Ethics, Access, and Care

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Abstract: There are two very different ways of understanding access and care that are at work in contemporary American society. One of these is the understanding that our society’s health professions have about access and care as they consider their ethical commitment to respond to patients’ oral health needs. The other is how these matters are understood within America’s public culture. In this view, needs—including health care needs—are no different in kind or ethical significance from unmet desires of any sort. This article will spell out the differences between these two ways of understanding care and access. Comprehending the distance that separates the health professions’ perspective from much of mainstream American thinking on these matters is essential to a careful discussion of the ethics of access to oral health care.

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The expression “access to care” is sometimes treated as meaning something rather straightforward. But, in fact, there are two very different ways of understanding access to care because two very different ethical frameworks are at work, side by side, in contemporary American society. These ethical frameworks lead to two very different views on how health care of every sort ought to be distributed in the United States, and therefore two very different views of how dentistry and dentists ought to act regarding persons and groups who are currently underserved. This article will spell out the differences between these two ways of understanding care and access.

A number of claims about America’s public culture are about to be made that cannot be substantiated here due to the limitations of space, although some general evidence for these claims will be offered below. But at a minimum, those who have objections to these claims about America’s public culture will at least have a clear target at which to aim. The views about the health professions and about the dental professions in particular that are presupposed here are formulated and defended in Dental Ethics at Chairside.1

Two Features of America’s Public Culture

Two features of America’s public culture need to be discussed in order to explain how the culture understands access and care. The first is that our society’s public culture views need as simply a subcategory of desire. It would not be far wrong to say that, within American culture, a need is simply a strong desire. The importance of this point will be developed more fully in a moment.

The second feature is more complicated to explain. To begin, our society’s public culture considers it perfectly reasonable for people to fulfill their desires simply because they are desires. A desire is precisely the sort of thing it makes sense to try to fulfill. This means that there are only two kinds of situations in which refraining from fulfilling a desire is rational and socially defensible. The first is the situation in which a person has a desire that is impossible of fulfillment, in which case it is an irrational desire and not really deserving of attention for fulfillment in the first place. All of us have such desires, and the role of reason in relation to such desires is to show us that the desire is impossible of fulfillment and so not deserving of our effort to try to fulfill it.

The second kind of situation in which it is rational and socially defensible to refrain from fulfilling a desire is if there is a conflicting desire such that the two desires cannot be fulfilled simultaneously. This conflict can occur within the life of a particular individual, e.g., I cannot eat a seafood entrée and a prime rib entrée and pay for only one entrée simultaneously. And it can occur between persons, e.g., Jack and I cannot both have the best seat in the house (assuming we think it is the same seat) simultaneously.

Regarding conflicting desires that occur within the life of a single individual, our public culture assumes that the role of reason is to resolve the conflict by ranking the competing desires as they are experienced by the person. The simplest ways of ranking

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Desires would be in terms of the desires’ intensity and duration. But more sophisticated ways of comparing desires have been offered, most famously by the British philosopher Jeremy Bentham. For example, in addition to intensity and duration, Bentham proposes desires can also be ranked in terms of certainty/uncertainty; closeness/remoteness of fulfillment; and purity/impurity, i.e., the relative mix of pleasures vs. pains produced in fulfilling the desire. Bentham also notes that these methods of comparison are all essentially quantitative.

Many people, including many people living in our society, believe that desires can also be ranked qualitatively. They believe some kinds of desires are more valuable than others for reasons different from their quantitative ranking. For example, there are people who rank desires in terms of relevance to certain ideals of character or relevance to living a good life (however interpreted) or coherence with a life plan (however chosen). But from the point of view of our public culture, all such so-called qualitative differences are just quantitative rankings in disguise. It is assumed by the public culture that all such qualitative rankings are themselves merely the quantitative work of other “second-level” desires, i.e., a strong desire to rank desires in such a way. So from the public culture’s point of view, whenever a person experiences conflicting desires, the role of reason is to rank the conflicting desires by comparing them quantitatively, either directly—i.e., on the basis of the desires’ relative strength, duration, etc.—or in terms of the strength, etc., of the person’s “second-level” desires for having those desires.

Culturally, all of this is considered to be straightforward, unobjectionable, and indeed an obvious way to understand human life. Because it is considered so obvious, there is little reflective awareness that taking such a view might be a mistake, that it would in fact be better to operate on the basis of some other view of how humans function. For the same reason, the impact of this view specifically on ethical thinking in American society is hardly noticed.

