



A Monthly Newsletter from ADEA Executive Director Richard W. Valachovic, D.M.D., M.P.H.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, reflects on the way that the dental education community met and has dealt with the challenge of HIV/AIDS.



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AIDS and Dental Education at 25 Years

Once upon an almost unimaginable time, we practiced "wet finger" dentistry, sans gloves, masks, goggles, and gowns.

That was our age of innocence, which vanished forever with the first report that a young Florida woman named Kimberly Bergalis had been infected with the virus that causes AIDS. The mode of infection was not clear, but at the time it was known that her dentist had been diagnosed with AIDS several months before he saw Ms. Bergalis in his office. Tragically, both patient and practitioner lost their lives to AIDS, and five more of the dentist's patients were found to be infected with HIV. An appalling new realm of possibility had very publicly revealed itself to our profession and to the world at large.

Commemorating 25 years of HIV/AIDS, the Centers for Disease Control this year reprinted [the earliest warning](#) that some new disease entity was among us: a brief note in the Morbidity and Mortality Weekly Report (MMWR) of June 5, 1981, that *Pneumocystis carinii* pneumonia had been diagnosed in five previously healthy young Los Angeles men.

I saw that report at the time. But I didn't realize its full significance until, very early in the AIDS epidemic, I was asked to see a 24-year-old who had been admitted to a teaching hospital with debilitating pneumonia complicated by mouth pain so severe that it interfered with eating and speech. I was an attending at the hospital at that time, and we had an oral medicine consult service there. When I entered the patient's isolation room, with some apprehension and in full surgical regalia, he gave me a look of absolute fear. "Do you really have to be dressed like that?" he asked. We talked and the illness assumed a human face. This was a young man who had been in relatively good health until not long before I saw him. His family was in the rural Midwest, and he had not told them that he was gay or that he was ill. What I saw when I examined his mouth was a surprise at the time but we all now know should have been expected: mobile teeth, generalized small black lesions of Kaposi's sarcoma, and a pervasive white coating and mucositis consistent with candidiasis. I arranged for some palliative measures and obtained a culture and a biopsy. I wore the protective gear out of his room and then took it off - carefully. I don't know who was more afraid of the other that day. I do know that from this first interaction with a hospitalized AIDS patient I had learned a great deal about the need to offer care with empathy and respect.

Dental school faculty and administrators in the mid-1980s quickly decided that it was a professional obligation to treat all patients who came to us for care, including those with HIV and AIDS. At that time, I was a dental school clinic director and a member of the ADEA (then AADS) Section on Clinic Administration. We reasoned that these patients needed care that they might not be able to receive in the community, that there was educational value for our students and postdocs in treating patients with HIV/AIDS, and that there was a chance that our research could enhance treatment outcomes. But it was a risky business. We really didn't know how transmissible the virus was, what level of infection control was required, or how the infection affected wound healing and other complications. We asked only that patients be up

front with us about their health status.

I'm proud to recall how quickly our dental education community grasped what was needed to meet the challenge of HIV/AIDS and did the right thing to make changes in our profession. ADEA and its members led the way, particularly in two major efforts.

First, there had to be a way to protect all patients and practitioners from infection, and that way had to ensure that no one was stigmatized. Trying to identify individual health status was a waste of time, because patients might not be willing to be candid or might not even know what their situation was at any given time. The only way that made sense was to assume that everyone - absolutely everyone - was infectious and to take appropriate precautions on that basis. Thus the concept of "Universal Precautions" was born, revolutionizing the day-to-day teaching and practice of dentistry. And it was ADEA and our members who contributed to the "Universal Precautions for Dentistry" (take a look at two MMWR reports from 1988, "[Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings,](#)" and, 15 years later, "[Guidelines for Infection Control in Dental Health-Care Settings - 2003](#)").

The second great effort was a way to help dental schools, hospital-based dental services, and now dental hygiene programs with the financial burden of providing an oral health care safety net for patients with HIV/AIDS. This was a responsibility that dental schools and other academic dental institutions had assumed (by default and through a desire to do the right thing) in the early 1980s and that they continue to fulfill to this day.

Though the mid 1980s and 1990s, I was a member of the ADEA (then AADS) Council of Faculties, and I participated in one of the first AADS Legislative Workshops in Washington, DC, to enhance the advocacy skills of dental educators. Armed with the right talking points, data, and lots of role playing, those of us in the Legislative Workshop headed to Capitol Hill to make the case for federal grants to reimburse dental schools for HIV/AIDS care. Taking a national leadership role, ADEA became a major architect of the federal dental reimbursement program that has returned more than \$111 million to dental schools and hospitals for HIV/AIDS care. Six years ago, ADEA advocated vigorously and successfully to make CODA-accredited dental hygiene programs also eligible for reimbursement.

The groundbreaking dental reimbursement program is now part of the Ryan White CARE Act, a memorial to the courageous teenager with hemophilia who was ostracized for having AIDS and who became a rallying point for those who decried the absence of federal HIV/AIDS programs. In another initiative under Ryan White auspices, dental schools, hospital-based dental services, and allied dental programs have been collaborating with community-based clinics by sending residents and students to learn and help.

None of this has been easy. Congress has flat-funded our dental education community's share of Ryan White funding for the past six years, and this past year the battle to maintain even that level in the current political climate required a herculean effort. But in the words of Myla Moss, ADEA's Director of Congressional Relations and Regulatory Affairs, "At the end of the day we saved our program intact." There was even a major victory. Oral health care is now deemed a "core medical service" in the context of the Ryan White CARE Act.

Meanwhile, HIV/AIDS is with us to stay. More than a million are living with it in the United States, and it is estimated that 250,000 of them are unaware of their HIV-positive status. Some 40,000 new HIV infections are expected this year. The availability of effective antiretroviral therapy actually increases the importance of oral health care, because patients cannot follow their medication regimen if it is too painful for them to consume the food required to take their meds!

There were many challenging times over the past 25 years, many of them political, and some of them were downright ugly. But there is such a thing as rising above the ugliness of a bad situation, and thus the highest standards of our profession have been mustered to deal with the public health and personal tragedy of HIV/AIDS. As the ADEA Policy Statements approved by the House of Delegates explicitly state, "No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease These patients must not be subjected to

discrimination." One positive thing has emerged from our 25-year experience with AIDS - in learning how to deal with this terrible disease, we have learned how to educate all dentists and allied dental professionals to take care of everyone and to treat everyone the same.



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