Basic Oral Health Needs: A Professional Priority?

Lawrence P. Garetto, Ph.D., F.A.C.D.; Karen M. Yoder, Ph.D.

Abstract: The inadequacy of access to oral health care is a complex problem facing society. Many in society who need care are unable to obtain it or do not seek it for a variety of reasons. Most commonly, these are the unfunded, who simply have inadequate resources; the “unaccepted,” who may not have dental coverage or have types of coverage that are not accepted by private practitioners; the inaccessible, who may be homebound or live in sparsely populated or low-income geographic areas without dental providers; the unconvinced, who may have resources but do not believe in or recognize the need for treatment; and the unmotivated, who may realize that they need care but for them it is not a priority. While the oral health care professions cannot be expected to shoulder the entire burden to “fix” inadequate access to care, we believe that they have important responsibilities. True professions have a unique relationship with society that places them in positions of trust. With this trust comes the responsibility for public policy advocacy and to actively participate in identifying realistic ways to reduce the access problem. The leadership of organized dentistry, as well as educational institutions, and practitioners themselves must be committed to improving access and thereby the health of those currently underserved.

Dr. Garetto is Associate Dean for Dental Education and Professor of Oral Facial Development, Indiana University School of Dentistry, and Adjunct Professor of Cellular/Integrative Physiology, Indiana University School of Medicine; Dr. Yoder is Associate Professor and Director, Division of Community Dentistry, Department of Preventive and Community Dentistry, Indiana University School of Dentistry, and Adjunct Faculty, Department of Public Health, Indiana University School of Medicine. Direct correspondence and requests for reprints to Dr. Lawrence P. Garetto, Office of Dental Education, Indiana University School of Dentistry, 1121 West Michigan Street, Indianapolis, IN 46202; 317-274-5418 phone; 317-278-1071 fax; lgaretto@iupui.edu.

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In his paper “Basic Oral Health Needs: A Public Priority?” Ozar1 focused on three important questions: Why focus on improved access? What makes it good? and Can it harm? In response to the first two, he provided a detailed bioethical rationale recognizing that choosing to focus on improved access and establishing why that focus is “good” clearly depend on the perspective one holds. By necessity, he defined the terms “access” and “care” and used an ethical reasoning process to examine the issues from multiple perspectives (in this case, from the perspective of underserved patients, patients in general—i.e., not just the underserved, dental care practitioners, the oral health care profession, health care professions in general, and American society/culture). He focused on the professional perspective in his paper, yet clearly described how the public/patient and professional perspectives are likely very different.

The basic thesis of Ozar’s presentation is that meeting some level of basic oral health needs for everyone should be one of society’s highest priorities. He asked the important question addressing the goal of improved access: What forms of oral health care are we referring to when we talk about needed care, and as determined by what standard of need? This question is beyond the scope of our reaction paper, but it must address, at the very least, health care needs that are in some manner essential to normal human function. While there are general needs that we could agree with (oral health that does not compromise general health, maintenance of one’s natural dentition, reduction or elimination of oral pain), Ozar clearly points out that there is necessarily an individual component to this determination (orthodontic care for a patient with a functional or serious esthetic condition, for example). Despite the question of what constitutes basic care being slippery, we like Ozar contend that, in some manner and certainly through discourse, basic oral health care needs should be definable.

Why Focus on Improved Access, and What Makes It Good?

The overriding issue apparent in Ozar’s presentation is the simplistic-appearing yet in reality complex notion of “access to care.” Ozar makes the point that discussions of access to care must realistically be discussions about the absence of or limitations on access.2 As he reminds us: “If we wish to discuss access to oral health care from the perspective of American public culture, we must focus on the factors that limit people’s ability to receive the oral health care they
do not believe in the need for treatment, while the unmotivated may believe in the need for treatment but, for them, dental treatment is not a priority. In other words, for some it could be practitioner unavailability or rejection or the patient’s inability or unwillingness to seek oral care that limits their ability to receive that care, not simply their finances.

