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Ethics and Leadership in Children's Oral Health

Wendy E. Mouradian MD, MS

Abstract: *Purpose: This paper reviews key ethical precepts in health care for children, and explores how interpretations of justice predict different and sometimes conflicting approaches to children's dental needs. Ethics is a core competency for health professionals because of their special responsibilities toward patients and the public. Ethical principles guiding health professionals include: (1) beneficence; (2) nonmaleficence; (3) respect for autonomy; and (4) justice. Different theories of justice lead to different responses toward public needs, such as access to dental care. The most frequently encountered response in the dental community is volunteerism, consistent with the libertarian perspective on justice. Though desirable, volunteerism alone will never solve dental access issues because such efforts do not address the problems systematically. A policy statement of the American Academy of Pediatric Dentistry (AAPD) explicitly recognizes that children have a right to oral health care. Children's unique characteristics—their vulnerability, dependence, and developmental processes—call for special arrangements to address their health needs. Given the importance of children to society, it is critical that all health sectors work together to address children's health and well-being. However, those with the greatest knowledge of children's oral health needs—pediatric dentists—must take a leadership role in creating and supporting solutions to these needs. The AAPD has an opportunity to support systemic solutions at the state and national level to ensure that all children have access to oral health care. One example of a systemic solution is the Access to Baby and Child Dentistry (ABCD) program in Washington State. (Pediatr Dent 2007;29:64-72)*

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A meeting of the College of Diplomates of the American Board of Pediatric Dentistry (ABPD) is a very appropriate avenue for a discussion of ethics and leadership in children's oral health. The ABPD exists as a manifestation of the social contract between health professionals and society, which includes the privilege and responsibility of self-regulation. As published on the organization's Web site, "The mission of the ABPD is to verify to the public and to the health professions that a pediatric dentist has success-fully completed...[the requirements] designed to validate the knowledge, application and performance requisite to the delivery of proficient care in pediatric dentistry."[1]

Ethics and professionalism represent a core competency for health professional leaders working in the maternal and child health (MCH) fields.[2] This competency includes both an internal moral compass and specific knowledge of the health professionals' ethical responsibilities toward patients and the public. In proposing an ethical framework for children's oral health, I will review the ethical responsibilities for health professionals including different notions of justice and then apply these to the pediatric context. To some extent, notions of justice predict the dental profession's preferred response to access issues—one of volunteerism. A strict reliance on volunteerism, however, is insufficient to address children's oral health disparities, which reflect deep systemic issues. A more pragmatic approach partners pediatric dentists with other health professionals and advocates creating systemic solutions. Since pediatric dentists have the greatest expertise in children's oral health, they have an obligation to take a leadership role in these efforts. This obligation is consistent with the strong written policy of the American Acade-my of Pediatric Dentistry (AAPD), which recognizes that all children have a right to oral health care.

Ethical precepts in health care

What is ethics? Simply put, ethics is about our actions and how we relate to one other as human beings. It includes both intentions and consequences, since one's actions don't always result in their intended outcomes. Despite the great cultural and religious diversity in today's society, there is considerable agreement on the tenets of a basic moral code. The "golden rule"—do unto others as you would have them do unto you—forms the basis for a personal code of ethics that has wide, if not universal, acceptance, even in today's diverse society.[3]

Dr. Mouradian is Director, Regional Initiatives in Dental Education (RIDE), Clinical Professor of Pediatrics, Pedriatric Dentistry, Dental Public Health Sciences and Health Services (Public Health), University of Washington, Seattle, Washington. Correspond with Dr. Mouradian at mourad@u.washington.edu

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Beyond a personal code of ethics, health professionals are accountable to an additional set of values.[4] These values and implied responsibilities arise from practitioners' unique relationships with patients and the public. First and foremost, practitioners are to benefit their patients, and above all do no harm. These principles are called beneficence and nonmaleficence, and are ascribed to Hippocrates, born in the fifth century in classical Greece.[5] To this day, all graduating medical students take the Hippocratic Oath. Dental students do not uniformly take such an oath, although dental professional associations have codes of ethics and dental schools may have "white coat ceremonies" or other similar rites of passage intended to reinforce a sense of professionalism. Despite a competency with respect to ethical behavior laid out by the The Commission on Dental Accreditation, this lack of uniformity raises the question of whether there is broad agreement on core concepts of professionalism across the dental community and within dental education.

A second important theme influencing one's notions of professional ethics is a need to care for the sick out of compassion or a sense of altruism. This obligation is apparent in many religious traditions. For example, the Judeo-Christian parable of "the Good Samaritan" is often held out as an example of the need to care for the sick, even at some risk to ourselves.[6] The establishment of hospitals and care for the sick by religious orders is an expression of this aspiration.

