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Societal Expectations and the Profession's Responsibility to Reform the Dental Workforce to Ensure Access to Care for Children

DAVID A. NASH, DMD, MS, EDD

ABSTRACT Societal expectations raise the issue of the nature of a profession and a profession's relationship with society. Influential policy leaders want reform of the oral health workforce and delivery system in such a manner as to ensure that improvements are made for accessing care, particularly for vulnerable and disadvantaged populations, especially children. This essay is based on a presentation to the House of Delegates of the California Dental Association on Nov. 13, 2009.

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This essay considers the inter-relationship of three concepts: the meaning of profession, societal expectations, and reform of the dental workforce; concepts with points of concurrence, but also elements of tension. However, the tensions existing must be responded to thoughtfully and creatively if the problem of access to oral health care for children is to be addressed.

There is increasing evidence that the expectations of society for access to oral health care are not being met with the current dental workforce and delivery system, and that influential policy leaders want reform. Dentists ask, "Upon what

basis can society hold expectations for dentistry and anticipate that the profession should respond? What evidence exists that suggests society is dissatisfied with the profession of dentistry? What sort of oral health care reform could satisfy societal expectations?" This essay will attempt to respond to these questions.

The Nature of a Profession

Societal expectations for dentistry are grounded in what it means to be a profession, and the nature of a profession's relationship with society; the society that authorizes the existence of dentistry as a profession.

Abraham Flexner, a public intellectual and a major reformer of medical education in the early part of the 20th century, identified the characteristics of learned professionals.¹ His characteristics established the criteria for understanding the nature of a learned profession in 20th century America and have endured until today: 1) the work of professionals is primarily intellectual; 2) their work is based in science and learning; 3) their work is practical; 4) their work can be taught and learned through education beyond the usual level; 5) they organize into democratic collegial units; and 6) they exist to achieve societally defined goals rather than the self-interest of their members. Flexner went on to say, “professions are organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights for the protection of interests and privileges of their members.” It is salient to reconfirm that the designation “profession” is not self-appropriated, but rather is a sociological concept; an appropriation of society earned as a result of achieving these specific criteria.

The terms profession and professional can have somewhat ambiguous meanings. In one sense a professional is “someone who is not an amateur.” Kobe Bryant is a “professional” basketball player — clearly, not an amateur. However, in the much more profound sociological sense, a professional is someone who is a member of one of the traditional learned professions of law; medicine, with dentistry as a specialty thereof; and the clergy. These classical learned professionals emerged in the late Middle Ages, when the overwhelming majority of people were illiterate. In that society, there arose groups of individuals who, as a result of education, could read and write and thus were able to provide practical and needed services for those

who were illiterate. Attorneys were able to draft contracts for the legal exchange of goods and property; physicians were able to read and study, thus learning of medicaments and procedures to palliate or cure disease; clergymen were able to study and interpret scripture for the unlearned.

These groups of individuals had access to knowledge to which the average human being had no access, and as a result possessed special power; knowledge is

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power. Attorneys had power over property; physicians — power over personal physical well-being; and the clergy power over divine providence. Lay people seeking assistance had to trust that these groups would use their knowledge in the public’s best interest. Attorneys, physicians, and clergymen professed — that is vowed or promised — that they would always use their knowledge to further not their own personal best interests, but rather the best interests of their clients, patients, and parishioners; that they could be trusted. Financial gain, though essential, was derivative.

The noted biomedical ethicist, William May, used the metaphor of covenant to help explain the nature of the relationship of a profession with society.² There are three elements in the classical concept of a covenant: 1) a pledge or promise; 2)

an exchange of gifts; and 3) a change of being. Marriage is a well-understood covenant today. When a couple marry they promise to love, honor, and cherish one another in their marriage; they exchange gifts, wedding bands, as a symbol of the promises made; and, finally, they undergo a transformation of being. They are no longer single individuals but are now understood by society to be in the relationship and role of “husband” and “wife.” Professor May argued that dentistry as a profession exists in a covenant relationship with society. Society has promised our profession a monopoly to care for the oral health of the American public. Our profession has promised society that we will care for its oral health faithfully and well. Society grants us the gift of self-regulation, and, in most instances, a dental education and student loans that are tax subsidized. We give society our knowledge and skills. As a result of the promises made and the gifts exchanged, a transformative change of being has occurred — we have become a profession; society has become our patient.

