President-Elect's Address

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This address by the President-Elect of the American Dental Education Association was presented to the membership on March 6, 2004, in Seattle, Washington. Dr. Catalanotto is Professor of Pediatric Dentistry and former Dean at the University of Florida College of Dentistry.

Thank you for giving me the honor to work with you this coming year as President of the American Dental Education Association. I am truly grateful! I also appreciate the opportunity to spend a few minutes with you now, talking about the presidential initiatives I hope to implement over the next year.

Let me begin by reviewing with you the Association's mission statement: "The mission of the American Dental Education Association is to lead individuals and institutions of the dental community to address contemporary issues influencing education, research, and the delivery of oral health care for the improvement of the public." This emphasis on the oral health care of the public is the reason the dental profession and academic dental institutions exist, and it is in this context that I present my remarks.

I have chosen access and diversity as key initiatives for the year. Why are these important issues, and what can ADEA do to address the challenges of access to care and diversity in the workforce?

For the next few minutes, I want to relate to you a personal journey that has led to my increased awareness about the relationship between poverty and access to care and why I believe that ADEA must continue to take a leadership role in addressing these issues.

My background is what I would call typical middle class. I think it would be fair to say that, in my younger years and in my early career, I simply did not see social and economic disparities and racial inequities as a problem.

My first faculty position was at Connecticut in 1974. For eleven years, I taught, practiced, and did research in a wonderful academic environment. Our college was located in the middle-class suburb of Hartford. We had a clinic in a "poor" section of town, the Burgdoff Dental Clinic, but for me personally, with a commitment to a growing family and my busy academic activities, I just did not "see" or understand poverty in our society or the lack of diversity in the workforce and how they affected access to care!

I moved to San Antonio, Texas in 1985. There, we had an inner-city clinic that was a real eye-opener for me in terms of the volume of very poor patients needing care and not being able to afford it. But the real enlightenment came from spending two weeks in the border town of San Elizario working with a team of physicians, nurses, dentists, and others, trying to survey the population to make recommendations to the El Paso Health District about how to manage the health needs of this population.

The poverty and the numbers of patients in need were staggering. But what really impressed me, in addition to the severe dental needs, was the 50 percent hepatitis rates, the obesity and diabetes, the untreated hypertension. The overall health status was something I just could not have imagined.

San Antonio was followed by seven years in New Jersey. While there, I carried out a research project on the oral health of pediatric HIV patients, for which we collected samples from patients in their homes. To this day, I have experienced nothing more chilling or depressing than walking up two or three flights of stairs in the Newark ghettos. Your initial reaction is shock that people can live under these circumstances in the United States.

I moved to Florida in 1995. Suffice it to say that the problems of access to care were the same as I had seen elsewhere. My favorite anecdote about access usually involves my 6 am arrival at the school. I pass by our adult emergency dental clinic and there are usually five to ten patients, waiting to sign up for the twenty-four slots we reserve for emergency adult care. This is in a community of over 100 practicing dentists.

I now think I understand the poverty and access to care problem in this country—but only after almost thirty-six years in the profession. My concern is that many of us in this profession, much as I was prior to 1985, do not really recognize the problem nor the context of our national health care system in which dental care is embedded. This is where I would now like to move this discussion.

I believe there are two critical challenges that should concern all of us. First, cost and quality problems in our overall health care system are pervasive and growing. Recent Institute of Medicine reports[1,2] document the enormous medical errors that occur in our health care system and the mounting evidence of racial and ethnic disparities in the actual quality of care given to some of our citizens—independent of the patients' income or education—and the escalating costs of our overall health care system. Second, we have our own crisis in oral health care. We are all very well aware of the concerns expressed by the Surgeon General's report[3] and the growing evidence of a shortage of dentists and other allied dental personnel, in the face of an increasing population.

I think we would all agree that health care for the underserved and indigent is a societal problem that must be addressed by the public at large. But we must ask this question: how has the dental profession dealt with this crisis?

We can look for some answers in the recent Future of Dentistry report published by the American Dental Association.[4] Consider the following quotation from this report: "Dentistry is known and celebrated for its high ethical standards and awareness of its social responsibilities and public trust. Whatever actions the profession takes in response to future challenges, that trust must be maintained. To do so, the profession must find ways to provide for those in need, regardless of their financial wherewithal or the challenges they present" (p. 3). With that statement as a framework, I want to touch on some solutions proposed in this report for addressing the access to care challenge.

Several reports suggest that dentists are, generally speaking, not seeing Medicaid patients. The Future of Dentistry report suggests that one solution is to improve reimbursement rates and decrease administrative burdens. However, the U.S. General Accounting Office reports that the results of past efforts in several states to increase Medicaid fees have been equivocal or marginal at best in terms of improving access.[5] The report also discusses the issue of philanthropic care. However, while dentists provided about 1.3 billion dollars in uncompensated care in 1998, this was only 2.4 percent of total dental expenditures compared to a rate of 5 percent of total physician expenditures. This might suggest that dentists can do a better job in donated dental care, but, to be fair, some authors have pointed out that dentists simply could not handle the entire burden of the underserved with current practice models.[6,7]

A third recommendation in the ADA Future of Dentistry report focuses on increased advocacy. However, a look at the past track record of advocacy suggests that our profession could do more here. A recent report[8] suggests that a consistent theme of dentistry related to access to care issues is a "lack of effective advocacy." The good news to me is that recent ADA leadership clearly has a focus on access!