The now commonly accepted principle of respect for patient autonomy did not become prominent until the mid 20th century, when advances in science and technology enabled medicine and dentistry to dramatically improve health, but also to do much mischief. The "doctrine of informed consent" specifies that all interventions require the free, informed consent of a competent patient.[7] More recently, the emphasis on patient autonomy parallels the rise of patient consumerism, where the patient as consumer shops to get his or her needs met.

Informed consent involves discussing various treatment options with patients, including the alternative of doing nothing, and reviewing the potential benefits and risks (eg, the commitment of time, travel, and resources) as well as the burdens of pain and any possible complications. It includes assessing, if only implicitly, the competence of patients or those making decisions for them. Informed consent implies respecting that patients have their own values and the free dom to act on those values. Through this process, the pull to a provider's self-interest—economic or otherwise—must be balanced by the:

1. health professional's commitment to the patients' best interests; and
2. recognition of the patient's vulnerability in this health encounter.

Indeed, the American Dental Association's (ADA) Code of Ethics explicitly proscribes health care interventions motivated by personal profit alone.[8] Patients must be able to trust that their health professional will act in their best interests.

This sense of trust is a core part of the relationship between health professional and patient, which is fundamentally an unequal one. The health professional is the expert, who has the knowledge and ability to order health tests and procedures. No matter how well the patient has researched the Internet, he or she is vulnerable in the face of this inequality of knowledge-and often- because of pain and disease. The patient must trust that the health professional will make recommendations in his or her best interest. There is an increasing concern that this trust has been eroded in an era of increasing commercialization and for-profit health care, as evidenced by calls for a renewed sense of professionalism in the medical community.[9,10] There have also been more discussions of ethics and professionalism within the dental community, particularly around access issues.[11,12] It is of note that the European Dental Education Association has placed professionalism as its number one competency for all dentists.[13]

Ethics in cross-cultural encounters

The relationship between patient and health professionals is more complex in today's cross-cultural health encounters. About 45% of children under age 5 are from minority families,[14,15] so such encounters will be increasingly common. In these cases, the establishment of trust and communication may be more difficult. Who makes decisions may vary across cultures. It could be a member of the extended family, or tribal elder, for example. Families may have different oral health beliefs and differing concepts of "best interests." Today's health professionals need cultural sensitivity. The importance of cultural factors has been highlighted by the Institute of Medicine (IOM) in its recent report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.[16] According to this report, a consistent body of research demonstrates significant variation in the rates of medical procedures by race—even with comparable insurance status, income, age, and severity of conditions. Racial and ethnic minorities in the United States are less likely to receive routine medical procedures and experience a lower quality of health services. These differences may stem from: (1) stereotyping; (2) discrimination; and/or (3) a lack of cultural sensitivity.

Cultural sensitivity starts with an awareness of one's own cultural assumptions, and a willingness to be open to the cultures of others. It includes the difficult task of negotiating across cultural barriers to accomplish effective health care. Culture is more than race, ethnicity, or socioeconomic status, of course. The underlying assumption here is that practitioners should be treating people fairly, without bias or discrimination. If the IOM report had included dental care, one

would probably find instances of the same unfairness that has been ascribed to medical decision-making. Dentists, too are subject to these cultural perceptions, and must guard against them. Practitioners must first acknowledge their role in perpetuating these attitudes before they can change them. Concern for fairness in the treatment of patients raises issues of justice for individual dentists and physicians.

Definition of a profession and its obligations

Issues of justice are also important for the professions of dentistry and medicine because they have a responsibility to ensure fairness in the promotion of the societal good. This obligation arises from the dental community's status as a profession. What is a profession? The definition of a profession includes the following components:

1. mastery of a complex body of knowledge and skills that are used in the service of others; and
2. a commitment to:
   a. competency;
   b. integrity; and
   c. ethical precepts, including altruism and the promotion of the public good within one's domain.[17]

The profession of this commitment is what distinguishes a professional from a highly skilled technician. This commitment forms the basis of a social contract between the profession and society.[17,18]

In this social contract, society grants the profession the right to:

1. "practice" on the public;
2. self-regulation, including the definition and maintenance of competency standards; and
3. monitoring for ethical breaches.

In return, society trusts the profession to: (1) act in the patient's best interests; and (2) be accountable on issues of self-governance. This social contract is a covenant—a binding contract for both parties; it is not optional or gratuitous.[19,20] The status of professional is not an entitlement that comes with the DDS or MD degree, but is granted by society with this understanding. In turn, the professional recognizes and accepts the burden of this social responsibility. Professional ceremonies can serve as powerful reminders of this relationship, or they can ignore this underlying social contract and only emphasize the trainee's achievement of competency—only a part of the social contract, albeit an important one.

