Eliminating Oral Health Disparities: Ethics Workshop Reactor Comments

Caswell A. Evans, D.D.S., M.P.H.

Abstract: Oral health encompasses dentistry and is broader in concept. Dentistry alone appears insufficient to ensure oral health for the population at large. Troubling disparities in oral health status and access to care have been documented. The segment of the population that has little or no access to care is growing; aging baby-boomers are adding to this problem. As suggested in *Oral Health in America: A Report of the Surgeon General*, partnerships and collaboration are essential to improving oral health. The ethics of dental practice and the profession are being called into question. Who will provide the necessary leadership to address and resolve these issues, so that oral health is attainable by all?

Dr. Evans is Associate Dean for Prevention and Public Health Sciences, University of Illinois at Chicago, College of Dentistry. Direct correspondence and requests for reprints to him at University of Illinois at Chicago, College of Dentistry, 801 S. Paulina, MC 621, Chicago, IL 60612; 312-413-2474 phone; 312-413-9050 fax; casevans@uic.edu.

Key words: ethics, health disparities, professionalism, access to care, leadership

I am pleased to have been asked to provide reaction comments for the second session of this workshop. The papers presented have given us all new and important perspectives. I know that I have broadened my view as a result of reading and thinking about the papers and the points they have raised.

Before I comment on specific papers, I would like to share some overall perspectives that will help you to place my remarks in context. Even prior to reading the papers for this session and others included in this workshop, I had been drawn to the conclusion that the practices of preventing oral diseases, promoting oral health, protecting oral health, and the provision of oral health care services, as professionally based pursuits, were in substantial jeopardy on several fronts. Also please note that in my comments, I will be careful to emphasize oral health as a professional practice in the broadest perspective. In that sense, oral health practice is broader than, but includes, the professional practice of dentistry. The specific practice of dentistry is a large and critical facet in this regard; but dentistry cannot be successful alone as it is not sufficient to resolve the challenges at hand. In many regards, it appears that the practices of dentistry may contribute as much to the problem as it has potential to participate in the solution.

What Are We? What Purpose Do We Serve?

No matter how we may attempt to rationalize it, profound disparities in oral health and disparate effects of oral diseases have been documented on our watch and during our time of leadership and stewardship for oral health! The range and magnitude of these disparities should trouble us all. They have been amply described elsewhere,1 so I will not elaborate on them here. In the classic lyrics of the Chicago Transit Authority band, “Does anybody really know what time it is? Does anybody really care?”

A key and fundamental issue, and one that I have commented upon before publicly, is embodied in the description of dentistry as a “cottage industry.” That term has been used in describing dentistry to Congress and in other public settings. At issue, and several of the papers have touched on the essence of this matter, is this question: Can dentistry thrive as a “profession” and also strive to be a “cottage industry”? In my view, and I believe this view is held by many, the two concepts are in conflict and are essentially immiscible.

David Smith, in his paper, points us firmly in this direction when he references the tension among the business of the distribution of services, “professionalism” (whatever that actually is), and the ability to provide some assurance of access to and provision of care for the poor. Steadfast adherence to the virtues of fee-for-service practice provides no access to those who cannot pay. He further states, and I agree, that we have an impoverished view of what it means to be a professional. He notes that the professional’s moral imperative to respond to health needs is not satisfied by ensuring access to only those patients of record; there is a societal commitment that must be addressed. I won’t cover the various characteristics that have been posited to describe and define a profession or professional practice, as papers for...
the workshop have provided those views. However, I do raise a question that we should consider: Given those characteristics, is dentistry operating as a profession?

Welie, in a three-part series of articles, has considered this question and concluded that while dentistry is probably acting as a profession, it appears on the brink of jeopardizing that status. He cautions that dentistry does not provide services that would be considered professional, to the extent that those services are not addressing basic health requirements, but are purely elective in nature. In this regard, the popular and profitable cosmetic services, tooth-whitening, and the like seem to marginalize the profession.

