Guest Editorial

The Work of Advocacy

Trudging down one of many hallways in a congressional office building on Capitol Hill last March at our Academy's Lobby Days, one of my residents asked me whether I thought lobbying made a difference. My first instinct, as a teacher, was to reframe her question in pontificating Plato-like pedagogy and ask her, "...did it make a difference for whom..." but the lateness of the day and the truth of the matter, made my answer simple. Yes.

Pediatric dentists and a healthy contingent of residents converged on Washington, D.C., to present our representatives with the 2011 legislative priorities of the American Academy of Pediatric Dentistry, in a process unknown to many Americans but as American as the eagle. Lobbying is a part of the fabric of our legislative process and vital --- yes, vital --- to government of the people, for the people.

I could have anticipated the skepticism of my resident. It is easy to become dismayed and even cynical about the lobbying process when you wait in meager office space with groups of undertakers, beer distributors, green activists and contingents from almost every aspect of American life, from the mundane to the monumental. When you speak with aides who are even younger than residents and find them seemingly disinterested in your issues or rushing to an appointment, it's not hard to become deflated. And this year, we were told by Democrats and Republicans alike, that there was no money to spend, a message that didn't lift our spirits.

This was a teaching moment, in the purest sense, so I dropped a metaphor. Lobbying is much like parenting. You spend a lifetime talking to a child, hoping some of what you say sticks, but often never knowing until much later whether it did or not. In all that talking, a relationship is forged, and for thoughtful parents, some self-reflection occurs, perhaps leading to a better second chance should it present itself. In the worst of cases, in a childhood gone astray, parents ask themselves why they didn't take the time to teach and listen. A lot like our days on the Hill.

I told my resident that lobbying, which is the real work of advocacy, makes a difference for many, on many levels. The residents at Lobby Days saw their government and colleagues at work, a civics lesson that few Americans get to experience. Thoughtful ones saw that these practitioners both lived the Academy's primary mission and felt strongly enough about it to lose a couple of days of practice in the hope of making things better for kids. They should have seen the analogy that most of our seasoned lobbying colleagues know from practice --- you teach, promote and hope that some of it pays off in better oral health for some patients, knowing full well that it won't for all. This is what we trained for and commit to do for children every day, and lobbying is that same work for a greater good, that same investment of time and energy without a solid metric or guaranteed outcome.

Residents left with a skill that will serve them well in professional life at many levels, as they are called upon to leave the office and work for pediatric oral health in their schools, local communities, and states. Know the need, know the facts, know your audience and know you're doing good work.

While not always obvious, a difference is made with legislators or their aides who may have no idea of the epidemic of dental disease or its ramifications. We come armed with the knowledge that decision-makers too often leave oral health out of healthcare. On our visits, we left them with the Academy's Red Book and its indelible images of pain and suffering and thousands of childhoods damaged. At the very least, the common people who we elect to make momentous decisions affecting our lives are a little better educated. The oral health of children, at the very least, is prioritized within the complex quilt of issues confronting these men and women every day.

Finally, as in parenting, relationships are forged. Some become lasting, with reliance of some of our elected officials on our expertise for future change. A very few lead to opportunities to influence legislation that impacts the oral health of children. As with any relationship, there is an investment of time and commitment. What each takes in proportion to what is given is often hard to quantify, but there is a difference.

About a quarter century ago, in the midst of the busyness doldrums, the dental profession committed significant resources from its members to promote oral health among Americans. Millions of dollars were spent on awareness and health promotion. In the aftermath, we know that dentistry enjoyed a rebirth. We will never know whether that came from a public health message broadly broadcast that

changed many people or simply from one patient who heard that message, was cared for well, and told another to create an ensuing snowball of individual doctor-patient relationships. Lobbying carries with it that same investment of time and treasure with no guarantee of return nor easily parsed cause and effect.

I hope my resident got the message that we judge the differences lobbying makes not by the exuberance of the day on the Hill, but by our Academy's body of work. Title VII, Head Start, CMS Medicaid Manual, Congressional testimony, representation on government panels, access to legislative offices, and the use of Academy guidelines in policy matters are just some examples of the fruits of advocacy's labor.

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Letters to the Editor

An Alternative Explanation for the Prevalence and Distribution of Enamel Defects

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I read with great interest the recently published article, "Enamel Defects in the Complete Primary Dentition of Children Born at Term and Preterm."[1] I would like to comment on the authors explanation of why defects of dental enamel (DDE) appeared more frequently on the facial surfaces of the anterior teeth, even in the term children who were not subjected to tracheal intubation. They propose that this location suggests "the local effects of local traumas....". However, they might have considered the following explanation proposed in the discussion section of an article authored by myself and others, "Macroscopic enamel defects of primary anterior teeth—types, prevalence, and distribution."[2]

"The thickness of enamel might explain our results that developmental defects were seen most commonly on maxillary teeth, facial surfaces, and the middle third of the crown. The primary maxillary anterior teeth have thicker enamel then their mandibular counterparts. Primary anterior teeth generally have thicker enamel on their facial surfaces and in the middle third of the crown. In addition, the incisal/cuspal third of exfoliated primary anterior teeth have the thinnest enamel and usually are worn significantly, precluding observation of enamel defects in many instances. Kraus and Jordan (1965) explain that the varying thicknesses of enamel in the same tooth may be due to "different rates of enamel apposition in different parts of the same tooth.., regardless of whether or not the ameloblastic life spans differ, or whether or not calcification ceases simultaneously throughout the crown..." This postulate is supported by our observations that the thickest surfaces and locations exhibited the highest prevalence of [developmental enamel defects] DED. If the secretion and maturation of enamel occurs most rapidly on these thicker teeth, surfaces, and locations, then the greater metabolic demand of the ameloblasts in these areas might make them especially vulnerable to any insult. A severe metabolic disturbance might affect all teeth and surfaces, while a milder perturbation might preferentially affect the most metabolically active ameloblasts or the most rapidly maturing enamel."

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