The social contract also acknowledges the public funding of much health professional training. While 91% of dental students owe an average of $115,000, according to the ADA,[21] the actual cost of a dental education averaged $312,000 in 2002.[22] Beyond tuition, costs are covered by public funds, private donations, and clinical services.

Are dentists fulfilling their social contract? Probably all physicians and dentists can think of ways in which they are not. The inaction or inadequate action of practitioners in the face of health disparities is one example. Furthermore, as professional associations and accrediting bodies are responsible for dentists, so, too, are dentists responsible for them. If these entities do not represent the strong ethical positions to which they are called, including a response to health disparities, then practitioners have an obligation to work to bring about change.

Notions of justice call for health care providers to redress unfairness in the provision of health care. There are different prevailing conceptions of justice in today's pluralistic society, however, and these different approaches lead to different responses to social inequities—including those affecting access to oral health care. Ours is also an eclectic society, and most people would favor a different approach to justice—depending on the particular issue. I hope to spark some thought with this paper, as I believe that some of our most deeply held—but rarely discussed—views of justice inhibit effective action in addressing oral health disparities. There are strong currents of several common approaches to justice in mainstream American culture.

Theories of distributive justice

Egalitarian theory. John Rawls is the major modern spokesperson of the egalitarian approach.[23] Rawls asks us to imagine that we are all blind to the social lottery that will determine the families into which we are born and the resources and opportunities we will have. Rational, self-interested people, Rawls argued, would prefer a system that favors the less fortunate, since one would never know into what position he or she would be born. Accordingly, people would—by virtue of the social lottery—arrange their social institutions to benefit those who are the worst-off. This would ensure more equal opportunities to all, including the most unfortunate. This thinking is behind the Americans with Disabilities Act[24] and school lunch programs.

It was later argued by Norman Daniels[25] that health care is so vital to equal opportunity that, as a matter of justice, it should be distributed to everyone. In essence, there should be a right to health care. Then it could be argued that oral health is important to overall health and is, therefore, vital for ensuring equal opportunity. Many here today are likely to agree on this position. In this vision, we are a just and fair people working hard to ensure equal opportunities for all. This viewpoint also recognizes that peoples' positions in life are profoundly affected by the social lottery, over which they have no control.

Libertarian theory. Libertarian notions of justice state that there is no greater good than liberty. Robert Nozick is a major proponent of this position.[26] The benefits of one's labor be-

long to oneself. This, too, is a profoundly American philosophy. In this vision of ourselves, we pull ourselves up by our own bootstraps and own the product of the sweat of our brow (whether the farmer's crop or the hard-won medical imagine or dental degree) We own it, and we don't have to give it away. This is the free market. This is individualism. (Note how this contrasts with the professionalism notion of the social contract, in which we owe something to society.) In its purest form, libertarianism is inconsistent with schemes of social redistribution to pay for public benefits—be they Medicare, Medicaid, social security, veterans' programs, or public education. If you are really going to be a purist, it will be difficult to support a libertarian position consistently.

The current US health care system—especially the dental care system—largely reflects the libertarian position that health care should be distributed by ability to pay and personal choice; there is no right to health care. As to children born into poverty, disability, or other compromising situations, the libertarian would call this unfortunate—but not unjust. The libertarian would not favor re-distribution of goods (taxes, Medicaid, etc), but would favor—even very strongly—volunteer efforts to redress this situation. Major volunteer efforts (eg, Give kids a Smile Day) are examples of such efforts organized by the dental community. Although well intended, few would argue that they constitute a system of care. Most dentists report pro-bono work, although fewer than 4 in 10 dentists participate in Medicaid, which is consistent with a strong bias toward volunteer solutions to dental access problems.[27]

Utilitarianism theory. Utilitarianism is a schema that supports the greatest good for the greatest number of people—focusing primarily on outcomes for the larger society. John Stuart Mills was the prime articulator of this notion, which is really America the pragmatist. Just get it done; move ahead, and never mind about the theories. Utilitarianism is an outcomes-oriented, consequentialist approach. At times, utilitarian approaches can over-rule individual interests in favor of the public benefit. Many public health measures—such as restriction of smoking in public places, mandatory reporting of sexually transmitted diseases with case tracking, and water fluoridation—favor the public's health over individuals' concerns for personal choice and privacy. Preventive efforts are favored in the utilitarian scheme, because of the overall cost-benefits to society. The current emphasis on outcome assessments, evaluation, and evidence-based thinking also reflects a utilitarian bias.

