Ethical Considerations in Community Oral Health

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Abstract: As the public’s oral health care needs increase in complexity, there is renewed attention to the ethical dimensions of community oral health decision making and the development of public health ethics in teaching and research in dentistry. Despite their reduction globally, oral diseases persist with a particular distribution pattern that is a reflection of the increasingly widespread inequality in access to community oral health preventive and dental care. This is due to differences in the appropriateness, availability, accessibility, and acceptability of oral health education and the care provided. This article provides an overview of community oral health from an ethical perspective, including the importance of equity, human rights, and social justice in providing oral health care to the underserved. The need for a paradigm shift from highly technical and individualistic dental training curricula is discussed, together with the need to instill a holistic approach to ethical and social responsibility in new dental graduates. It concludes with some possible strategies, using the overarching principles of ethics and bioethics that are applicable to practice among vulnerable populations.

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Global patterns of oral diseases continue to reflect widespread inequality in the access to public preventive and dental care. The oral health status of global populations highlights differences in the availability, accessibility, and acceptability of education and oral health care. In this context, ethics can be used as a tool for the discussion, improvement, and consolidation of citizenship, human rights, and social justice. By the early 2000s, bioethics had expanded from biomedical health issues to incorporate broader public health, biotechnological, and social issues such as health and the environment.1 It has been difficult to define bioethics as a topic since it has constantly changing themes that vary according to the social context in which it is developed. On a conceptual level, the bioethical principles proposed by Beauchamp and Childress, based on four essential tenets of autonomy, beneficence, nonmaleficence, and justice, are the most widespread.2 Autonomy relates to the basic concern of developing public policies that avoid undue limitation of individual free will, and justice serves to reflect on inequalities and the allocation of scarce resources. This article will offer a reflection on community oral health in underserved populations from a bioethical standpoint. To do so, it is necessary to start with an analysis of the role of bioethics in public health and to approach some of the ethical issues surrounding dental care in public health systems.

Public Health Bioethics

Public health is the societal approach to protecting and promoting health. It is through social rather than individual actions that this approach seeks to improve the well-being of communities. However, this population-based focus has often given rise to ethical dilemmas regarding the appropriate extent of its reach and whether its activities infringe on individual liberties.3 Bioethics is a subfield of ethics that explores ethical questions related to the life sciences. It enables health professionals and public policymakers to make decisions about their behavior and about policies that governments, organizations, and communities must consider on how best to use new biomedical knowledge and innovations. Bioethics resulted from the sociopolitical, cultural, and technoscientific developments that occurred in the mid-twentieth century. However, the interpersonal principalist approach of clinical bioethics was found to be inappropriate for the social concerns of public health, and there was a need to adapt it to the issues raised by public health policies and interventions.1 Public health and bioethics have many issues in common since both are concerned with issues of human rights, citizenship, social movements, and public policy.4

Public health bioethics has developed along the lines of responsibility, prevention, and precau-
Global Burden of Oral Diseases

Oral diseases affect both well-being and quality of life. Poor oral health may have a profound impact on general health, and several oral diseases are related to chronic diseases like diabetes and obesity. Dental caries is the most common of all chronic diseases in industrial and in most low- and middle-income countries. According to Marcenes et al., “Oral conditions affected 3.9 billion people, and untreated caries in permanent teeth was the most prevalent condition evaluated for the entire Global Burden of Disease (GBD) 2010 Study with a global prevalence of 35% for all ages combined.” Although the prevalence and severity of dental caries have decreased substantially in the past two decades, it remains a preventable disease, is still common, and remains a public health problem.

In children, tooth decay not only affects the child’s overall health but has other ramifications such as school absenteeism for the child and work absenteeism for the parents. According to the U.S. surgeon general’s oral health report published in 2000, over 51 million school hours are lost each year due to dental diseases. Treatments are expensive, and in many industrialized countries, oral diseases are the fourth most expensive diseases to treat: it has been estimated that if treatment were available for all, the costs of dental caries in children alone would exceed the total health care budget for children.