The status of dentistry as a profession is the legacy of previous generations of practitioners who, in advocating for water fluoridation and personal preventive therapies, were viewed and understood by society as placing the public good above personal monetary gain. Historically, dentistry has focused on serving the oral health needs of patients and society, with the financial gain derived 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, functioning within the context and culture of a business enterprise rather than that classically expected of a profession.³

The eminent free-market theorist,

Adam Smith, in *The Wealth of Nations*, drew a distinction between social goods and consumer goods.⁴ He argued that for a market economy to function, it must be based on a foundation of what he called social goods. Among the identified foundational social goods are safety, security, education, and health care. Such social goods were for Smith outside the marketplace and not subject to the forces of supply and demand. Rather, they were seen as basic human needs and imperatives to be met by society in order for a marketplace to even exist. It is difficult to imagine a market-based economy surviving without citizens having a strong sense of personal safety and security, the physical health — including oral health — with which to work, and a basic education in the cognitive skills necessary to function in the marketplace. Smith was correct in affirming that health, including a “decent, basic minimum” of oral health, is a social good, not a consumer good. Basic oral health care is not analogous to purchasing furniture or buying a television. Oral health care, basic care that is not elective, care that is focused on preventing and/or eliminating oral disease, is not a commodity to be purchased in the marketplace. To accept basic dental care as a consumer good is to accept the access problem to oral health care that exists today.

Talcott Parsons, frequently referred to as the dean of American sociology, put it this way, “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 certainly are not members of proprietary groups.”⁵

Rashi Fein, the noted Harvard health economist, expressed 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.”⁶

Emeritus professor Kenneth Arrow of Stanford University won the Nobel Prize in economics in 1972 partly because of his ability to demonstrate that health

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care cannot be considered a commodity of the marketplace due to the complexity of medical knowledge that creates a significant power differential between health professional and patient; thus precluding the patient from being able to correctly determine the relationship between the cost of care and its value — a requisite for a marketplace transaction.⁷

Arnold Relman, long-time distinguished editor of the *New England Journal of Medicine* put it bluntly, “Health care is not a business.”⁸

The American medical educator and ethicist, Edmund Pellegrino, in an article in *The Journal of Medicine and Philosophy*, concluded, “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.”⁹

Dentistry as a profession serves the end of human well-being, that is, oral health for individual patients and for society at large. While professionals derive financial gain from their life’s work, it is truly derivative; a byproduct 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 understood as a business sees the oral health of patients, 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.¹⁰ Dentistry is, or should be, a profession. This is not to deny the business dimension of a profession. Professionals must pay overhead costs, provide for their families, and certainly deserve an honorable financial return for their services to individuals and society. However, dentistry is a business only in the sense that good business practices must exist in support of professional practice.

Societal Expectations

Today, society is examining its relationship with dentistry and is beginning to conclude that it is not being treated fairly in the social covenant, that the profession is failing in its responsibility of caring for the public’s oral health. One of the most important and influential books of philosophy written in the 20th century was *A Theory of Justice* by the late professor John Rawls of Harvard University.¹¹ Rawls defined justice as fairness:

fairness in our individual interactions with one another, and fairness in the social contract — how we live and relate to one another in society and negotiate relationships that are fair. Justice is the foundational concept of ethics. Ultimately, all notions of ethics are about people cooperating with one another and in so doing, treating one another fairly. In all good relationships there is a sense of reciprocity, of mutuality, of believing one is receiving as much as one is giving. Society is concluding that its relationship with dentistry is out of balance — that it is giving more than it is receiving, primarily due to the inability of significant numbers of members of society being able to gain access to oral health care.

