



Summer 2007

# A Larger Sense of Purpose: Dentistry and Society

David A. Nash

University of Kentucky, [danash@uky.edu](mailto:danash@uky.edu)

**Right click to open a feedback form in a new tab to let us know how this document benefits you.**

Follow this and additional works at: [https://uknowledge.uky.edu/ohs\\_facpub](https://uknowledge.uky.edu/ohs_facpub)

 Part of the [Dentistry Commons](#)

---

## Repository Citation

Nash, David A., "A Larger Sense of Purpose: Dentistry and Society" (2007). *Oral Health Science Faculty Publications*. 16.  
[https://uknowledge.uky.edu/ohs\\_facpub/16](https://uknowledge.uky.edu/ohs_facpub/16)

This Article is brought to you for free and open access by the Oral Health Science at UKnowledge. It has been accepted for inclusion in Oral Health Science Faculty Publications by an authorized administrator of UKnowledge. For more information, please contact [UKnowledge@lsv.uky.edu](mailto:UKnowledge@lsv.uky.edu).

---

**A Larger Sense of Purpose: Dentistry and Society**

**Notes/Citation Information**

Published in the *Journal of the American College of Dentists*, v. 74, no. 2, p. 27-33.

Copyright © by the American College of Dentists, Gaithersburg, Maryland, U.S.A. All rights are reserved.

The copyright holders have granted the permission for posting the article here.

# A LARGER SENSE OF PURPOSE

## DENTISTRY AND SOCIETY

David A. Nash, DMD, MS, EdD, FACD

### ABSTRACT

Dentistry is undergoing a subtle shift away from being a profession to becoming a business. The two cultures of professionalism and business are contrasted. Among the forces driving this change are the emphasis on esthetics in dentistry and the increasing inability of a large class of patients to access dentistry on a business basis. The shift toward dentistry as a business entails the unhealthy transition toward regarding patients as means to satisfy the dentist's ends rather than patients' health being an end in itself. Dentists run the risk of "objectivifying" rather than "humanizing" patients. This trend must be overcome with a larger sense of purpose; placing dentist's self-interests within the larger context of enlightened self-interest.

In 2005, Harold T. Shapiro, former president of Princeton University, published *A Larger Sense of Purpose: Higher Education and Society*, a book based on his 2003 Clark Kerr Lectures at the University of California. The book prompts a consideration of a larger sense of purpose in the profession of dentistry as it relates to society. The intention of this essay is to convey the notion that the profession of dentistry ought to serve interests that include, but move beyond, narrow self-serving concerns. As Shapiro indicates, the Latin expression *non nobis solum*, loosely translated, "not for ourselves alone," echoes this thought.

We are all concerned with purposeful existence—of living a life filled with meaning—with purpose. Viktor Frankl, the distinguished Austrian psychotherapist, authored what has become an internationally best-selling classic: *Man's Search for Meaning*. In it, he documents the trauma of his years in Nazi concentration camps, trauma that led him to a pivotal understanding of human existence—and an understanding that provided the foundation for his work in psychotherapy for the remainder of his life. His world-famous approach to therapy he called logotherapy, or meaning therapy. The foundation of his therapeutic approach is the imperative for us to create a deep and abiding sense of meaning for our lives. He said, "Man's concern about a meaning of life is the truest expression of the state of being human." Humans need a reason to live, a meaning for life, a purpose. Frederick

Nietzsche, the German philosopher, expressed it in *Twilight of the Idols* as "He who has a why to live can bear with most any how."

My thesis is that changes are taking place in the profession of dentistry that are eroding the sense of purpose and meaning that dentists in the past have derived from their professional existence. My belief is that we must challenge and resist these eroding forces and forge "a larger sense of purpose" for our professional lives. To do so, I will argue that we need to reaffirm two basic principles: that our patients are not simply a means to our ends, but rather ends in themselves; and that as a profession, we are responsible for ensuring access to a decent, basic minimum of oral health care for all.

### DENTISTRY AS A PROFESSION

Clearly, a significant dimension of the life of each of us who are dentists is the life we experience in our practice of dentistry. In becoming dentists, and professing dentistry, we have acknowledged that one important purpose for our existence is to assist our patients gain and maintain the benefits of oral health.