When we limit the discussion to “people’s ability to receive the oral health care that they desire,” we miss what is most likely a significant number of individuals. Of course, ethically we must respect the autonomy of patients who need care in the view of oral health care providers, but do not seek it. On the other hand, ethically is it the role of a dental professional to attempt to educate someone who does not desire care but truly needs it? Suppose the person needing care is an eleven-year-old with rampant caries? Obviously, such an individual is not autonomous in seeking care. He or she must rely on the judgment/values of parents or guardians. Would it be considered by some as “abuse by neglect” if a guardian were to not seek care that we in the profession know could allow the child to maintain natural dentition and without which he or she would not? (The question of abuse by neglect related to dental neglect has been tested. Child neglect charges have been filed against parents, and the court has acted to require the parents to provide care. This was done partly because if the court requires care, and the parents can’t pay, then the township trustee [common only to Indiana] has to pay the bill. Now in Indiana, the State Children’s Health Insurance Programs [SCHIP] will enroll children up to 200 percent of the poverty level and will pay the whole bill. In Indiana, that agency is Hoosier Healthwise.)

If one substitutes life-sustaining care for oral care in the example above, is that the issue—i.e., oral care is not a necessity of life? This too is a discussion beyond the scope of this reaction, but it relates to another point made by Ozar, namely, that in the view of oral health from the perspective of the professional, “a health need has nothing to do with what the person (e.g., patient) happens to desire.” In other words, it may very well be an oral health care need whether the patient desires it or not. This factors into a primary central value of the profession: the need to maintain or recover a patient’s health may supersede his or her autonomy. This contention makes no sense for people with the capacity for health decision making who have chosen not to seek care (the uninvolved or unmotivated). But for those who might desire care but not have access or acceptance,
ethically it must be considered. Children and other segments of the population who have no control over their own access to care are principally affected by this circumstance.

Responsibility of the Oral Health Care Professions

Ozar makes the important point that the oral health care professions cannot be expected to shoulder the entire burden to “fix” the limitations on access to care. Society must bear a great deal of this burden because failing to provide care has both financial and moral implications. So, what is the responsibility of the profession? First, “care” should start by “accepting” a patient, so that discussion can take place to enable triage and diagnosis. It may be that the “accepting” dental professional’s action is to refer the patient for care, but in this manner an overt action of care has been initiated.

The profession’s second responsibility is to accurately articulate that inadequate oral health is a true health care problem. Again, it is beyond the scope of this reaction to respond to this question in detail. As Ozar points out, “when there are significant unmet oral health needs, the ethical dental professional may not respond with indifference.” But just as we must look to society to bear a great deal of responsibility in improving access to care for those in need, professionally, we must also reflect inwardly and assess our own actions and inactions. After all, maintenance of a patient’s general/oral health is considered by some to be a “central value” of the profession for all patients, especially those whose oral and general health may be the most compromised and at risk. But volunteerism and selectively providing free or discounted care are only band-aids that will not cover the gaping wound of disparities in access to care. These approaches are important and necessary, but are not sufficient. Volunteerism should occur, but in tandem with working for access to care for all children and for adults who choose to participate. Only dramatic policy changes will make universal access to care possible. Dentistry needs to develop the capacity to influence public policy. Yet, has dental education fostered skills in health policy advocacy among its students who are the future of the dental profession? Do they learn to unashamedly and convincingly argue that funding for basic oral health care for all is a necessary and achievable goal? Accrediting bodies should consider requiring competency in oral health advocacy as a measured standard.