In summary, different philosophical approaches to justice underlie different responses to health disparities. The dental community's response of volunteerism most closely approximates a libertarian approach, and explains the predominate approach to children's oral health disparities.

Codes of ethics of health professions

ADA's Principles of Ethics and Code of Professional Conduct. With these considerations in mind, practitioners can review their professional organizations' positions on the ethical issues that this paper has considered. The 2005 version of the ADA's Principles of Ethics and Code of Professional Conduct[8] represents the latest tweaking of the 1998 revision, which has a much stronger positioning on ethical issues compared with earlier iterations of the Code. The ethical precepts elaborated include (in the following order): (1) autonomy; (2) nonmaleficence; (3) beneficence; and (4) justice (ie, treating patients without bias). Desirable character traits for the dentist include: (1) truthfulness; (2) compassion; (3) integrity; (4) fairness; and (5) charity. The ordering of the principles may be significant. Autonomy is stated first, possibly reflecting the libertarian bias toward individual liberties. It is all a matter of personal choice, and what one can pay for. While personal liberty is an important American value, the emphasis upon personal choice in this context gives the message that oral health is not that important—it is elective, a matter of choice. The more common—and certainly the historic ordering of bioethical principles—places patient benefit first.[9,10]

Although justice as fairness in treatment of individual patients is articulated in the Code, there are other statements in the Code which place justice in a broader social context, consistent with discussions of professionalism and the social contract:

> *"The dentist's primary obligation is service to the patient and the public-at-large"; "...Dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community" (both statements from the discussion of beneficence). "The dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all" (from the discussion of justice).*

In the last statement, dentists are encouraged to address access issues, but only as a matter of choice. No guidance is provided as to how an individual dentist might do this, or what the obligations of the dental profession are in the social contract.

AAPD

The AAPD in its Reference Manual[28] includes a brief discussion of ethical principles, with definitions: "Dentists have an obligation to act in an ethical manner in the care of patients. Commonly accepted virtues of ethics include autonomy, beneficence, nonmaleficence, and justice." The order follows that stated in the ADA Code of Ethics. A much stronger statement follows, however, under the section AAPD Policy Statement:

"Justice expresses that the dentist should deal fairly with patients, colleagues, and the public. Infants, children, and adolescents, including those with special health care needs, have a right to dental care. The AAPD believes it is unethical for a dentist to ignore a disease or condition because of the patient's age, behavior, or disabilities. Dentists have an ethical obligation to provide therapy for patients with oral disease or refer for treatment patients whose needs are beyond the skills of the practitioner."

Summary of ethical framework

In summary, ethical principles of beneficence, nonmaleficence, and respect for autonomy guide the individual health professional in the care of patients. Underpinning this is the doctor-patient relationship, based on the trust that the professional will act in the patient's best interests. In addition to competence, the virtues of compassion, altruism, trustworthiness, confidentiality, and justice are expected of the health professional. The social contract between society and health professions requires the professions to engage in self-regulation and take responsibility for the public's health. As a matter of justice, dentists and physicians should support access to health care for all citizens. Depending upon one's philosophical approach to justice, there will be vastly different responses to health disparities. In the case of the pediatric dentist, the AAPD's statement of children's right to oral health care raises the required response from a desirable charitable act to an obligation to address the issues. The question is not whether, but only how to address children's oral health disparities. To answer this question, one must first consider how children differ from adults, and why the response toward them must also be different.

Ethics in pediatric context

The unique case of children. The AAPD's intensified statement of the right to oral health care reflects the fact that pediatric dentistry is a profession caring for children. Children are different in ways that impact dentists' responses to their needs. Most obviously, children are vulnerable and dependent upon others to access health care and home health practices. They are at the beginning of the life span, with maximal opportunities for disease prevention and health promotion. Children are constantly developing and changing, and their developmental processes are vulnerable to diseases and disability. Long-term consequences may not be apparent for years. Moreover, children are not responsible for their health problems. In today's society, children are the most diverse segment and they are the poorest. Health professionals who work with children recognize these differences; health systems that serve children must take these differences into account.[29]

Ethical principles applied to children. When the ethical framework is reviewed in the pediatric context, all the principles apply—with some caveats. For example, the outcomes of one's interventions may be less predictable because of developmental processes and the time needed to assess benefits. Moreover, data to guide these decisions are often lacking due to the cost and difficulty of longitudinal studies. Patient autonomy is now ensured through the parent or caregiver, who must act in the child's best interests by providing assent.[30] Later, children participate as age and abilities allow. The health professional's legal responsibility is to the child, not the parent.[31] Pediatric dentists are very aware of this triangle.