Dr. Nash is the William R. Willard Professor of Dental Education at the College of Dentistry, University of Kentucky, Lexington, Kentucky 40515; danash@email.uky.edu.

Learned professions evolved in the Middle Ages as some members of society became literate, and with that literacy acquired practical knowledge and skills based in learning. These individuals held considerable power over others as they knew when others did not know. As the Dutch philosopher Baruch Spinoza affirmed in *Ethics* (1677), “knowledge is power.” The knowledge these learned professionals held, and the skills they acquired, were relevant and important because they were required by members of society in order for society to function. Traditionally, these learned professionals have been understood to be physicians (including we oral physicians/dentists), attorneys, and the clergy. Physicians held power over the physical well-being of others; attorneys held power over much of material well-being through their ability to draft contracts; and clergy held power over spiritual well-being. This power differential in the relationship between these learned professionals and those they served required that patients, clients, and confessants place trust in the professional’s knowledge and abilities. They were vulnerable in the face of the knowledge differential, and therefore had to trust the learned professional to act in their best interests. As a consequence, these professionals made promises or vows to society that they could be trusted to place the interest of those they served above any narrow self-interest. The word profession is rooted in the word “profess,” which literally means to vow or make a promise (May, 1980). Thus professions

and professionals have been understood through time as individuals who have promised society that they would place their learning and expertise at the service of society in order to advance societal well-being. Our profession of dentistry has been granted a virtual monopoly to practice dentistry as a result of the trust and respect society has in our profession’s promise to make the oral health of our patients and of society our primary purpose.

### **TWO FACTORS DIMINISHING MEANING AND PURPOSE IN DENTISTRY**

There are two trends occurring that are threatening to undermine the traditional understanding of what it has meant to be a profession and that, in my judgment, are potentially diminishing the sense of meaning and purpose we derive from being dentists. First, an increasing number of dentists are coming to understand dentistry as primarily a business; and second, as an outgrowth of this understanding, too many dentists are neglecting the many individuals in society who are in need of care, but lack the economic wherewithal to pursue care in the marketplace of dentistry as a business. I want to protest against these two circumstances, and suggest that our traditional calling as professionals in dentistry challenges us to “a larger sense of purpose.”

### **THE CHANGING FACE OF DENTISTRY**

The last half of the twentieth century brought significant improvements in the oral health of Americans. These improvements were ushered in by the significant research conducted in our colleges of dentistry and research institutes in preventing the ravages of dental caries and periodontal disease. Many of our citizens under forty years old have had relatively little experience with dental

caries that decimated my generation. While there has been a significant reduction in oral disease for the majority of our population, the socioeconomically disadvantaged have not experienced the success of preventive dentistry to the same degree as our more socioeconomically advantaged citizens. Today, the majority of oral disease exists among those who cannot economically access oral health care, and in many instances, have also not yet learned through education to value it (U.S. Department of Health and Human Services, 2000).

Today there is a valuing, not only of oral health, but also of oral esthetics. As a consequence, many dentists are spending much of their practice time providing esthetic services to individuals who are relatively free of oral disease. With so many services being elective and esthetic in nature, and with what seems to be an increasingly materialistic and individualistic orientation to life, many dentists have developed a sense that dentistry is primarily a business, and they have begun to abandon some of the traditional attitudes, understandings, and behaviors of dentistry as a profession.

### **DENTISTRY AS A PROFESSION AND DENTISTRY AS A BUSINESS**

The concept of profession has strong cultural overtones. “Culture is the collective mutually shaping patterns of norms, values, assumptions, beliefs, standards, and attitudes that guide the behavior of individuals and groups, whether those groups be families, religions, races, geographic regions, nations, businesses, or professions” (Gibson, Ivancevich, & Donnelly, 1988; Kuh & Whitt, 1988; Sergiovanni & Corbally, 1986). Norms are what the culture understands as normal; that which should occur naturally; the culture’s guiding rules or principles. Values are what the culture desires; desires create purpose; purpose provides meaning. Assumptions are what the culture takes for granted, what it

presupposes. Beliefs are those notions in which the culture places its trust and confidence. Standards are the uniform referents of the culture; the touchstones used in measuring and evaluating. Attitudes are the emotional intentions of the culture, what it feels and wills.