One question we might ask at this point is: what are some of the reasons we in the dental profession are not adequately responding to the access challenges? The following responses come to mind:

1) Is there a lack of awareness of the nature and magnitude of the issues? That was certainly my problem prior to 1985.
2) Is the ethical framework of our profession focused on the right issues?
3) Does the profession truly understand cultural competency and diversity issues as they affect access to care?
4) And finally, are there, in fact, real workforce issues that are preventing an effective response to the access issues?

The question I now put before you is: how can ADEA help dental and allied dental education deal with these issues of access to care? One could make the argument that we in dental education are responsible for the knowledge, skills, and attitudes of our graduates. So have we failed our students and graduates by not educating them about these issues? Are there ways academic dental institutions can better educate our students that would make them more aware of and sensitive to the access to care problems and more amenable to innovative solutions?

The desire to grapple with these issues is why we came up with a focus on access and diversity initiatives for next year, along with the theme of "Access and Diversity: Educating for Change" for our 2005 meeting in Baltimore.

ADEA and our members are about education. That is what we do. So, we must ask ourselves, what do we want to happen if academic dental institutions

make changes in our educational programs focused on access and diversity? There are four long-term results I would like to see for our graduates and for the profession:

- First, more advocacy by the profession, which should lead to better awareness by patients about oral health and legislative support for public assistance programs.
- Second, more dentists willing to provide care to Medicaid and other public assistance patients.
- Third, more pro bono care.
- And fourth, more receptivity on the part of the profession to innovative solutions and new models of care.

And what type of changes in our educational programs should academic dental institutions make to achieve these goals? In responding to the question, I turn first to the report of the ADEA President's Commission on Access.[9] While there are numerous recommendations about what academic dental institutions can do to help address the challenges of access to care, I will focus for now on one particular part: summarizing what we called "Guiding Principles for Academic Dental Institutions." Incorporation of these principles into dental and allied dental education can help the profession—in particular, future practitioners—deal in a better way with access to care.

Although some in our society, and even in this organization, will debate this point, one of the key guiding principles is that "Access to basic oral health care is a human right." Second, the oral health care system must serve the common good. Third, and here I think we would all be in agreement, the oral health needs of vulnerable populations have a unique priority.

To me, the first three of these guiding principles are ethical issues. I believe one of the reasons why the dental professions may not deal well with the access to care challenges is, in fact, a fundamental weakness in the ethical framework of our professions. To quote the ADEA report[9] on access: "Currently in the United States, the provision of . . . oral health care services is treated like a manufactured commodity. . . . In such a marketplace economy, the variety of factors influencing demand gives way to one major factor: the ability to pay for services rendered" (p. 565).

Fortunately, there is an alternative perspective founded in the concepts of Social Justice, the moral responsibilities of health care professionals, and the concept of "the good society," all discussed in the ADEA report on access.

The ADA Code of Ethics addresses issues such as Beneficence and Justice, but makes little mention of the concepts just mentioned. From this discussion, I would conclude that dental and allied dental education needs to help the professions reframe their ethical foundations by providing learning experiences for our students that focus on issues such as the good society, social justice, and the moral responsibilities of health care professionals.

The fourth guiding principle identified in the ADEA report on access addresses two key issues: cultural competency and diversity in the workforce. A recent article in the *Journal of Dental Education* by Wendy Mouradian[10] provides a wonderful discussion of cultural competency. The questions we need to ask ourselves are: do we incorporate enough cultural competency into our educational programs, and do we help our students to recognize how critical culture is in our patients' response to disease?

Before I turn to the diversity issue, I would like to conclude this section with a recommendation that ADEA, which adopted a policy on cultural competency in 2000, needs to find ways to help academic dental institutions to provide more substantive educational experiences related to the ethics of health care and cultural competency. Hopefully, this will help our graduates become better practitioners who are more aware of and sensitive to the access to care issues facing our professions. This will be one of our goals this upcoming year.

That leaves the diversity issue. I would direct our attention to the newest IOM report dealing with this issue; it was released on February 5 of this year. Entitled "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce,"[11] this report makes a number of recommendations as to how the higher education community can assist in this goal of a more diverse workforce. I want to first spend a minute on the opening chapter, which to me is critical as it lays down the foundation for why we actually need a diverse workforce.

The report does a thorough review of the scientific literature to back up its claims that greater diversity among health professionals is associated with:

1. improved access to care for racial and ethnic minority patients,
2. greater patient choice and satisfaction, and
3. better patient-clinician communication.

The current problem, as we all know, is that we do not have enough minorities in the healthcare workforce. This latest IOM study clearly lays out some suggestions for us in dental education about how to increase minority enrollment.

ADEA and our academic dental institutions need to consider some of these recommendations as ways to help us all meet this challenge of increased diversity in the health care workforce. We are not short of methods that should work, but we must have the will to focus on implementation! Again, this year we will explore how ADEA can help academic dental institutions pursue such initiatives.

In closing, I want to thank you for your attention. I welcome your input and participation and suggestions for implementing these initiatives of improving access to oral health care for the public at large and diversity in our workforce. I ask for your personal support and commitment in helping ADEA help our academic dental institutions to achieve these goals.

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