Evidence for society's unrest with the profession can be found in a 2002 report of the National Conference of State Legislatures (NCSL).¹² The Robert Wood Johnson Foundation had commissioned the NCSL to conduct a study of policy barriers to accessing oral health care, and to suggest opportunities for intervention by the foundation. The report expressed the view that “those who work on oral health issues seem very much rooted in the present and are not thinking about bold, new solutions.” The report stated that a constant theme was “the lack of advocacy for oral health issues in general and access to dental care for low income people in particular.” A consistent finding was that there is a steady undercurrent of negative feelings about dentists among the public policy leaders interviewed. Leaders in every state made offensive comments about dentists. The report went on to emphasize that the main and most powerful advocacy group for oral health issues in most every state is the state dental association.

The report expressed the view that dental associations are “poor advocates for access to dental services,

particularly for Medicaid and S-CHIP beneficiaries, as they are perceived as self-serving in seeking increased reimbursement rates.” It also suggested we are perceived as providing “false leadership or lip service to access issues for low-income people.” The report stated that even though reimbursement rates may be below usual and customary fees, many state legislators believe that dentists “have a community service obligation ... [to participate in these programs] that they are not meeting.”

THE CHARACTER OF a society can be evaluated in terms of its concern for and care of the health of its children.

The Alaska Native Tribal Health Consortium's successful initiative of introducing dental therapists in Alaska gives testimony to dentistry's failings.^{13,14} The Minnesota Legislature passed legislation authorizing the training and practice of dental therapists documents our failing.^{15,16} The current interest of the Kellogg Foundation in funding multiple initiatives to expand the dental workforce through the addition of dental therapists annotates our failure.^{17,18} The Health Research and Services Administration (HRSA) recently announced funding of \$2.4 million to the Institute of Medicine to study ways to guide “federal investments in service delivery models that expand access to oral health care and improve its quality” is indicative of failure.¹⁹ The Children's Health Insurance Program Reauthorization

of 2009 (CHIPRA) mandating that the Government Accountability Office report to Congress on alternative dental care delivery models suggests dissatisfaction with dentistry's performance in caring for children.²⁰ Finally, the Patient Protection and Affordable Care Act, the bill passed by Congress and signed by President Obama on March 24, 2010, includes funding for demonstration projects for alternative dental health care providers, suggesting the inadequacy of the current workforce model in addressing societal needs.²¹

While society is upset with oral health care access generally, society is frustrated with the profession's inability to care for poor and minority children, our most vulnerable populations; a population that cannot be personally held responsible for their lack of oral health. To the extent that the Patient Protection and Affordable Care Act deals with oral health, it focuses on children, with dental insurance for children being a mandate in all policies sold through the exchanges.²¹

Norman Daniels, professor of bioethics at the Harvard School of Public Health, contends that a just society should provide basic health care to all, but redistribute health care more favorably to children.²² He justifies this conclusion based on the effect health care has on equality of opportunity for children, with equality of opportunity being a fundamental requirement of justice. Poor and minority children, the most vulnerable individuals in our nation, have the highest prevalence of disease, the poorest access to care, and the poorest overall oral health. Justice demands they ultimately have “equal opportunity” to do well. If justice is to be served, and if the profession of dentistry is to fulfill its moral imperative, the dramatic inequities that exist in the oral health and oral health care for children must be ad-

dressed. The character of a society can be evaluated in terms of its concern for and care of the health of its children. President John F. Kennedy said it well, “Children may be the victims of fate; they must never be the victims of neglect.”

In the a 2009 issue of the American Academy of Pediatric Dentistry’s journal, *Pediatric Dentistry*, a past president of the academy said in an editorial, “There is no access problem where dentists are reasonably reimbursed.”²³ There is scant evidence to support this view. Dr. Burt Edelstein, founder and executive director of the Children’s Dental Health Project, in testimony before Congress in October 2009, on health care reform, cited evidence that an increase in professional fees appears to only marginally improve dentists’ participation in Medicaid.²⁴ The academy past president went on to state, “The United States has the best model of delivering care that exists.” However, the criteria for such as assertion were not described.