To describe differences among cultures is not necessarily to draw moral conclusions or judgments, only to characterize differences. Of course, one can prefer one culture over another. Preferences are not necessarily moral statements. There are differences between the cultures of France and of China, between the cultures of Europeans and of Americans, and between the cultures of Jews and of Muslims. And, to the point of this discussion, there is a difference between the culture of a profession and the culture of a business.

Based on the concept of profession, the culture of dentistry can be described (Nash, 1992). The norm of dentistry is that oral health is a primary good, an end in itself. The values of dentistry are care and concern for all people and their oral health. The assumption of dentistry is societal good. The belief of dentistry is that cooperation and reciprocity with society can result in good for all. The standard for dentistry is justice and fairness in all dealings with patients and society. The attitude of dentistry is egalitarianism. Dentistry has historically understood itself to be a profession, to have the culture of a profession, and thus has laid claim to professional privileges.

Understanding dentistry and its culture as a profession is in tension with understanding dentistry and its culture as a business. Yet many dentists today seem to be adopting the culture of business. In the culture of business, the norm of dentistry is that oral health is a means to a private end, that of the

dentist; with patients being part of the means to that end. The values of dentistry in the culture of business are entrepreneurial: building a successful enterprise—making profits. The assumption of dentistry as a business is that the private, personal good is to be maximized. The belief system of dentistry as a business is that dentistry is a component of the free enterprise system. The standard of dentistry as a business is the marketplace. The attitude of dentistry as a business is social Darwinism.

The late Talcott Parsons (1968), of Harvard University, considered to have been the “dean” of American sociologists, defined a profession by contrasting professions with businesses. “The core criterion of a full-fledged profession is that it must have means of ensuring that its competencies are put to socially responsible uses...professionals are not capitalists, and they are certainly not independent proprietors or members of proprietary groups.”

Traditionally, dentistry as a profession has focused on serving the oral health needs of patients and society, with the financial gain derived from such being a natural and appropriate consequence of the service provided. Today, increasing numbers of dentists understand themselves to be practicing in the marketplace of health care, competing for patients, treating patients with the primary motivation of earning a significant profit for their services. In short, they are operating within the culture of a business.

Rashi Fein (1982), the noted Harvard health economist, expresses distress regarding the transformations occurring: “A new language has infected the culture of health care. It is a language of the marketplace, of the tradesman, and of the cost accountant. It is a language that depersonalizes both patients and health professionals, and treats health care as just another commodity. It is a language that is dangerous.”

My thesis is that changes are taking place in the profession of dentistry that are eroding the sense of purpose and meaning that dentists in the past have derived from their professional existence.

In *The Republic*, Plato presents a dialogue between Thrasymachus and Socrates in which Socrates responds to Thrasymachus: “But tell me, your physician [dentist] in the precise sense of whom you were just speaking, is he a moneymaker, an earner of fees or a healer of the sick? And remember to speak of the physician [dentist] who really is such....Can we deny then, said I, that neither does any physician [dentist], insofar as he is a physician [dentist], enjoin the advantage of the physician [dentist] but that of the patient.”

In contrasting the nature of dentistry as a profession versus dentistry as a business, it is necessary to draw a distinction between social and consumable goods, a distinction pointed out by the intellectual father of market economics, the Scotsman, Adam Smith. In his 1776 work, *An Inquiry into the Nature and Cause of the Wealth of Nations*, Smith argues for such a distinction. He affirms that there are basic “social goods” upon which the free market for “consumable goods” is dependent. The marketplace cannot function absent safe, secure, healthy, informed customers. Ensuring such should not be considered commodities of the marketplace. Basic oral health care is, or should be, a social good comparable in nature to police protection, public safety, fire protection, public education, and basic general health care. Basic oral health care is not, or should not be, a consumable product of the marketplace similar in nature to furniture, electronics, sporting equipment, travel, or entertainment.

Increasingly, we are coming to appreciate that oral health and general health are intimately linked. Oral health

has an important relationship to general health and well-being. One is not healthy without good oral health. The health of a country’s citizens, including its oral health, is an important requisite for a market economy. As such, it is imperative that dentistry as a profession should advocate for access to a decent, basic minimum of oral health for all. One bioethicist (Callahan, 1987) has defined a decent, basic minimum as “that level of care our society would cringe at the thought of someone not receiving.”