The prevalence of dental caries in children has declined markedly over the past 30 years in most countries. This is the result of successful implementation of a number of public health measures including effective use of fluorides, changes in living conditions and lifestyles, and improved self-care practices. However, disparities remain for certain demographic groups. For example, many children, older adults, people with little education or low socioeconomic status, racial and ethnic minority groups, and individuals with special health care needs are defined as high-risk groups. Health education programs and health care public policies have been only partially effective in reducing dental caries rates in these populations. In essence, the populations most affected—the vulnerable—are those who receive the least care.
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Obligations for Oral Health Care

Meeting the oral health needs of a population protects the range of opportunities people can exercise, and any social obligation to protect opportunity implies an obligation to protect and promote the oral health (normal oral functioning) for all people. On the fair equality of opportunity view, meeting the oral health needs of all persons (viewed as free and equal citizens) is therefore of special moral importance. Recent theories of justice affirm that there are social obligations to protect opportunity, converging on the importance of protecting oral health and health in general. On the opportunity-based view, justice requires that we protect people’s share of the normal opportunity range by treating illness when it occurs, reducing the risk of disease and disability before they occur, and distributing those risks equitably.21

Within the dental milieu, this means that all people must have access to a reasonable array of services that promote and restore normal oral functioning and that preventive measures must not be neglected in favor of curative ones. There is a need to look beyond clinical dental settings to traditional public health measures that profoundly affect oral disease risk levels and their distribution. In addition, one needs to look beyond the health sector to the broader social determinants of health and their distribution. However, since all oral health needs that arise inside or outside the dental sector cannot be met, one must be accountable for the reasonableness of resource allocation decisions that are made.21

Social Inequities and Access to Oral Health Care

The availability of oral health care, prevention, and health promotion affects the level of oral health, and this in turn reflects differences in the availability, accessibility, and acceptability of oral health care and education.22 In general, current disparities in the epidemiological picture of oral health reflect differences in socioeconomic development among countries. Inequalities affect oral health in the same way that they affect a wide range of health issues. Tackling inequalities in health requires strategies tailored to the determinants and needs of each group along the social gradient and cannot be strictly interpreted as a lack of dentists, lack of health care, or poor professional education models.

Health inequalities among social groups count as unjust or unfair when they result from an unjust distribution of the socially controllable factors that affect population health and its distribution.23 Socioeconomic inequality is the most prominent characteristic, with severe consequences for health, especially oral health. In turn, inequality in access to oral health care has sparked a broad bioethical debate because such inequality has been observed in many countries, and it is often characterized by the fact that individuals with lower socioeconomic status have less access to oral health services.

To illustrate what a just distribution of factors might be, let us consider Rawls’s principles of justice as fairness.24 These principles ensure equal basic liberties and worth of political participation and rights; ensure fair equality of opportunity through public education, early childhood supports, and appropriate public health and medical services; and constrain socioeconomic inequalities that result in the worst off and best off groups. Together, this distribution of key determinants of population health would significantly flatten the socioeconomic gradient of health and would minimize various inequities in health, including race and gender inequalities. In many countries, public health services constitute the main resource for the majority of the underserved population, especially for women and children of lower economic status.25

Access to oral health is not restricted to dental treatment; it is also expressed in the access to preventive measures against oral diseases. Water fluoridation is recognized as a beneficial collective action because of its guaranteed effectiveness and large area of coverage, but it has yet to be implemented in many countries around the world. In terms of public policy, the great inequality in the implementation of fluoridation originates at the country level. Its expansion has been so slow that, in the 21st century, only 35 countries covering 377 million people have fluoridation programs.26

