



Great Expectations

The next few years hold promise to bring unprecedented activity in children's oral health. Much has happened already this year and 2000 is shaping up to be remembered as the year of children's oral health. The Surgeon General's activities, programs proposed by HRSA and HCFA, and special initiatives from the Secretary of Health and Human Services will showcase the oral health needs of children. What happens from here is in our hands.

The seeds of interest in kids' teeth have grown slowly over the last decade as the realities of health disparity among our poor and minority populations, the failing Medicaid system, and growing sub-populations of immigrants have dissipated the euphoria of claims of victory over dental caries late in the 20th century. Today, the federal government, states, health professions, and child advocates recognize that oral health remains a major unfulfilled promise of our generation to the next. Even more, oral health has emerged in many states as the primary unmet health need of citizens.

What comes from the next several years of activity remains to be seen. Dentistry has seen fervor like this before—for special needs patients and for the elderly—and one need only recall that once the rhetoric died, the funding for programs ended and the dust cleared, not much had changed in the dental office. I believe that 2000 will be different because of the overwhelming, irrefutable and unacceptable realization that in this society of economic plenty, in a time of medical wonders, and in spite of a generation of effort by government and the profession, tens of thousands of children lie awake at night in pain, can't eat or learn for their dental pain, and have no hope that this will change.

I am optimistic that we all can solve this problem. A solution is rising from the grassroots. This is happening for children's oral health as teachers, school nurses, dentists, public health officials, child advocates, emergency room physicians, parents, hospital administrators,

dental educators, pediatricians and many others, often quite distant from oral health, experience the ripple effect of this failure.

To achieve a meaningful and sustainable improvement, we need to move past rhetoric and obfuscating intellectual banter, past blame and turf issues to a solution. When the sun rises on 2001, I hope we are well along the way to a new era when all children have access to dental care in their communities in a stable and compassionate dental home, that will not disappear when the grant funds run out. These things must happen.

1. *We need a total nationwide improvement in Medicaid or to replace it with a program that makes the poor child competitive in the private dental office.* The model for this is already working in several states. The guiding principle should be access and quality, not cost containment. This "access" half of the Medicaid promise has never been realized. Medicaid fees and the bureaucracy's treatment of its clients—children and dentists—must change.
2. *Major effort and resources must be devoted to treatment.* Yes, prevention must still be a part of the solution, but ethically, we must first stop the pain and screaming. A generation of poor children have never known oral health. We must help the millions of children who suffer daily and give them hope. We must let them eat and learn. We must empty our hospital emergency rooms of children with swollen faces. Then, and only then, can we ethically build a preventive consciousness.
3. *All of dentistry must take a role in caring for forgotten children.* Dental education has shifted what once was a strong and effective pediatric emphasis to other things. Once, long ago, dental education taught dentists what we needed to know to provide the public what it needed. We need a renaissance in pediatric dental education of the general dentist if we are ever to realize oral health for children. The

specialty of pediatric dentistry is too small to do it alone and we desperately need help from our generalist colleagues. It is in their offices where most children belong.

4. *We need to unite around the first year dental visit.* Immunization against infectious disease was a good idea for children, and communities of interest united to make it happen. A similar goal needs to be set for oral health. Every child in a dental home by age one should be our mantra and we must then work to make it a reality. More and more evidence implicates the failure to address the preschool child appropriately. Infant oral health is the next frontier of caries reduction.
5. *We need to expand our knowledge of the extent of the problem of dental caries in children.* Our national data are old and don't adequately probe those populations most vulnerable. Seldom, if ever, is need quantified so that the true extent of disease is noted, the cost of care predicted, or the burden of human suffering made clear to policy makers. It is difficult for me to accept national caries data when almost a third of the patients who seek care in our hospital need to be treated under general anesthesia and half are under four years of age. Until we can feel comfortable that our data accurately reflect our inner cities, the hollows of Appalachia and the border states of this country, we need to do more.
6. *Oral and systemic health must be one.* The dismemberment of the mouth from the rest of the body in health policy, insurance coverage, comprehensive health initiatives, and from the consciousness of the health community has contributed to oral health disparities. Oral health is an afterthought in medical education and practice, yet our national standard of care mandates that physicians be responsible for the oral health of children until they are three years old. Getting paid for hospitalization for dental surgery and restoration under

general anesthesia is a health coverage crap shoot. Even in the seriously ill child, poor oral health is often only a problem if it stops surgery or chemotherapy.