In the U. S., 75-80% of the dental caries in children occur in 20-25% of the child population; these children are from our lowest socioeconomic groups (Kaste et al, 1996). Well over one-third of the population, over one hundred million people, do not have access to the oral health care delivery system, and over twenty million of them are children—our most vulnerable population (U.S. Department of Health and Human Services, 2000).

The practice of dentistry is, or should be, the practice of a profession. Dentistry is only a business in the sense that good business practices must exist in support of professional practice. Clearly there is a tension between understanding dentistry as a profession and viewing it as a business. If a practice of dentistry is to be economically successful, it must be managed with good business practices. However, the tension that exists enables one to easily mistake means for ends.

### MISTAKING MEANS FOR ENDS

Dentistry as a profession serves the end of human well-being, oral health for individual patients and for the larger society. While professionals derive financial gain from their life’s work, it is truly derivative; a by-product of fulfilling the promise or vow they made in becoming a professional. A profession is a way of life, a vocation, not only or simply a way of making a living. Dentistry as a

business sees the oral health of individual patients specifically and society generally, not as ends in themselves, but merely means to the dentist’s personal ends.

Dentistry as a business serves the end of personal profit, with oral health being understood as a means to that end. Understanding dentistry primarily as a business places dentistry in the marketplace, where oral health care becomes a commodity produced and sold for a profit. The business model of selling cures undermines the professional model—a model rooted in a tradition of caring.

The distinguished American medical educator and ethicist, Edmund Pellegrino concluded in a 1999 article in *The Journal of Medicine and Philosophy*: “health care is not a commodity, and treating it as such is deleterious to the ethics of patient care. Health is a human good that a good society has an obligation to protect from the market ethos.”

Immanuel Kant, the nineteenth-century German philosopher, emphasized the universal moral imperative of treating others as ends in themselves, rather than as means to our personal ends. The second formulation of his “categorical imperative” states: “Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time an end” (Kant, 1785).

Martin Buber (1958), the Jewish theologian, spoke of the “I-Thou” relationship between individuals, and distinguished it from an “I-It” one. According to Buber, human beings may adopt two attitudes toward others. In an I-Thou relationship, one fully engages one’s whole self with the other person as a unique human being deserving of respect, to be related to as an end in their self, not as a means to one’s own ends. It is a relationship of



reciprocity, or mutuality, one of subject to subject in which there is a meaningful experiencing of the other. In contrast, an I-It relationship is one in which the other is treated as a “thing,” a “what,” not a “who.” He speaks of “thingifying” others, treating another in a relationship as a thing to be used as a means to achieve one’s own ends or purposes. It is a relationship of separateness and detachment, one of subject to object. As things, people—in our context, patients—are viewed as objects of action rather than subjects. Patients must be understood and acknowledged as ends in themselves, not simply means to the dentist’s ends.

In his recent book, *Social Intelligence*, the popular author of *Emotional Intelligence*, Daniel Goleman, discusses the significance and importance of Buber’s understandings. He says that the I-It relationship implies the most superficial of relationships. The emotional indifference and remoteness of an I-It stands in direct contrast to the attuned I-Thou. He indicates that empathy is the critical foundation to an I-Thou relationship. Empathy is the capacity to imagine oneself as the other, to project one’s self into another’s circumstance to sufficiently understand the other’s feelings. Goleman suggests that the defining quality of an I-Thou relationship is that the other has a sense of “feeling felt.”

Dentists are called to care for patients—care, not in the sense of managing or handling something, as in “you take care of that,” rather in the sense of being genuinely concerned for the welfare of patients. There is increasing discussion in the literature of the health professions regarding the importance of empathy as a critical quality of the health professional. (Branch, 2000; Charon, 2001; Halperin, 2001; Tong, 1998). Empathy is an imperative for an ethics of caring.

A practitioner who uses and manipulates patients, to whom patients

and their oral health is valued because it enables the dentist to achieve his or her financial (business) ends and goals, who adopts an I-It relationship with patients rather than an I-Thou one, dehumanizes the professional relationship.

