Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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dentist to get involved between two divorced parents, who may or may not have had an amicable separation. The dentist's ethical responsibility is to the proper treatment of the child.

Divorce laws differ from state to state, so it would be beneficial for dentists to know the law in their own locales. However, in New York State, section 2504 of the New York State Public Health Law¹ gives either parent the right to consent to treatment of their child, regardless of their status in divorce proceedings. The fact that the person authorizing treatment for the minor is the child's parent is enough for the dentist to treat the patient legally. In addition, the other parent cannot overturn the consent given by the first parent.

It also should be noted that the dentist can seek payment from either parent for the child's treatment, regardless of the divorce decree. That agreement is between the parents, and does not include the dentist. Both parents are legally liable for the child's debt. More in-depth information can be read in the New York State Dental Journal article, "Keep Your Divorce Out of My Dental Office."²

Dentistry is tough enough without having to determine the court proceedings of a divorcing couple. This law puts the health of the child first, without placing undue burden on the practitioner.

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1. N.Y. Public Health Law § 2504.

2. Plunkett LR. Keep your divorce out of my dental office. N Y State Dent J 2000;66(3):6-7.

Author's response: Dr. Porcelli states that the dentist's ethical responsibility is the

proper treatment of the child. I certainly agree with this statement. I believe that the child can be best treated when both parents are informed and agree to the treatment plan the dentist has presented. Anything less is ethical treatment of the child's teeth, not the child.

Sometimes the ethical professional goes beyond the legal minimum and accepts the burden and the responsibility of educating the patient and the parents, not just for the present, but for the child's future as well.

I often have met with parents who are married, and yet are not in an amicable relationship, and are unable to agree on the treatment of the child. I have spent time with parents in separate appointments to outline treatment of a child, because the parents do not have good communication. I have presented treatment plans to mom, dad and stepmom, all in the same room. The one thing we had in common was the goal of the best treatment of the child. Are these enjoyable times? Absolutely not, but they result in an understanding about the health of the child by all parties involved.

The situation described in the Ethical Moment was real for me as I began practice. I have not researched the laws of my state, but my attorney has. I have been advised that only the custodial parent has the right to make health care decisions for the child. The situation I encountered was resolved by mediation between the parents' attorneys and the threat that the child would be removed from the mother's care if appropriate dental treatment was not obtained. The treatment was completed in my office, and al-

though she was angry and reluctant, in the end, the mother was grateful for the treatment rendered.

Treatment of children is often complex due to relationships. If the health and welfare of the child is placed first, everyone wins.

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Note from the Division of Legal Affairs: It is important for dentists to determine and follow applicable state law and to consult with their attorneys. From a risk-management perspective, dentists are wise to secure parental consensus before rendering a course of treatment when it is known that one of the parents has objections or concerns.

DEPENDING ON VACCINES

I read with interest Dr. Michael Glick's June JADA editorial, "Vaccines, Epidemics, Pandemics and Us" (JADA 2006;137[6]:706-10). He clearly pointed out the weakness of depending on vaccines to protect us from an emerging infection.

An infectious agent must be positively identified and isolated before meaningful development of a vaccine can even begin. In the case of avian flu, it is unlikely that a vaccine developed before the virus makes the projected jump from birds to routine human-to-human transmission will be effective.

The example of the recent mumps outbreak that was traced to apparent aerosol transmission during domestic air travel has far-reaching implications for dentistry. There are well-documented cases of

airborne transmission of tuberculosis during air travel,¹ the airborne spread of measles through the heating, ventilating and air conditioning system in a medical office,² and the long-range airborne spread of the severe acute respiratory syndrome virus during the Amoy Gardens outbreak in Hong Kong.³

The potential for any of these organisms, probably including a human variant of avian flu, to be spread by dental aerosols/splatter arising from the mouth of an infected person to dental personnel and other patients was discussed in a JADA 2004 article written by me and Dr. John Molinari.⁴

While vaccines are a long-term answer to many public health threats, they usually are available only after the threat has been isolated. Until an effective vaccine exists, the use of simple and inexpensive infection-control procedures for the control of dental aerosols/splatter is dentistry's only defense against potentially being implicated as a source of infection in the rapidly expanding area of emerging and re-emerging infections. Unfortunately, this facet of dental infection control often is ignored.

Steve K. Harrel, DDS
Dallas

1. Kenyon TA, Valway SE, Ihle WW, Onorato IM, Castro KG. Transmission of multidrug-resistant *Mycobacterium tuberculosis* during a long airplane flight. *N Engl J Med* 1996;334:933-8.

2. Bloch AB, Orenstein WA, Ewing WM, et al. Measles outbreak in a pediatric practice: airborne transmission in an office setting. *Pediatrics* 1985;676-83.

3. Yu IT, Li Y, Wong TW, et al. Evidence of airborne transmission of the severe acute respiratory syndrome virus. *New Engl J Med* 2004;350:1731-39.

4. Harrel SK, Molinari J. Aerosols and splatter in dentistry: a brief review of the literature and infection control implications. *JADA* 2004;135:429-37.

DENTAL EDUCATION

As Dr. Michael Glick observes in his July JADA editorial, "Dental Education: An Evolving Challenge," dental education faces a number of challenges as our institutions prepare future dental professionals and the next generation of teachers and researchers (JADA 2006;137[7]:940-4). Even with these challenges, U.S. academic dental institutions remain the fountainhead of a competent work force to meet the oral health care needs of the public.

In 2005, the American Dental Education Association (ADEA) formed the Commission on Change and Innovation in Dental Education (ADEA-CCI) as its primary mechanism to lead and coordinate the Association's efforts to assist in the development of curricula for the 21st century. ADEA-CCI was formed based on the premise that no meaningful curricular change can occur unless it is systemic and includes the various external agencies and stakeholders that influence curricula.

Members of ADEA-CCI include the ADEA Council of Deans, ADEA Council of Sections, ADA Board of Trustees, ADA Division of Education, ADA Council on Dental Education and Licensure, ADA Joint Commission on National Dental Examinations, the Commission on Dental Accreditation, the ADA Foundation and higher education administration.

ADEA-CCI's purpose is to build consensus within the dental community by providing leadership and oversight to a systemic, collaborative and continuous process of innovative

change in the education of general dentists so that they enter the profession competent to meet to oral health needs of the public throughout the 21st century, and to function as an important member of an efficient and effective health care team. ADEA-CCI has discussed the issues Dr. Glick raises at great length and is in the process of developing a broad-based plan for change. ADEA-CCI will serve as a facilitator of change and innovation.

Dental education has been, and must remain, firmly rooted in scientific discovery. Advances in genetics and molecular biology promise to change the health care system in significant ways—probably within the lifetime of today's dental school graduates. But, beyond the acquisition of scientific knowledge at a particular point in time, the capacity to think scientifically, to apply the scientific method, is pivotal if students are to analyze and solve oral health problems, understand research and practice evidence-based dentistry. The explosion of scientific knowledge makes the acquisition and retention of all the information necessary for a lifetime of practice during dental school impossible. Students must learn how to learn.

Lifelong learners providing evidence-based care to meet the needs of society: that is the theme underlying ADEA-CCI's work for dental education in the 21st century. We invite JADA readers to learn about and comment on ADEA-CCI's activities by visiting its Web site at "www.adea.org/CCI/default.htm".

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