Desires can also conflict between persons, and America’s public culture does understand that resolving these conflicts is more complex. For many people, conflicts of desires between persons are to be resolved by reference to the qualitative differences between the desires. But as was just indicated, our public culture views all qualitative differences between desires—understandings of qualities of personal character or qualities of social relationships, etc., that might enable us to arbitrate among different people’s conflicting desires—as nothing but differences in personal taste (second-order desires). Therefore, American public culture is left with only three ways to resolve conflicts among desires between persons.

The first and most ideal resolution would be the result of face-to-face negotiation that would enable the persons involved to identify which of their desires can be fulfilled realistically. This negotiation, if it is realistic, will necessarily include their being aware that their initial reading of their desires has involved a conflict and that simply wishing that conflict away will not work. It will also include the awareness that the resolution of such conflicts through violence or other exercises of power would typically involve a number of undesirable outcomes (harm) for one or both parties. Assuming the parties grasp the costs of non-peaceful resolution, our culture presumes they will try to find a course of action in which each makes adjustments in what is sought in order to maximize his or her own outcomes while taking account of the fact that their desires conflicted as initially experienced.

A second possible resolution when desires conflict between persons is that one party is able to employ violence or exercise other forms of power over the other in order to secure the fulfillment of his or her initial desire, to the detriment of the other party and possibly with significant costs to both. But most people believe that, if we were living in a society in which this was people’s habitual way of addressing conflicting desires, the risks to each of us would be very great. This is why people often try to resolve such conflicts by person-to-person negotiation. But such negotiations are often difficult, and they are made extremely complex as soon as more than a few individuals are involved. This is why many people consider it desirable for societies to devise social systems to prevent or at least lessen people’s recourse to violence and other exercises of power when person-to-person negotiations break down or are impossible to begin with.

These social systems are the third way of resolving conflicts of desires between persons. Among them are systems of law, social roles, and social rules and mores of many sorts. Whatever the more concrete settings in which they have come into being, at one level they have all been devised precisely to address conflicts of desires between persons. But simply having such systems in place is not enough because they are only effective when most members of the society learn to habitually use them to avoid
or resolve conflicts of desires without resorting to violence or other exercises of power.

A complicating factor in this is the fact that it is very difficult to devise such systems without these systems themselves, through the various social roles they create, also creating new inequities of power among people and hence new possibilities of conflicts of desires between persons. Most societies and social systems therefore develop what might be called “meta-systems” for trying to preserve as much opportunity for person-to-person negotiation of conflicts as possible and also, when social systems seem needed, as much equality of voice as possible in the creation of the social systems themselves. Thus, American society’s persistent appeals to ideals of liberty, equality, and fairness can be thought of as expressions of the recognition that personally negotiated resolutions are preferable to resolution by rule, principle, and law and that the rules, principles, and laws that we do devise ought themselves to be created through a system in which all participants have voice and power in their creation.

It is important to notice that nothing in the explanation of this third way of resolving conflicting desires between persons—via rules, principles, and laws—counts the assumption that a person’s desire is something to be fulfilled simply because it is a desire (provided it is not impossible of fulfillment). The commitment to live by rules, principles, and laws is a commitment to deal with conflicts of such desires and does not involve any challenge to the understanding of desires as comparable only in quantitative terms of strength, duration, etc., that was laid out above.

As mentioned above, there obviously are many individuals and groups within American society who are committed to systems of value different from this one, including systems in which certain values or principles or rights or ideals of character have moral weight of their own, independently of whether they are desired. Such persons and groups hold that these values, principles, rights, and ideals are qualitatively different from our desires and that they are not just second-order desires or social tools for managing conflicting desires. I will argue momentarily that the health professions, including the dental professions, have a view of need, its priority over other desires, and its ethical significance that makes it countercultural in precisely this way. But from the point of view of our society’s public culture, all such commitments are merely the work of particular desires, i.e., the desire to rank other desires in such ways.

Our public culture recognizes no privileged ranking of desires and no privileged evaluative tool for estimating desires. All desires of every person, it is presumed, may be ranked only quantitatively, only on the basis of their strength, duration, etc. Efforts to resolve conflicts of desire, both personally and socially, are therefore precisely efforts to maximize fulfillment of desire across the various desires and individuals involved.