My argument is that the transformation from understanding dentistry as a profession to understanding dentistry primarily as a business results in a seemingly subtle, but actually significant, impact on one’s sense of purpose, from a meaningful and purposeful caring for patients’ and society’s oral health to being in business to make money. Life demands a “larger sense of purpose.”

### ENLIGHTENED SELF-INTEREST

The European Enlightenment of the eighteenth century brought new social and political understandings. Among them was the appreciation and valuing of self-interest. However, there was also the realization that our personal, private good, our self-interest, is ultimately grounded in the good of others—the common good. Thus emerged the notion of enlightened self-interest. While we are all self-interested, and not inappropriately so, our self-interest is best served when we reflectively rise above it and focus on the good of others.

It is my belief that we must call on our Western intellectual and cultural tradition of enlightened self-interest as a needed corrective to the individualistic and business culture that is infecting our profession today. Unless all of our fellow citizens are stakeholders in the good of society, none of us will be. Understanding such and acting accordingly is an acknowledgement of an Enlightenment principle fundamental to the concept

Today, the majority of oral disease exists among those who cannot economically access oral health care, and in many instances, have also not yet learned through education to value it.

of what it means to be a profession—and a professional.

Ironically, contemporary business has increasingly come to understand that the orientation that has been traditionally associated with the professions is what is best for business—that is, placing the customer's needs and interests first and foremost, developing a trust relationship with customers. The watch cry of the marketplace in the past has been *caveat emptor*, or “let the buyer beware”—beware because the marketplace is a competitive and financially dangerous place where the seller is trying to sell a commodity at the highest price, and the purchaser is trying to buy it at the lowest price. Currently, there are individuals who are suggesting that the customer stands a better chance of being treated fairly in the marketplace, because of guarantees offered by contemporary corporations and merchants, than the patient can expect in the professional healthcare delivery system (May, 1977).

Charles O. Wilson, a noted entrepreneur of the marketplace and the chief executive officer of General Motors at the apogee of its success, while testifying before a Congressional committee, made a statement that became widely misquoted; possibly because it seemed a counter-intuitive comment for the leader of America's largest corporation. He is frequently reported as saying, “what is good for General Motors is good for the country.” He spent the remainder of his life correcting people who misquoted him. As the Congressional Record

indicates, what he actually said was “what is good for the country is good for General Motors.”

Let us affirm that what is good for the oral health of the citizens of United States is good for the profession (and its related business dimension) of dentistry. However, we must be vigilant to ensure that we neither come to believe nor promulgate the reverse: that what is good for the profession of dentistry is good for the country's oral health.

### JUSTICE IN THE RELATIONSHIP OF DENTISTRY WITH SOCIETY

John Rawls, the late Harvard professor of philosophy, in his influential book, *A Theory of Justice* (1971), explicates the nature of justice by using what has become a famous hypothetical. He asks one to stand behind a “veil of ignorance” and envision a world into which one will be born, but not knowing into what circumstance he or she will be born, that is, to a rich or poor family, intelligent or dull, male or female, American or Asian. He argues that given such a condition, people will design a world with some degree of risk aversion. In such a rationally designed world of self-interest, the following three conditions would exist: a) each person would have an equal right to the most extensive system of liberties comparable with a system of equal liberties for all; b) persons with similar skills and abilities would have equal access to offices and positions of society; and c) social and economic institutions would be so arranged as to maximally benefit the worst off. This last condition is the one most directly relevant in considering the responsibility of dentistry to society. Rawls affirms that in such a world, differences in status will ultimately result due to the range of differences among individuals in native talent and ability. However, he states that while these resulting status differences

may be unfortunate, they are not unfair.

Given a Rawlsian view of justice as fairness, the profession of dentistry—as a “social and economic institution,” and one granted a virtual monopoly to practice by society—has an obligation to work for a healthcare scheme that permits the “worst off” in society to gain the benefits of oral health. Today, the socially and economically disadvantaged have the worst oral health and the poorest access to care (U.S. Department of Health and Human Services, 2000). Such is clearly an issue of social justice. A lack of definitive action on behalf of society's disadvantaged calls into question the reciprocity of the profession of dentistry with society, creating the question of fairness in the relationship, an issue of justice—of ethics.