From the collective point of view, the bioethical principle of justice concerns equal access to health services for all people, the distribution of resources, and the criteria to fairly resolve these issues.21 Public health systems are usually based on the egalitarian doctrine that all human persons are equal in fundamental worth or moral status and should have their
Regarding social injustice and the need to improve the quality of oral health of the population. Teachers do not seem to acknowledge their clear social and ethical responsibilities. There is a need for the integration of education and service delivery, which should guide the process of ethical reflection on the role of university leaders and their contribution to the construction/reconstruction of good practice. The teaching of bioethics in academic dental institutions should constitute a framework that allows for reflection and a critical view of the world by focusing attention on the social, cultural, and economic problems of a population resulting in a social commitment to improving people’s quality of life by one’s professional actions. Students need to be aware that poor health prospects are not just a matter of misfortune, but rather a matter of justice. The theory of justice serves many roles by helping to focus attention on needs and by conceptualizing problems in ways that guide action and reform. Schuh and de Albuquerque’s study showed the need for transmission of humanistic values at the university level in the ethical training of health professionals. They argue that it is with admission to university that the process of professional socialization begins when the incorporation of professional morality is determined by the adoption of models and the internalization of behaviors and attitudes that are accepted among peers. Furthermore, these authors found that, in health professions education, the teaching of ethics lags behind the needs of society. Dental curricula should include ethical-moral features related to professional attitudes and behaviors towards patients and institutions. Dental school environments with high academic and professional integrity of all members of the faculty should promote personal and human development of students. Teachers’ attitudes and values affect students’ opinions, especially in their final year.

Financial Considerations

Populations that have access to oral health care are more likely to receive basic preventive services and education on how to attain and maintain good oral health and to have oral diseases detected at earlier stages. In contrast, lack of access to oral health care as is often experienced by underserved populations can result in delayed diagnosis, untreated oral diseases and conditions, compromised health status, and, occasionally, even death. Their poor conditions of life have a major impact on their levels of general and oral health. A major reason for the decline in utilization is the increasing financial barriers to care. In addition, provision of public oral health care has been hampered by factors related to the financing of preventive activities and services. Sociodemographic factors, including gender, age, income, and education, remain the main predictors of access to oral health services. While there has been progress in the investment in oral health care in recent years, the funding of these actions have often required large investments in the public sector by governments around the globe.

Dental Professional Training in Ethics

The teaching of ethics is controversial primarily because the dominant ethos of most health professions is empiricist, quantitative, and oriented toward precise, definitive solutions to discrete problems. Most dental professional training may seem inadequate to support the desired profile of an empathic, caring public health professional committed to meeting the health needs of the population. This deficiency has a direct influence on the quality and effectiveness of a health care system.

It has been reported that there is a lack of reflection by university leaders on everyday teaching and practice, and this shows a degree of indifference regarding social injustice and the need to improve the quality of oral health of the population. Teachers do not seem to acknowledge their clear social and ethical responsibilities. There is a need for the integration of education and service delivery, which should guide the process of ethical reflection on the role of university leaders and their contribution to the construction/reconstruction of good practice. The teaching of bioethics in academic dental institutions should constitute a framework that allows for reflection and a critical view of the world by focusing attention on the social, cultural, and economic problems of a population resulting in a social commitment to improving people’s quality of life by one’s professional actions. Students need to be aware that poor health prospects are not just a matter of misfortune, but rather a matter of justice. The theory of justice serves many roles by helping to focus attention on needs and by conceptualizing problems in ways that guide action and reform. Schuh and de Albuquerque’s study showed the need for transmission of humanistic values at the university level in the ethical training of health professionals. They argue that it is with admission to university that the process of professional socialization begins when the incorporation of professional morality is determined by the adoption of models and the internalization of behaviors and attitudes that are accepted among peers. Furthermore, these authors found that, in health professions education, the teaching of ethics lags behind the needs of society. Dental curricula should include ethical-moral features related to professional attitudes and behaviors towards patients and institutions. Dental school environments with high academic and professional integrity of all members of the faculty should promote personal and human development of students. Teachers’ attitudes and values affect students’ opinions, especially in their final year.

Strategies to Expand Oral Health Care

Dental Caries, a Chronic Disease

In 2002, the World Health Organization (WHO)’s Global Oral Health Program adopted a new strategy: dental caries was included in chronic disease prevention and general health promotion. This was because the risk factors for several chronic
diseases are common to most oral diseases, and the common risk factor approach was the new public health strategy for the effective prevention of oral disease. This approach was justified by the fact that dental caries is a chronic disease that progresses and needs to be managed throughout the lifetime of most people. Therefore, the common risk factors such as dietary and nutritional factors need to be addressed together with the socio-environmental factors that are distal causes of oral diseases.

