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GUEST
EDITORIAL

Dental treatment of pediatric AIDS patients—whose obligation?

AT THE MARCH conference/workshop on Oral Complications of HIV Infection in the Pediatric Population, Dr. James Oleske, Department of Pediatrics, New Jersey Medical School, was a keynote speaker. Dr. Oleske began his talk by pointing out that Newark is the primary epicenter for pediatric AIDS. Furthermore, as director of the Pediatric Aids Clinic, he sees two major problems on a daily basis. The first is finding relief for gastrointestinal pain and malabsorption for these children. The second is access to dental care for this population. At that, the audience became hushed; perhaps they felt guilty; perhaps they were stunned. Dr. Oleske pointed out that many of these pediatric AIDS patients are becoming long-term survivors and can easily sit through out-patient dental procedures. (Of course there are still many children who require treatment in a hospital setting.) Where are the pediatric dentists who are willing to treat these children?

An editorial in *The New England Journal of Medicine* asked "Do physicians have an obligation to treat patients with AIDS?" Eight months later, emotional letters to the editor still flood the *Journal*. It will be interesting to see how many letters this editorial elicits.

The ADA has made its position very clear. "It is safe to treat AIDS and seropositive individuals in the dental operatory. The decision not to provide treatment to an individual because the individual has AIDS or is seropositive based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual's dentist believes he or she has need of another's skills, knowledge, equipment, or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment."

So, where do the 1400 children with pediatric AIDS go for their dental care? Certainly, everyone would agree that all pediatric dentists have a moral and legal obligation to provide care for these children. Do most of these children go to an inner city hospital postgraduate program for care? Probably yes, unless there is a familial or special existing relationship with a local pediatric dentist. Even then, the pediatric dentist probably does not want to advertise that he treats pediatric AIDS patients because of the potential negative impact on his practice. I do not advertise that I treat these children.

Many issues are involved. Is pediatric dental treatment medically essential or is it an elective intervention? Anyone would agree that a cellulitis of odontogenic origin in an immunoincompetent child requires immediate dental intervention. More often than not this child would receive treatment in an inner city hospital. Should pediatric dentists extract teeth for orthodontic purposes in a child with AIDS? Pediatric dentists should be resolving these questions before others dictate the answers.

And of course, the question of money further complicates the picture. Who pays for the increased cost of compliance with CDC and OSHA guidelines? Will the Department of Public Welfare increase its reimbursements to allow for the cost of multiple autoclavable handpieces? Will the Children's Hospitals increase the operating budgets of their dental divisions to offset the cost of barrier technique? Will insurance companies reimburse us for all the disposables as we "treat each child as if he has hepatitis or AIDS?"

A program director who attended the pediatric AIDS workshop in March said that he has a pregnant postgraduate student who refused to treat a child with pediatric AIDS. Assuming the CDC guidelines are good enough to protect the a child from the

previous dental patient, then the guidelines are good enough to protect her unborn child. Otherwise no treatment should go on in that dental setting. Sterilization and barrier technique either work, or they do not.

If this editorial was written 30 years ago, you could have substituted the word handicapped for AIDS. Access to dental care for the handicapped was similar then to the problem of access for pediatric AIDS patients today. The 30-year-old assumption that familiarity through education reduces fear is still valid. Postgraduate programs today **must** include pediatric AIDS in their curricula. Pediatric dentists should develop solutions to the medical, ethical, and financial issues. Programs in epicenters for the disease should allow students to rotate through their hospitals so they can gain experience in treatment modalities.

The Massachusetts Department of Public Health/Office of Maternal Child Health funded the March conference/workshop on pediatric AIDS. This conference was a first step in publicizing the magnitude of the problem in pediatric AIDS patients. Federal and state agencies must be partners with pediatric dentistry in the solutions to this problem. It is their obligation as much as ours.

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