethical principle; it is a precondition for any ethical relationship. No promise is meaningful without a

Leadership



presumption that those involved will refrain from being misleading. Autonomy also has a special meaning in discursive ethics. To be valid, all promises must be freely given and uncoerced. This means the promisor must be informed and have the opportunity to promise or refrain from promising as they see fit. The opposite of autonomy is paternalism. This is the position of withholding information, attempting to decide for others what is in their best interests, coercing or

the extreme view, it might be said that without informed consent—the ability to create a mutually satisfactory relationship through promises—all of the other ethical principles are substantially diluted.

With respect to making promises and other uses of performance language, dentists are in powerful positions. Their training gives them wide expertise and freedom of choice; they are recognized by society generally and by law specifically as having authority to do

creating the kind of world they would like to live in.

As a rule dentists prefer a world that is orderly and trusting. They give the benefit of the doubt to patients and their professional colleagues. Occasionally they are disappointed by a bad actor, but for the most part they persist in making promises along high, ethical grounds and expecting that others will do the same. Dental malpractice is confined to a fraction of practicing dentists, but it is more damaging than its numbers would indicate. A dentist who mistreats patients or defrauds an insurance company is guilty of a transgression against the patients or the company *and* of a significant offense against the profession and the community at large. Not only has a promise to be competent or truthful been broken, but the whole fabric of trust—a community based on mutual promises—has been eroded.

*Each of us is qualified...to create relationships
with others that commit us to predictable behavior
in the future.*

limiting the options of others, and in general denying them the right to make reciprocal promises. Discursive ethicists are very keen on informed consent. In

things with words, such as make diagnoses, that no one else can do. This power gives them unusual influence in



Recommended Reading

* Austin, J. L. (1962). *How to do things with words*. (J. O. Urmson, Ed.). New York, NY: Oxford University Press. No ISBN; 166 pages; \$1.35.

Austin argues that certain types of statements “do” something rather than merely being descriptive. “I offer to pay \$1M for the house” or “The jury finds you guilty” are examples. The book is an analysis and classification of such statements, which Austin calls performatives. The meaning of performatives is in their impact on listeners not in their being true or false. This small book was published posthumously from lecture notes of Austin’s 1955 William James Lectures given at Harvard. Austin was a professor of moral philosophy at Oxford and a prominent figure in the philosophical movement known as ordinary language analysis. This group included Wittgenstein and made an effort to discover the meaning of language in the way we talk naturally rather than by inventing rules that tell us what we should mean when we talk.

Ayer, A. J. (1946). *Language, truth, and logic*. New York, NY: Dover Books.

Another of the English philosophers who studied how language is used to find out what we mean. Ayer clearly distinguishes between sentences that are verified by empirical observations and those that are verified based on the meaning of words.

Chambers, D. W. Faux ethics and the ethical community. *Journal of the American College of Dentists*, 1999, 66 (Spring), 36-42 and Chambers, D. W. Looking for virtue in a virtuous society — Discursive ethics and dental managed care. *Journal of the American College of Dentists*, 1996, 63, (Winter) 39-42.

Introduction to discursive ethics in the context of dentistry. These will be the most accessible—physically and intellectually—of the references supporting this column.

* Covey, Stephen R. (1989). *The seven habits of highly effective people: Restoring the character ethic*. New York, NY: Fireside. ISBN 0-671-70863-5; 358 pages; about \$12.

Success is a matter of expressing your character grounded in principles rather than techniques that give surface results. The first three habits (be proactive, begin with the end in mind, and put first things first) are private victories that must precede the public victories of think win / win, seek first to understand then to be understood, and synergize. The seventh habit is continuous renewal — sharpening the saw.

* Fisher, Roger, & Ury, William (with Bruce Patton for the second edition) (1991). *Getting to yes: Negotiating agreement without giving in* (2nd ed.). New York, NY: Penguin Books. ISBN 0-14-015735-2; 200 pages; about \$13.

Negotiating should be based on interests and negotiated agreement about the process of negotiation rather than on positions and compromise. Your true power comes from your Best Alternative To a Negotiated Agreement. “It is suggested that you look for mutual gains wherever possible, and that where your interests conflict, you should insist that the result be based on fair standards independent of the will of either side.” Fisher was at Harvard Law School and Ury was at Harvard Business School when the book was written. They developed the Harvard Negotiation Program, a multidisciplinary program teaching negotiation skills and consulting on negotiation, especially in international issues.

Habermas, Jürgen (1993). *Moral consciousness and communicative action*. (C. Lenhardt & S. W. Nicholsen, Trans.). Cambridge, MA: MIT Press.

Excellent source for studying to discursive ethics. The rule that ethics cannot exist aside from a foundation in truthful, uncoerced communication is laid out in detail.

Wittgenstein, Ludwig (1966). *The philosophical investigations*. (G. Pitcher, Ed.). New York: Doubleday.

The Austrian-British philosopher who invented “word games”—the serious practice of analyzing sentences by looking at how they can be used and what they cannot be used for in ordinary language. Warning: we are talking about 500 pages of essays that will put anyone to sleep. Unless you suffer from incurable insomnia, memorize the first sentence in this paragraph and work it into conversations at the opera and leave the book in the library.

Editor’s Note

Summaries are available for the three recommended readings preceded by an asterisk. Each is about four pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Office in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on promises; a donation of \$50 would bring you summaries of all the 2000 leadership topics.

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