Burt and Eklund⁴ have proposed six distinct strategies to address limitations on access: 1) strengthen the safety net system; 2) provide adequate payment; 3) optimize the use of appropriately educated or certified allied dental personnel; 4) make special arrangements for special populations; 5) develop a “cultural competency” for providers of oral health care; and 6) expand the “mindset” of dentistry to recognize that nonconventional patients (seriously ill, unappreciated, child, elderly, too complex, too easy, unable to pay) are as much a part of their responsibility as any other patient. A number of these strategies are addressed by others at this conference. Ozar has suggested that the professional organizations and dental schools can do more by educating “dentists about what they claim to stand for and to lead more of them to stand for it articulately.” Being articulate requires a firm grasp of the issues at hand. It also requires those of us who are responsible for educating the next generations of oral health care providers to stand for the professional principle of service to society as a practical action or outcome and not just an ideal or goal. In this manner, graduating professionals may better recognize that providing service to all patients in need is not something that one does by volunteering once in a while in a safety net clinic, but rather is a commitment made within one’s own practice and one’s own pool of patients of record to those currently considered “nonconventional.” Perhaps another central value of dental practice is necessary, one that speaks to basic care for all patients. While controversial, the concept of “basic oral health care” must be addressed because the current mantra of the profession asserting one level of care for all practically results in the situation of adequate care for some and limited or no care for others.

The role of our graduating dentists in patient and public education is also imperative. Viewing as a professional responsibility the need to educate the unconvinced/unmotivated members of a community about the value of oral health may improve the likelihood that they will seek care. These ideals speak toward dentistry as a profession, not simply as a business providing a service.⁵

As Burt and Eklund⁴ have discussed, dental practice exists within a context of social culture, the only constant of which is change. On both a short- and long-term basis, the economy, technology, and demographic trends relative to health and life in general are changing. These authors importantly state what
should be obvious to us in the profession: “Dentistry cannot be a bystander as these issues continue to demand public attention.” We believe, as do they, that dentistry must take a leadership role in the shaping of not only health policy, but also in modulating and advancing our profession’s health care responsibilities beyond that of volunteerism for health care in the community. To do so, we must come to view the concept of “community” as larger than simply those people who seek out the oral health care provider on their own. For many in the community, we must actively work to bring them into appropriate care. Our profession’s leaders will do that by advocating for better funding for public programs in dentistry that target unfunded individuals and by developing expectations within the profession that patients with public funding will be accepted and respected in private practices. We also need to work to improve our ability to educate those in true need of oral health care so that the value of this care is more apparent.

Finally, we believe that our schools of dentistry must work to better embrace and emphasize the professional ethic of “selfless service to society” and the ethic of “acceptance” as a routine part of dental practice that is expected of all graduates. The ethic of selfless service is espoused by professional organizations such as the American College of Dentists’ and is a hallmark of professionalism. This in itself is no small task as it will necessarily involve role-modeling by faculty who may not necessarily see this as their own role.

Can Focusing on Improved Access Cause Harm?

From the perspective of the third question addressed by Ozar, if we in the oral health care professions delude ourselves into thinking that access to care is solely an economic issue that would be cured by the liberal application of dollars, then we miss that segment of the population who, from a professional perspective, need care but are unaware of it, don’t seek it, can’t get to it, or are afraid of it. From a professional perspective, we must also focus on this segment of the population as well, not to force care on them but to help them recognize the need for and the benefit of that care.

Also relative to the question “Can it harm?” is the manner and tone of discussion that we must necessarily have within our profession if changes are to be made. We believe that, in a vibrant and forward-looking profession, no harm results from vocalizing doubts or misgivings about core values or about potential discrepancies between the values we espouse and our behavior. It is important both to recognize and to be prepared for the likelihood that good people who are members of our profession will have passionately disparate beliefs about both the need to make substantive changes and the direction of change itself. It is possible that potential harm could arise from those who would view vigorous debate within the profession as a sign of weakness and division or an inability to focus on a common purpose. Yet, by the nature of this inevitable discussion, great benefit should be derived from being compelled to provide a reasoned rationale and to make underlying thinking processes available for all to see. Doing so will not only cause no harm, but in fact should produce the benefit of enabling us to clearly identify the problems we need to address and help make solutions more apparent.

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