### CONCLUSION

A meaningful, purposeful existence—it is something we all cherish. It has been said that life is for learning, loving, and leaving a legacy. We dentists spend an extraordinarily portion of our days and hours focused on our professional work. Continually learning from the expanding scientific base that supports our clinical endeavors so we can provide the highest quality care possible, and loving our patients and society by empathetically caring for their oral health, will permit us to reflect on our lives in such a manner as to be able to acknowledge that we have lived with a “larger sense of purpose,” and that we are leaving a genuine legacy. ■



## REFERENCES

- Branch, W. T. (2000). The ethics of caring in medical education. *Journal of Medical Education*, 75 (2), 127-132.
- Buber, M. (1958). *I and thou*. R. G. Smith (Trans.), New York: Charles Scribner's Sons.
- Callahan, D. (1987). *Setting limits: Medical goals in an aging society*. New York: Simon and Schuster.
- Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession and trust. *Journal of the American Medical Association*, 286, 1897-1902.
- Fein, R. (1982). What is wrong with the language of medicine? *New England Journal of Medicine*, 306 (14), 863-864.
- Frankl, V. E. (1962). *Man's search for meaning: An introduction to logotherapy*. New York: Simon and Schuster.
- Gibson, J., Ivancevich, J., & Donnelly, J. (1988). *Organizations: structure, behavior, processes*. Plano, TX: Business Publications.
- Goleman, D. (2006) *Social intelligence: The new science of human relationships*. New York: Random House.
- Halperin, J. (2001) *From detached concern to empathy: Humanizing medical practice*. Oxford: Oxford University Press.
- Kant, I. (1785) *Groundwork of the metaphysics of morals* (1998). New York: Cambridge University Press.
- Kaste, L. M., Selwitz, R. H., Oldakowski, R. J., Brunelle, D. M., & Brown, L. J. (1996). Coronal caries in the primary and permanent dentition of children and adolescents 1-17 years of age: United States, 1988-91. *Journal of Dental Research*, 75, 631-641.
- Kuh, G. D. & Whitt, E. J. (1988). *The invisible tapestry: Culture in American colleges and universities*. Washington: ERIC, ASHE.
- May, W. F. (1977). *Notes on the ethics of doctors and lawyers*. Bloomington, IN, Indiana University.
- May, W. F. (1980). Professional ethics: Setting, terrain, and teacher. In D. Callahan & S. Bok (Eds.) *Ethics in higher education*, New York: Plenum Press.
- Nash, D. A. (1992). Calling for a culture of collegiality in our colleges of dentistry. *Journal of Dental Education*, 56 (9), 604-609.
- Nietzsche, F. (1895). Twilight of the idols. In W. Kaufmann (Ed.) *Basic writings of Nietzsche* (1968). New York: Modern Library.
- Parsons, T. (1968). *Professions, International encyclopedia of social sciences*. New York: Macmillan Company and Free Press.
- Pellegrino, E. D. (1999). The commodification of medical and health care: The moral consequences of a paradigm shift from a professional to a market ethic. *Journal of Medicine and Philosophy*, 24 (3), 243-266.
- Plato. *The republic*. B. Jowett (Trans.) (1986). Buffalo, NY: Prometheus Press.
- Rawls J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University Press.
- Sergiovanni T. J., & Corbally J. E. (1986). *Leadership and organizational culture*. Urbana/Chicago, IL: University of Illinois Press.
- Shapiro, H. T. (2005). *A larger sense of purpose: Higher education and society*. Princeton and Oxford: Princeton University Press.
- Smith, A. (1776). *An inquiry into nature and causes of the wealth of nations* (1991). Buffalo, NY: Prometheus Press.
- Spinoza, B. (1677). *Ethics*. R. H. M. Elwes (Trans.) (1989). Buffalo, NY: Prometheus Press.
- Tong, R. (1998). The ethics of care: A feminist virtue ethics of care for healthcare practitioners. *Journal of Medicine and Philosophy*, 23, 131-152.
- U.S. Department of Health and Human Services (2000). *Oral health in America: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

Dentistry as a business sees the oral health of individual patients specifically and society generally, not as ends in themselves, but merely means to the dentist's personal ends.