This is a very complicated picture, and detailed evidence for it cannot be given here. Nevertheless, it is arguable that this view of humans and their desires, and the companion view of how conflicts of desires are to be addressed, can easily be identified in the workings of a number of major components of contemporary American public culture. It is obvious at work in the world of commerce at every level from individual purchases to corporate competition and corporate alliances to the content and spirit of American advertising. It is similarly at work in many aspects of American political life. It is also at the heart of how the news media portray our society to itself, and it is central to the powerful role of entertainment/sports/diversion in our society. It also plays a powerful formative role as the bedrock philosophy of American public education.

Access and Care in the Light of These Features

It is fairly easy to explain the understandings of access and of care that flow from this way of viewing human life, human desire, and human society. Viewed positively, access is simply a person’s ability to fulfill his or her desires, whatever they are. Since the only rational and socially defensible limitation on a desire’s being something to be fulfilled (except that it is impossible of fulfillment) is that the desire conflicts with another desire (one’s own or another person’s), it follows that, so to speak, every desire “deserves” access simply because it is a desire—unless, as has been discussed, it conflicts with another desire which similarly “deserves” access because it too is a desire.

Thus, in this view of things, the positive meanings of the term “access” tell us nothing that the term “desire” did not already tell us. That is why, in our society, most discussions of access—whether of access to health care or jobs or anything else—are discussions of the absence of access or of limitations on access. (The term “opportunity” is similarly
emptied of positive meaning in this view of things, and discussions of “equality of opportunity” in our society are therefore similarly almost always discussions of the absence of opportunity or of limitations on opportunity.)

Consequently, if we wish to discuss access to oral health care from the perspective of American public culture, we must focus on negative factors—on factors that limit people's ability to receive the oral health care they desire. The expression “access to care” can have no other significant meaning within this way of viewing human life and desire.

What about care? The key to understanding care, as used in the expression “health care” (the word has many other uses), is the fact that in our public culture's way of viewing things, there is no criterion for determining that something is desired except that someone desires it. Therefore, what counts as oral health care in this view is whatever the parties involved desire. If a patient desires to receive certain services, that is oral health care for that patient. If a dentist desires to offer those services, that is oral health care for that dentist. And if these two parties successfully negotiate a way to deal with their various desires in the matter—or if they choose to act according to some rule, principle, or law to this end—then good for them! But if they cannot resolve the fact of their both having desires in the matter, then clearly they have desires that are impossible of simultaneous fulfillment and it is irrational to continue desiring that! And that is all there is to say about it. In other words, in this view of things, the patient's and dentist's business negotiation, whether successful or not, tells the whole story of their relationship. They each desire something that is legitimately, in this view of things, considered to be oral health care; and if they can agree to desire the same thing, then they will come to be in agreement about what is oral health care for them. (Of course, one of them could choose to exercise power or resort to violence to resolve a conflict of desires between them. But there are, as mentioned, significant costs that a rational person would take into account when considering this, particularly given some of the laws and other social standards that have been devised in our society to cover such situations.)

Notice that, when someone who has a desire learns that it is impossible of fulfillment, it is reasonable and socially acceptable in this view of things to refrain from fulfilling it. In fact, it is ordinarily considered irrational to continue to try to fulfill a desire when one has learned it is impossible to fulfill. So if a patient's desire for oral health services proves to be a desire that cannot be fulfilled (because of irresolvable conflicts with the desires of dental providers), there is no special ethical significance to this unfulfilled desire. It is just one of many desires that we humans have, and in the real world we are not able to fulfill them all. In this view of things, unmet health care needs are just unfulfilled desires, and nothing more.

This leads us to what is, for present purposes, the most important point about our public culture's understanding of health care. Within this cultural view, there is no category of health care need available for discussion except, as indicated, whatever the patient happens to desire and whatever the dentist or dental hygienist happens to desire. There is no category of oral health need that can be used by either the health professional or the patient to identify what properly counts as care. In this view of things, there is nothing more to say about care except that people desire what they desire, and they maximize their fulfillment of their desires personally and in relation to others the best they can.

**Access and Care from the Professional Point of View**

America's public culture views need as simply a subcategory of desire, most easily articulated by saying that, within this view, a need is simply a strong desire. But clearly this is not how the health professions, including the dental professions, view need. Need is different from other kinds of desire, and because of this difference, health professionals have special ethical commitments in regard to it. There is a professional moral imperative to attend to the health needs of patients, and any health professional who recognized an unmet health need in a patient and failed to be concerned about it and to respond in whatever way is appropriate would be acting unprofessionally, unethically.