**Therapeutic Patient Education and Vulnerable Populations**

As many public health policies have been inefficient in dealing with underserved and vulnerable groups, it has been necessary to find other strategies to decrease the incidence and burden of oral diseases. By defining dental caries as a chronic disease that needs lifelong management, the concept of therapeutic patient education (TPE) can be used in underserved populations to reduce the burden and gravity of oral diseases.

TPE enables patients to self-manage or adapt to treatments and cope with new processes and skills that allow them to optimally manage their lives and their disease. It is an ongoing process that is integrated into their overall health care designed to help patients understand the disease and associated treatment, cooperate with health care providers, live in good health, and maintain and improve their quality of life. TPE was initially developed for other chronic diseases like asthma and diabetes.

An example of TPE was piloted in 2009 by the American Dental Association (ADA) as a project of the community dental health coordinator (CDHC), who delivers oral health education and prevention services and helps patients to navigate an often daunting public health system to receive care from dentists. Most CDHCs come from the inner city, rural, and American Indian communities and provide a critical link between underserved communities and good oral health. The CHDC model provides outreach that has not been done before in dentistry.

**Ethical Aspects of Patient Education Programs**

Oral health education is a social practice aimed at collective and other preventive measures, such as oral hygiene, fluoridation, and non-carcinogenic diet, as an opportunity to enhance the practice of oral health promotion in public spaces. It requires a patient to change his or her identity to meet a dental ideal and therefore poses ethical dilemmas. In some ways, oral health education is an ideal public health intervention as it is voluntary and attempts to empower people to make their own decisions regarding their own oral health once they have been provided with relevant information on how to do so. However, despite its obvious advantages, it may not be appropriate for all situations. It may not work in all settings, so a clearly defined population may need to be targeted, which will raise questions and create tensions, such as: What criteria will be used to select those who will take part in the program? How can we justify these criteria? Is the will to change the behavior of a patient an instrument of social control that may infringe on the freedom of the subject, or is it an ethical action aimed at improving the patient’s oral health?

To increase effectiveness, educational programs may use ethically questionable practices such as manipulation or coercion, and in some instances health education programs have the potential to be paternalistic suggesting that certain traits are universally valued. Oral health care workers must take care not to usurp patient’s choices by assuming someone else’s goal (societal or provider), nor to deprive the patient of the knowledge and skills necessary to exercise his or her choice. The key outcome is to get patients accustomed to act as shared decision makers in treatment, thereby granting them highly desired autonomy. The kinds of care owed to patients, how that care is determined, and what constitutes appropriate access to care must be made clear, given that there are diverse barriers to access. In instances in which there is disagreement after repeated discussion, the patient’s informed choices and best interests should prevail. Oral health professionals need to be trained to educate a patient in order to manage treatment of his or her condition and to prevent avoidable complications. This requires a paradigm shift from the traditional treatment-based culture to a culture of prevention or a combination of the two.

**Concluding Remarks**

There are many and varied reasons why oral diseases persist in the world, especially among underserved populations; among these reasons are a population’s access to public dental services and actions that contribute to inequities in oral health. In
general, it is the responsibility of public health services to ensure well-being of the population by ensuring access to health services and other health programs and taking necessary actions to meet health needs of the population. However, the ethical principles of protection and responsibility are not restricted to the state and its representatives, but must be embraced by each dental professional whether in his or her practice or within the larger community in which they work. The principle of justice is applied when health professionals use the resources of epidemiology and social risk criteria to detect vulnerable individuals, especially those in underserved areas, and facilitate their access to oral health care.4

The teaching of ethics in dental schools must be taught effectively and practiced in our dental schools, despite the fact that the field is not well unified and does not have a clear consciousness of itself as a profession. Values such as dignity, human rights, respect for autonomy, and vulnerability must be incorporated into academic practice to develop attitudes that go beyond the limits of clinical care. There is a need for a clear conceptual and intellectual ethical framework to develop a community oral health ethos in faculty and students. Such a framework should result in a health professional who is truly educated to care for the community with sound judgement and having an ability to recognize and analyze ethical issues, a tolerance for ambiguity, and a capacity for empathy in the broader context of human experiences and values.

REFERENCES