7. *The socioeconomic realities of getting the poor healthy must be addressed if we are to ever end oral health disparities.* This may be our biggest hurdle because of the conditioning of both the practitioner and patient. In my own hospital's high risk population, our physicians have difficulty getting parents of chronically ill children to comply with medical instructions that can save their child's life! If we think that traditional approaches to prevention and care seeking of non-life threatening dental ills will make an impact, we truly have a long way to go. If our solution to getting a Medicaid child to the dentist is to pay cab fare that exceeds the dentist's fee, we have failed.

8. *More pediatric dentists are needed.*

There are some children who require our skills and who can't be treated in general practice. There are hospitals to be staffed and dental students to be taught. We need to work for Title VII funds, pediatric hospital GME funds, and any other forms of aid that increases the numbers of seats for training. It is naïve to think that the oral health needs of children can be met without the special skills of pediatric dentists. To think that just a few short years ago, pundits were predicting our demise! The reality is that we are all very busy and need help.

9. *We need to answer the question of who is to care for the patient with special needs.* The pediatric dentist, like the pediatrician, cares for the special needs child from childhood. Thirty years ago, we believed that these patients

would graduate into general practice. For some patients, this is true, but for many more, the pediatric dentist remains the clinician who provides the care that accounts for the myriad of needs of special patients.

The next year holds great promise for children. We must all join together and accept that what is, and what has been, has failed to address the needs of our most vulnerable. Yes, solutions will cost money and challenge us to put the needs of children before our own.

Can we do it? I know we can.

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LETTER TO THE EDITOR



Chicken Soup

The popular book series, *Chicken Soup for the Soul*, is a collection of stories of how random acts of kindness can result in life altering experiences. They are stories of touching someone's life and affirming our belief in improving the human condition—one person at a time.

The newest release in the series, *Chicken Soup for the Dental Soul*, debuted at the recent ADA Scientific Session. In our universe of dentistry, we hear the stories such as treating the emergency patient that we didn't charge, or treating patients in third world countries, or treating that disfigured patient with a little bit of dignity and compassion.

In the world of kids, our chicken soup stories are perhaps not as dramatic. Nevertheless, our chicken soup is what we do for a living one kid at a time.

We've all had that kid, screaming and yelling in the reception room before you even meet her. Mine is Robin. I first treated her when she was 3. She's now 12. The family moved away. Mom drives her some 25 miles back to our office. Robin still gives me a hug every six months.

We've all had that kid who we hadn't seen in awhile—return to us. Mine is

Desere. She started with us when she was 2. The last time I saw her, she was 6. I walked into the operatory one day and this gorgeous teenager came in and asked, "Do you remember me?" It was Desere. She is now 16. Her mom took her to other dentists due to insurance limitations. She gave her mom such a hard time over the years about taking her away from us. Her mother relented and returned her to us. "I missed you Dr. Chan."

We've all had that kid who finds it tough to transition to an adult dentist. Mine is Marley. "I tried going to my mom's dentist, but it didn't look right. Someone came in to take my x-rays. Someone came in to clean my teeth. Someone came in and looked in my mouth. That was it. Nobody really talked to me. I want to come back." Marley is now 21 and still refers to me as her dentist.

We've all had that kid who graduated from the practice and returned just to say hi. Mine was Ryan. I ask each kid for a picture—every check-up. I've got my kids and parents conditioned. I bring out the pictures and periodically show them what they looked like as they grew up. One day, my staff told me I had a visitor. It

was Ryan. I hadn't seen him in awhile. He came back as a US Marine. He barely fit through the door. He came back to say hi. He came back to give me a picture of himself when he graduated from the Marine Corps training camp.

We've all had that kid who now has become a parent. Mine is Lisa. Lisa was the kind of kid who nearly ran out the door her first appointment. Lisa is now a mommy. She will trust her kid to no other. As I was talking to Lisa, her child gave me a look with daggers. "Why did you call my mom, 'Sweetheart'?" "That's the way that I talked to your mom as she was growing up. Your mom will always be one of my babies."

We've all had scores of Robins and Deseres and Marleys and Ryans and Lisas in our careers. It's said, pediatric dentistry is equal parts technical skill and behavioral skill. It's our Robins and Deseres and Marleys and Ryans and Lisas that we get our kicks out of our profession. These kids are our chicken soup for our souls.

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