Furthermore, because of what health professionals understand by need, they consider a patient's health needs important whether the patient desires to have them met or not. Admittedly, in our society, there are ethical reasons why, in most situations, a health professional may not address a patient's health needs without the patient's consent. But nothing about these ethical reasons indicates that, from the health professions' perspective, needs are simply strong
desires on the part of the patient or cease to be needs if the patient does not desire them.

In fact, for the health professions, what counts as evidence that something is a health need for a person has nothing to do with what the person happens to desire at the time. Health needs are identified by comparing the patient's situation with an understanding of ideal human health. Judgments of health need through the application of a health professional's diagnostic expertise depend in turn on each health profession's understanding of ideal human health, which is in turn shaped in a complicated dialogue on that topic between the profession and the society at large. From the perspective of the health professions, health need is ordinarily an objective category. It is far from being something whose meaning can simply be negotiated between two parties or defined in terms of whatever the two parties might desire at the time. Consequently, it is something that has no place at all in our public culture's view of human desires and their role in human life.

How do the health professions view need when other desires conflict with it? The answer to this question is clear: health needs are more important than other desires. Health needs are to be met first, and ranking other desires ahead of them is irrational. Of course, the health professions recognize other categories of need besides health needs. That is, once the category of need has been differentiated as a special category, there is good reason to think that it contains other kinds of needs along with health needs and that other kinds of needs might be as important as or possibly even more important than health needs. And, of course, the health professions understand the importance in human life of fulfilling desires that are not needs.

But the point to be emphasized is that, in the view of the health professions, health needs trump "mere" desires, indeed trump everything that is not itself a genuine need. Therefore, for health professionals, health needs are the sorts of things that ought to be addressed first and, because the health professions possess the relevant expertise, health needs are specifically what health professionals are ethically committed to address first for their patients. Since needs are considered to be more important than "mere" desires in the life of the health professional's patient, the patient's needs also outrank other desires in the ethical life of the health professional caring for that patient. In sum, for the health professions, conflicts between health needs and other desires are to be resolved in favor of the needs.

Furthermore, health professionals believe this ranking is one that every rational person ought to employ when he or she has a conflict between needs and desires, and it is therefore the ranking that the health professions believe society ought to use in the allocation of its resources. This is why the health professions and their members are profoundly troubled when there are social systems in place, especially those that shape the distribution of health care resources, that do not structure such distributions so that the health needs of the society's people can be met.

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**Care and Access from the Professional Perspective**

From the health professions' perspective, care (i.e., health care) refers precisely to—and is simply another name for—the health profession's and the health professional's response to need. What counts as health care in any particular situation is determined principally through the diagnostic expertise of the professional identifying something as a health need. In practice, as the patient responds to this expert judgment, there is a negotiation with the patient that seeks to incorporate the patient's understanding of this need and any related desires that he or she might have. But in a proper relationship between dental professional and patient, as the health professions understand it, what the patient desires is neither the first nor the primary determinant of what will count as care. It is the professional's expert determination of the patient's needs that is primary.

The point about negotiation with the patient is important, but for different reasons. The patient's long-term oral health will be best served by a collaborative professional-patient relationship. In addition, our society is deeply committed to values of equality and liberty in all social relationships. For both of these reasons, a dental professional in our society certainly must educate the patient about his or her oral health needs and seek not only the patient's consent but his or her active collaboration in the determinations of treatment and other aspects of their relationship. But even so, it is the status of the patient's needs as needs, not their status as desires, that determines—in the view of the health professions—how the two parties should view their situation and what decisions they ought to make about it.

Access within the view of the health professions is also understood in terms of needs. A person
has adequate access when his or her needs are being diagnosed and addressed. In addition, precisely because access is about responding to needs, access is understood in terms of relative urgency. That is, some needs require immediate attention if actions are to be consistent with the ideal of health that guides professionals’ (and their patients’ in professional-patient relationships) judgments of need and care. Access consists first in responding to the most urgent needs and then to any other needs that are still unmet. Thus, where unmet needs are numerous, the ranking of needs from most urgent to less urgent will assist the health professional in rationing resources ethically. But any patient who has unmet needs is someone that the ethical health professional will be concerned about.

In practice then, dental professionals often have to reflect on whether it is reasonable to try to presently and personally respond to all the needs the patient is presenting. Dental professionals have to determine what is actually possible, assess the impact of their possible interventions against other ways of attending to unmet oral health need in the society, and weigh these considerations against the professional’s other commitments as a professional and in other aspects of his or her life. It will often be important to ask whether, rather than tackling unmet need personally and alone, it would be preferable to try to develop collaborative action with other dental professionals, other groups in society, etc., especially when the causes of the inadequate access to oral health care that he or she observes are systemic.