One of the greatest risks for health professionals who feel passionately about the best interests of children is negative handling of parents who do not seem to be following prescribed health behaviors. While such negativism may be understandable, it can hurt children by alienating parents. The best chance for helping the child is to form a positive alliance with the parent and gradually work toward common goals for improved health outcomes of the child. A promising approach recently utilized in the oral health context starts with parent's current health behaviors and develops small steps toward more healthy behaviors over time. Use of this approach, called motivational interviewing, has led to improved oral health outcomes for children in a culturally diverse setting.[32]

Obviously, the social contract includes children: it is intensified because of children's special significance to society's future. When one considers the extent of poverty among today's children, there is room for concern for the robustness of our future society and its economy. If Medicare and Social Security crises exist today, what will it be like if children from poor or low-income families—representing an astounding 40% of today's children[33]—do not have opportunities to become productive citizens? These opportunities should include, among other things, access to good oral health care. Because of their special expertise, pediatric professionals have a particular responsibility to advocate for children's health needs and a unique opportunity to benefit children.[34]

Theories of justice and health care for children. In the case of children, all conceptions of justice support special efforts to help children.[35,36] From an egalitarian perspective, society must provide extra resources for underserved children to ensure equal opportunity; from a utilitarian standpoint, it is necessary to prevent disease early because this is more cost effective, and because healthy children mean a more robust society for the future. The libertarian favors helping children as a matter of compassion. The big difference is how these approaches guide practitioners to act on children's needs: the egalitarian and utilitarian approaches support changes

in institutions and policies, while the libertarian approach would support voluntary efforts.

In a pluralistic society, perhaps the most cogent question to ask is "what works?" While all approaches seem to make sense, voluntary efforts by themselves—though admirable—can never fully address problems that are systemic in nature. Hence, they cannot be the primary approach to solving health disparities. AAPD supports a universal right to health care for children; accomplishing this worthy goal will take efforts across multiple health sectors. The high level of volunteerism seen in many sectors of the dental community indicates that there is good will and contributions of time and resources by dentists to help those without access to dental care. All the essential components that the dental community can contribute are present, but they need to be harnessed and organized in a way that makes a difference. A dentist giving of his time and resources would certainly want them to make a difference. Of course, all care counts for the individual child or family, but more organized efforts have a greater chance for substantial improvement across populations.

Disparities in children's oral health and access to care

Exactly what are the health disparities that need to be solved? Despite efforts to redress the situation, American children still experience significant disparities in oral health outcomes and access to dental care. While some measures report increased access to preventive dental visits for older children,[37] caries rates are actually rising among the youngest children.[38] There are likely multiple reasons for this worsening. Demographic factors that place them at increased risk for health disparities include the: (1) persistence of child poverty; (2) increasing diversity of children; (3) Western diet; (4) use of bottled waters; (5) lack of water fluoridation; (6) educational status of parents; and (7) recent immigrant status. Furthermore, these risk factors are interwoven. Poor diets that put children and adults at risk for caries also put them at risk for obesity, diabetes Type 2, and cardiovascular disease, for example. Teasing out the factors for disparities is complex—with biological behavioral, environmental, and sociocultural factors at play. Access to dental care is affected by insurance status, geographic location, and access to pediatric providers: most dentists—90% in one study—will not see 1-year-olds, regardless of insurance status, despite AAPD and ADA recommendations that all children should have a dental visit by age 1.[39]

Health disparities can be addressed when there is political will and systemic solutions. For example, 89% of poor children have a regular medical provider, while 74% of children 19 to 35 months old receive all their immunizations.[40,41] By contrast, of poor children covered by Medicaid insurance, fewer than 1 in 5 received a preventive dental visit, according to the Inspector General.[42] Oral health disparities may persist, in part, because practitioners eschew systemic solutions in favor of volunteerism and due to deeply held but rarely discussed beliefs. Volunteer efforts reflect dentists' desire to help, which is a good thing. Such an approach also keeps the dental community in charge of the kind of care that is provided. While this might also seem like a good thing, one unintended consequence is a failure to increase appreciation for the importance of oral health and to ensure buy-in among other health professionals, policy makers, and the public. The other problem with volunteer solutions is that they just don't work. To me, disparities and how you respond to them are the biggest ethical issues you face as a profession.

Responding to children's oral health disparities

Why do "band-aid" solutions fail? The author is indebted to the organizers of a dental ethics conference held at the ADA in Chicago in 2005 that addressed this particular issue. What is conveyed briefly in this paper will be articulated more fully in a special issue of the Journal of Dental Education devoted to ethical considerations in access to dental care.[43,44] Band aid solutions can be defined as nonsystemic, largely sporadic volunteer efforts directed at improving dental access issues.