Before going further, it is important to point out that dentistry is not alone in facing professional jeopardy. The practice of medicine is facing similar issues concerning the ability to maintain its professionalism in light of the parameters of corporate and profit-driven interests, managed care, the influence of the drug industry on education and its recent practice of direct marketing to the public, and state and federal regulation, among other factors. In 2002, Harold Sox, editor of the *Annals of Internal Medicine*, published a proposed physician charter entitled “Medical Professionalism in the New Millennium.” The preambles to that charter states: “Professionalism is the basis of medicine’s contract with society.” It goes on to outline the fundamental principles of primacy of patient welfare, patient autonomy, and social justice. What follows is a presentation of a set of professional responsibilities that include commitments to professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients, improving quality of care, improving access to care, a just distribution of finite resources, scientific knowledge, and maintaining trust by managing conflicts of interest.

The position paper, “Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans,” recently revised by the House of Delegates of the American Dental Education Association (ADEA), appears to lead dental education in the right direction to produce dentists that are more attuned to making a difference.

In his papers for this workshop, David Ozar notes the disharmony between “society’s public culture,” which views “need” as simply a strong “desire,” compared to the dentist’s view that a diagnosed oral health need is absolute and requires redress. He points out the conflict inherent in that difference of viewpoint. I follow the logic and believe that it is applicable and worthy of full consideration. However, I question the universality of his interpretation of “society’s public culture.” I think of Jonathan Kozol’s book *Savage Inequalities*, in which he describes the dour condition of oral health of Bronx school children and concludes, “Children live for months with pain that grown-ups would find unendurable. The gradual attrition of accepted pain erodes their energy and aspiration.” Treatment and remedy of these conditions surely would not be considered “desires” by these children or their guardians. Although Kozol’s observations were made fifteen years ago, the disparities data imply that in all likelihood little improvement would be found today among similar children in that setting.

Likewise, in an earlier life when I was the health officer for Los Angeles County, California, we conducted numerous community meetings focused on health and unmet needs. While these public health meetings addressed a wide range of issues and problems, invariably oral health issues would be presented. A son reported removing his father’s teeth at home using pliers wrapped in cloth and screwdrivers, due to the family’s lack of access to standard dental care. There were also regular reports of neighborhood basement or garage “dental practitioners,” who fabricated dentures, removed teeth, and provided a range of oral health services not otherwise available in these communities. Those were the realities of the time. While I have been away from Los Angeles for several years now, I venture to say that there has probably been little change in these realities. Those experiences were unfortunate, but I assume they would reflect the situation today in many other low-income areas, urban and rural, in this country.

My point here is that I am not so sure that “society’s public culture” as described by Ozar is fully applicable in the context of low-income, underserved, and ignored populations that have not had the relative luxury of appropriate access to dental care. Perhaps specific consideration should be given to this construct from the perspective of these populations. It is possible that among these groups other views regarding the “need” for care are equally or even more important.

However, when Ozar advises that dentists should be catalysts for effective action, I could not agree more. Ozar also notes that responsibility for advocating for improved oral health and access to care should have a broad societal base, beyond only
involving dentists. He points out the unrealized opportunity for oral health leaders to establish a broader base in the ethical domain that supports improved access to care. Similarly, Garetto and Yoder, in their paper, emphasize that dentistry must take on leadership roles in shaping not only health policy but also modulating and advocating the profession’s health care responsibilities in the community. Smith sees dentistry’s role in term of social justice and states that dentists should care about oral health whenever and among whomever the issue arises.

Those advisories were also articulated by U.S. Surgeon General David Satcher in *Oral Health in America: A Report of the Surgeon General*. This report noted that oral health was everybody’s domain and that partnerships should be formed to be most effective in improving oral health and particularly improving access to care. Today, more than ever before, it does seem that partnerships are forming and growing for this purpose. Does dentistry feel threatened by these partnerships and incursions into its domain, or are these other concerned parties seen as necessary and welcomed, allies in creating effective changes? I will let you decide that one.