But what the dental professional cannot ethically do is view unmet oral health needs as simply unfulfilled desires. In this respect, the dental professional is thinking contrary to our society’s public culture. For as has been explained, culturally speaking, one assumes that someone’s unmet needs are simply desires (strong desires, but still just desires) that are going unfulfilled because the person weighed them against other conflicting desires and maximized his or her fulfillment in favor of the other desires rather than these.

Access is thus a concept with an important positive meaning for the oral health professional. It refers to the provision of care in response to need. But its negative referents, already noted, are also relevant. Where there are people whose oral health needs go unmet, inquiring about access will typically reveal the reasons why otherwise available care is not being chosen by these persons or why care is not otherwise available to them. Because access and care are about response to need, such barriers to care are matters of ethical significance to the dental professional and, especially where these are systemic barriers, to the dental professions as well. The professional moral imperative to respond to need is not satisfied by ensuring access only to one’s patients of record or only to everyone in one’s local community, for example. Every dental professional, by reason of being a member of the dental professions, also has thereby an obligation of concern and effort regarding unmet oral health needs in the whole society, not only to those close to hand.

For most dental professionals, this larger obligation to the whole society will ordinarily be fulfilled through the actions of organizations and other groups. But such actions do not happen without generous commitment of time and resources by individual members of the profession. Therefore, especially in the face of systemic barriers to access affecting many people in our society, each member of the dental professions ought to be actively contributing, whether ideas or time and effort or resources of other sorts, to the dental professions’ efforts to lessen and ideally remove the systemic barriers to oral health care, i.e., to secure access to care for those who presently do not have it.

**Conclusion**

If this analysis of the situation of the oral health professions and their members within American society is correct, the ethical puzzles that have motivated this conference are no surprise at all. Dentistry and dental hygiene as professions are situated in a culture that views human desires and needs in a way that is profoundly different from the perspective of the health professions and health professionals. As the dental professions and their members inquire what to do about unmet oral health needs, one lesson of this article is that we would be foolhardy to think that we can make significant progress if all we do is put forth in clear terms the perspective of the oral health professions. For there is no reason, given the distance between these two perspectives, to expect the larger society to salute!

It is certainly possible, in fact, that dental professionals themselves are not on exactly the same page even about these matters. In my judgment, not a few seem to be incorporating strong elements of the public culture’s perspective in the ways in which they present dentistry to the public. Consider, for example, some of the advertising that is out there, and also the
powerful attraction of aesthetic dentistry that seems driven much more by patient desires than by any carefully considered concept of oral health need.

Concerning patients, many dentists and dental hygienists will be able to think immediately of individual patients who clearly understand the professional perspective and collaborate enthusiastically (and counterculturally) with their oral health care providers. But there are many patients in whom the strain of the conceptual mismatch described here is evident and who make their choices about oral health care in an almost self-contradictory manner, trying to function in the world of fulfilling desires and the world of meeting needs at the same time. And there are significant numbers of patients who approach oral health care solely from the perspective of our society’s public culture as described above.

And then there are the manufacturers and insurers and other parties with whom oral health professionals must interact regularly in order to provide needed care to patients. Most of these entities function as corporations within the commercial sector of our society, deeply imbued with the conceptual framework characteristic of America’s public culture. There are exceptions, of course: both individuals within these organizations and organizational practices and programs that are consistent with and support the distinctive value commitments of the oral health professions (e.g., through grants and educational activities supportive of the professional perspective, including to a limited extent improved access to needed care for the underserved). But even when they are at their best from the health professions’ point of view, these entities still appear to be trying to work in both conceptual systems at the same time, unable to resolve the contradictions involved.

It follows that one very significant contribution that could be made by those concerned about access to oral health care would be to become far more articulate about the conceptual mismatch that prevents their message from being heard. It is conceivable that the health professions could put themselves at odds with American culture by stressing the difference between health needs and the public culture’s take on human desires. But to me, it seems more likely that many people in our society would be willing to join the health professions in carving out a special place for health needs within our public valuing system. What is needed is for the conceptual mismatch described here to be made clear, along with its serious implications for health care practice, and to do so in terms the populace can understand. This is not the only thing that needs to be done to address unmet oral health needs in the population. But it should be an important part of whatever the oral health professions undertake to address this problem.

REFERENCES