Inadequate sense of profesionalism. It has been argued by Smith that band-aid solutions fail in part because of insufficient efforts due to an inadequate sense of professionalism within dentistry.[45] There is some evidence for this in the earlier ADA Code of Ethics, as revealed in a detailed critique and analysis.[19] The more limited view of the dentist's professional obligations in the earlier Code may be the result of the separation of dentistry from the overall health system, including its bioethical culture. This separation has also contributed to a devaluing of oral health and a more elective view of dental care, the latter reinforced by the profession itself. If much dental care is cosmetic, then clearly no just distribution of this resource is required. But an even more widespread sense of professionalism, if expressed primarily as volunteerism, cannot solve the problem.

Health disparities are too big a problem. The main reason band-aid solutions fail is the complexity of health disparities. Oral health disparities are systemic problems that require systemic solutions. They cross health sectors and disciplines, and no one person alone can solve the underlying issues. Because dentistry is also a business, a business question should be posed: What business would expect to deliver a service with sporadic efforts that occurred once a year or only on specified days or only at the personal choice of the workers? Dentistry has received enormous criticism because these disparities have not gone away. But why would you ex-

pect them to? It is hard to make a dent in these problems with essentially random acts of kindness. Such efforts and energy should be part of larger systemic approaches—not by themselves the solution.

The core problem is that band-aid solutions are not geared to match population needs. Volunteer care is typically offered when and where volunteers are willing and able to provide such care. For example, volunteer efforts may be limited to sites that a particular community has available—such as a community health center (CHC) or other volunteer dental clinic. But what about locales that don't have these sites, such as small towns and rural areas? Band-aid solutions are not based on the needs of patients or populations regarding the: (1) location; (2) timing; (3) type of services needed (eg, pediatric); or (4) language of the transaction. Band-aid solutions do not address needs for continuity or comprehensiveness of care, including prevention and health education, and do not ensure creation of a dental home. Such approaches do not help children who don't get in the door. The assumption here appears to be that responsibility stops at the door, which is in contrast to the social contract, which insists that a dentist's responsibility is to the public at large.

The second major problem with band-aid solutions is that they do not address larger health system issues such as dental provider capacity—including numbers, diversity, training in specific skills (eg, in the care of children, elderly, and special populations; cultural competency; communication skills), and distribution of such providers. Such solutions do not usually engage other health professionals who could help promote oral health, such as primary care providers or others working with young children in day care or other facilities (eg, Head Start, WIC – the Women, Infants and Children program of U.S. Department of Agriculture, etc).

Engagement of the larger health community could expand advocacy for oral health with families, insurers, and policymakers. Without a broader investment in oral health, the larger health system issues cannot be solved, such as the absence of dental coverage for large numbers of people, inadequacy of reimbursement, etc. If oral health is not promoted at a system level, then it remains a dentist-only issue. The result is that oral health remains marginalized, not part of overall health.

There are other issues that can be easily forgotten when dentists focus on volunteer efforts. To solve health disparities, practitioners should be empowering families and communities to find solutions that work for them and that include other parts of the health and social safety net.[46] Perhaps most worrisome, band-aid solutions don't get at the deepest professional issues; they risk framing dental efforts as gratuitous efforts – not part of the social contract; they provide a false sense that practitioners are all "doing some good," when actually only a few are doing the good; finally, band-aid solutions do not recognize the responsibility for leadership in systemic change.

With the strongest possible reasons to prioritize children's oral and overall health, practitioners have become accustomed to an approach to oral health disparities that no individual dentist would find acceptable as a solution for a problem in his or her own business.

Unique leadership role for pediatric dentistry

The AAPD has an opportunity to change this status quo. This organization and its members speak loudly—if not with one voice. The AAPD can support a systemic approach to change and call on other dental professionals to join in this challenge. But first, dentists need to admit that the problem is bigger than their professional efforts alone can address.

Example of a systemic solution

The Access to Baby and Child Dentistry (ABCD) program is one of a number of efforts that take systemic approaches to health disparities.[47] This award-winning program is an outreach effort of the Department of Pediatric Dentistry, University of Washington – in partnership with the Washington State Dental Society, component dental societies, local dentists, the Medical Assistance Administration (Washington's Medicaid Agency), local health departments, and the Washington Dental Service Foundation (WDSF). In this model, pediatric dentists train general dentists in preventive care for infants and young Medicaid-eligible children. In turn, dentists are eligible for a somewhat enhanced Medicaid fee, while the health department provides transportation and case management for underserved families and offers guidance on how to behave in a dental office. Support from the WDSF helped establish the program, which is now active in over half the counties in Washington State and has been applied to locales in other states. This program:

1. emphasizes prevention for parallel construction and the establishment of a dental home for young children,
2. recognizes that general dentists may need extra training to feel comfortable providing care for children; and
3. addresses some of the common barriers to access to care that families may experience.