Ozar is empathic in stating the need for dentistry to get its house in order, noting that dentists (and I would include dental students as future dentists) need to be educated regarding these issues and be better prepared to take actions within and outside the dental community if greater success is to be achieved. He is not optimistic regarding our ability to affect significantly society’s distribution of resources to better favor oral health.

I particularly like Ozar’s reasoning that supports oral health care as a basic health requirement and essential to ensuring people’s sense of effective autonomy and serving to ensure the “unity of the self.” That he includes prevention and early intervention into this logic framework is grand indeed and should provide guidance to us all. He also makes an interesting case to validate the essential nature of some cosmetic services.

One of the problems we face in broadening and deepening the ethical basis for decision making in oral health practice is that dental students, as future dentists, for the most part have too few role models and little observational opportunity regarding ethical decision making prior to themselves entering into practice. Further, much of the exposure they do have to dental faculty may result in only selective if not biased and narrow exposures to these ethical issues.

Before I close, I want to share some additional prior personal experiences regarding access to care issues that are illustrative and raise deep concern in my mind about how serious or effective our efforts would be in remediation of the problem. Before I went to Los Angeles, when I was dental director for the Seattle-King County Department of Health, it was my job to ensure access to care for the underserved, including increasing the department’s treatment capacity if that were needed. The resultant blood war with the local dental society at the time was grim. My position was: if you don’t want the department to do this, then you provide the services. But they would not ensure provision of the needed services, nor were they willing to support the department to do so. The department proceeded regardless, and I dropped my ADA membership for several years as symbolic of my refusal to help finance the other side. These types of scenarios continue today.

Further, as a part-time dental consultant for Head Start programs when I was otherwise working in public health in DHHS Region IV and again in Region X, my role was to contact and recruit dentists to provide services for the three- to five-year-old children in the program. Most of this effort took me to rural communities. I found the general cynicism of local dentists in their refusal to provide care to be appalling. It was common to find no dentists within a five-to-six-county area, representing as much as two hundred miles, willing to provide these services. (Having recently visited a Head Start program in Chicago, I can tell you that finding providers here in this city, today, is no less problematic.) The programs were funded to pay for the care, and these were children in need. To exacerbate the problem, there were other particularly unfortunate instances where dentists did examine the Head Start children and knowingly submitted bills that exhausted the program’s entire dental budget, leaving no payment capacity for the dental services that the dentists had deemed to be required.

There is another looming and major challenge that will further exacerbate the issue of access to care. In the early 1960s, dentistry fought to be excluded from Medicare, which was enacted in 1965, perhaps for what seemed to be sound reasons at the time. Regardless, the result today is that there is no Medicare coverage for dental care and therefore essentially no coverage at all for that group sixty-five years and over. At present, they are the fastest growing age cohort in this country. Now consider that the baby-boomers, approximately 77 million people, will begin to join this cohort in about five years. Compared to past
similar age cohorts, the cohort sixty-five and older is proving to be more diverse, has more resources, is better-educated and more health literate, has retained more teeth, has better oral health status, and has a longer life expectancy. They will also have more underlying chronic health conditions than their earlier counterparts, so their dental care services will be more complex for that reason alone. Their expectation to preserve their oral health will be high. A particular challenge will be ensuring effective access to care for this group. Whether the standard approach of fee-for-service will prove effective is not clear, but seems doubtful.

In closing, I believe that a platform based on ethics to improve access to care and eliminate oral health disparities could serve oral health practitioners and society well. To what extent current practitioners could be affected, or would participate, is open to question. The value of directing this effort at dental students as the future of the practice is quite evident. In that regard, the ADEA statement provides a valuable roadmap that we should follow. However, where is the leadership for this effort to come from? Who or what will provide the necessary direction? At its core, the ADA represents only its members. What about the National Dental Association, the Hispanic Dental Association, and the many other membership organizations? Who has the fire in the belly to move this issue forward to an effective outcome?

REFERENCES