Another example of a systemic approach to children's oral health care is the North Carolina Into the Mouths of Babes program.[48] One leadership opportunity for pediatric dentists would be to adapt these programs—which have outcomes data—to other states and regions.

Conclusions

In summary, an ethical framework for health care professionals defines their responsibilities to their patients and the public. Children's unique characteristics lead to ad-

ditional ethical responsibilities, but how dentists respond to children's oral health disparities is influenced by deeply held, but rarely challenged, philosophical views. Prevailing views within the dental community primarily support a volunteer approach to oral health disparities. Effective leadership, however, requires that practitioners also create systemic approaches to disparities. Pediatric dentistry has a leadership role to play in these efforts, which could include building on existing, successful efforts such as the ABCD and Into the Mouths of Babes programs. To further the cause of children's oral health, other actions to support ethics and professionalism education in dentistry should include:

1. reviewing the teaching and assessment of professionalism in predoctoral and postgraduate dental education, including pediatric dentistry training; and
2. reviewing professionalism content on examinations by the American Board of Pediatric Dentistry.

In seeking systemic solutions, it is important to focus on the best interests of the child—a dentist's primary ethical mandate—and to collaborate across health systems and sectors because disparities are complex.

References

1. American Board of Pediatric Dentistry. Mission Statement. Available at: "http://www.abpd.org/organization/mission.html". Accessed January 17, 2007.
2. Mouradian WE, Huebner CE. Future directions in leadership of MCH professionals: cross-cutting MCH leadership competencies. Matern Child Health J. In press
3. Ontario Consultants on Religions Tolerance. Shared belief in the "golden rule": The ethics of reciprocity. Available at: "http://www.religioustolerance.org/reciproc.htm". Accessed January 17, 2007.
4. University of Washington School of Medicine. Ethics in medicine, bioethics tools. Available at: "http://depts.washington.edu/bioethx/tools/index.html". Accessed January 17, 2007.
5. Edelstein L. The Hippocratic Oath: Text, Translation, and Interpretation. Baltimore, Md: Johns Hopkins Press; 1943.
6. Cramer RN. Parables of Jesus: In the canonical gospels and the Gospel of Thomas, Luke 10: 25-37. Available at: "http://www.bibletexts.com/texts/parables.htm". Accessed January 17, 2007.
7. Katz J. Committee on Ethics—Education: Reflections on informed consent: 40 years after its birth. American College of Surgeons. Available at: "http://www.facs.org/education/ethics/katzlect.html". Accessed January 17, 2007.
8. American Dental Association. ADA Principles of Ethics and Code of Professional Conduct. Available at: "http://www.ada.org/prof/prac/law/code/index.asp". Accessed January 17, 2007.
9. American Board of Internal Medicine. Charter on Medical Professionalism. Ann Intern Med 2002;136:243-24.
10. American Medical Association Appendix. Declaration of Professional Responsibility: Medicine's Social Contract with Humanity. Available at: "http://www.ama-assn.org/ama/upload/mm/369/declaration.pdf". Accessed January 17, 2007.
11. American Society for Dental Ethics. ASDE Newsletter. Available at: "http://www.societyfordentalethics.org/pages/ASDENewsletter10_05.pdf". Accessed January 17, 2007.
12. Catalanotto F, Dharamsi S, Ozar DT, Patthoff D, Zarkowski P. Professional promises: Hopes and gaps in access to care. J Dent Educ 2006;70:46-50.
13. Plasschaert AJM, Holbrook WP, Delap E, Martinez C, Walmsley AD. Profile and competencies for the European dentist document, September 2004. Available at: "http://adee.dental.tcd.ie/ec/repository/EJDEProfile---final---formatted-for-web-.pdf". Accessed January 17, 2007.
14. US Census Bureau. Nation's population one-third minority. Available at: "http://www.census.gov/Press-Release/www/releases/archives/population/006808.html". Accessed January 17, 2007.
15. Cohn DV, Bahrampour T. Of US children under 5, nearly half Are minorities. Available at: "http://www.washingtonpost.com/wp-dyn/content/article/2006/05/09/AR2006050901841.html". Accessed January 17, 2007.
16. Institute of Medicine, Board on Health Sciences Policy. Unequal treatment: Confronting racial and ethnic disparities in health care, 2003. Available at: "http://www.nap.edu/books/030908265X/html/". Accessed January 17, 2007.
17. Cruess SR. Professionalism and medicine's social contract with society. Clin Orthop Relat Res 2006;449:170-176.
18. Cruess SR, Johnston S, Cruess RL. "Profession:" A working definition for medical educators. Teach Learn Med 2004;16:74-6.
19. Nash DA. The ethics of profession in dental medicine. Health Matrix 1984;2:3-15.
20. Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. Acad Med 1997;72:941-52.
21. ADA. In debt? You're not alone: Financial planning. Available at: "http://www.ada.org/prof/ed/students/index.asp". Accessed January 17, 2007.
22. Brown LJ, Meskin LH. Economics of Dental Education. Chicago, Ill: ADA; 2004.
23. Rawls J. A Theory of Justice. Cambridge, Mass: Belknap Press of Harvard University Press; 1971.
24. US Department of Justice. Information and technical assistance on the Americans with Disability Act. Available at: "http://www.usdoj.gov/crt/ada/". Accessed January 17, 2007.
25. Daniels N. Just Health Care. New York, NY: Cambridge University Press; 1985.

26. Nozick R. Anarchy, State and Utopia. New York, NY: Basic Books; 1974.
27. Association of State and Territorial Dental Directors. Annual synopses of state and territorial oral health programs: Five-year trends, 1998-2002, August 2004. Available at: "http://www.astdd.org/docs/StateSynopsis5yearReport.pdf". Accessed January 17, 2007.
28. American Academy of Pediatric Dentistry. American Academy of Pediatric Dentistry 2005-06 Oral Health Policies and Clinical Guidelines, Policy on the Ethics of Failure to Treat or Refer. Available at: "http://www.aapd.org/media/policies.asp". Accessed January 17, 2007.
29. Wehr E, Jameson EJ. Beyond health benefits: The importance of a pediatric standard in private insurance contracts to ensuring health care access for children. Future Child 1994;4:115-33.
30. Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. Pediatrics 1995;95:314-7.
31. Mouradian W. Making decisions for children. Angle Orthod 1999;60:300-6.
32. Weinstein P, Harrison R, Benton T. Motivating parents to prevent caries in their young children: One-year findings. J Am Dent Assoc 2004;135:731-8.
33. National Center for Children in Poverty at Columbia University. Basic facts about low-income children: Birth to age 18. Available at: "http://www.nccp.org/pub_lic06.html". Accessed January 17, 2007.
34. Mouradian W. Ethical principles and the delivery of children's oral health services. Ambul Pediatr 2002;2 (suppl 2):162-8.
35. Childress JF. Summary and synthesis of papers and discussion at ethics in oral health policy seminar, January 21, 2000. Available at: "http://www.nidcr.nih.gov/AboutNIDCR/SurgeonGeneral/Children.htm". Accessed January 17, 2007.
36. Kopelman L, Mouradian W. Do children get their fair share of health and dental care? J Med Philos 2001;26:127-36.
37. Maternal and Child Health Bureau. The Oral health of children: A portrait of states and the nation, 2005. Available at: "http://mchb.hrsa.gov/oralhealth/index.htm". Accessed January 17, 2007.
38. Beltran-Aguilar ED, Barker LK, Canto MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis--United States, 1988-1994 and 1999-2002. MMWR Surveill Summ 2005;54:1-43.
39. Smith RG, Lewis CW. Availability of dental appointments for young children in King County, Washington: Implications for access to care. Pediatr Dent 2005;27:207-11.
40. Centers for Disease Control and Prevention. Vital and Health Statistics. Atlanta, Ga: CDC; 1997.
41. CDC. National Immunization Program. Atlanta, Ga: CDC; 1998.
42. US Inspector General. Children's Dental Services Under Medicaid: Access and Utilization. San Francisco, Calif: US Department of Health and Human Services, OEI 09-93-00240; 1996.
43. Smith D. Band-aid solutions to problems of access: Their origin and limits. J Dent Educ 2006;70:1170-1173.
44. Mouradian W. What's wrong with band-aid solutions? J Dent Educ 2006;70:1174-1179.
45. Mouradian W. Children's oral health disparities: Widening the lens. Dent Abstr 2006;51:132-3.
46. Kobayashi M, Chi D, Coldwell SE, Domoto P, Milgrom P. The effectiveness and estimated costs of the access to baby and child dentistry program in Washington State. J Am Dent Assoc 2005;136:1257-63.
47. Rozier RG, Sutton BK, Bawden JW, Haupt K, Slade GD, King RS. Prevention of early childhood caries in North Carolina medical practices: Implications for research and practice. J Dent Educ 2003;67:876-85.
48. Cruess RL, Cruess SR. Teaching professionalism: General principles. Med Teach 2006;28:205-8.