An editorial, *The ADA and Health Care Reform*, written by the chair of the ADA Council on Governmental Affairs, was published in the October 2009 issue of the *Journal of the American Dental Association*.²⁵ Highlighted in the sidebar of the editorial is the comment, “Fundamentally, our advocacy is guided by ADA policy based on a belief that the dental delivery system works extremely well for most Americans and should be left untouched by any reform effort.” He continued by saying, “Reform bills don’t address the fundamental problem with access to dental care in America: improving funding for dental services in Medicaid.” The financial shortages that exist in state and federal budgets make such increased funding problematic. Society is becoming increasingly upset with the profession’s lack of responsiveness and is beginning to demand creative, alternative, and afford-

able approaches to ensuring that every child in America has equal opportunity to flourish in life by having good oral health.

It is no longer reasonable, nor practical, nor effective for dentistry to advocate in defense of the current delivery system and workforce that cares for children. Society is simply exhausted with dentistry continuing to say essentially, “Give us more money and leave us alone.” A professional association that evidences an attitude of protecting professional prerogatives will result in a

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diminution of society’s respect. Dentistry has earned much societal respect over many years for advocating for water fluoridation and preventive dentistry, whatever is best for the oral health of Americans — not necessarily what is best for dentists. However, the language and work of our professional associations today sometimes belies a commitment to protecting dentists, rather than promoting the public good. To the extent this is true, we fail as a learned professional organization and deserve the appellation of a trade association.

The Profession’s Enlightened Self-Interest

The European enlightenment of the 18th century brought new social and political understandings. Among them was the appreciation and valuing of self-interest. However, there was also the

realization that self-interest is ultimately grounded in the good of others — the common good. Thus emerged the notion of an enlightened self-interest. All are self-interested, and appropriately so. However, the self-interest of a profession is ultimately best served when it focuses on what is in the best interests of the society that has authorized its existence.

Charles E. Wilson, a noted entrepreneur of the marketplace and the chief executive officer of General Motors at the apogee of its success in the 1950s, while testifying before a congressional committee, made a statement that became widely misquoted, possibly because it seemed a counterintuitive comment for the leader of America’s then-largest corporation. He is frequently misquoted 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 indicated, what he actually said was, “What is good for the country is good for General Motors.”²⁶

What is good for the oral health of the citizens of United States is good for the profession of dentistry, including its business dimensions. However, the profession must be vigilant to ensure that dentistry never comes to believe nor promulgates the reverse: That what is good for the profession of dentistry is good for the country’s oral health. ADA President Tankersly affirmed a position comparable to Charles Wilson’s when he said at the 2009 ADA Annual Session, “What is best for the patient is what is best for the profession.”²⁷ Society is the profession’s patient, and access to care for all of America’s children is best for dentistry.

In 2004, the American Dental Association legally challenged the existence of dental therapists practicing in Alaska.^{28,29} The challenge failed in the courts and in the court of public opinion.³⁰ Such action was and is perceived by the public as being

blatantly self-interested — protecting our turf. Native American children have the highest rate of dental caries of any population group in the nation.³⁴ There are inadequate numbers of dentists to care for them. Dental therapists have been shown to be able to safely and effectively care for children for almost a century in other countries of the world, and now for almost five years in Alaska.³²⁻³⁵ It would have been much more thoughtful and effective for dentistry's leadership to say, "Dental therapists could possibly be valuable members of our dental team in caring for America's children. The Indian Health Service clinics would be an excellent place to conduct a demonstration project to test their effectiveness. Let's advocate for health care reform that calls for demonstration projects for alternative dental providers, and encourage projects with the IHS." Such a statement would have been an example of enlightened self-interest.

Calling on the Western intellectual and cultural tradition of an enlightened self-interest is a needed corrective to the individualistic and business culture that is infecting the profession of dentistry today. The professional status granted dentistry by society, with the monopoly it affords, can be lost absent taking seriously the obligation that exists to ensure all of America's children have access to oral health care.

Conclusion

Dentistry must ensure that access to oral health care exists for all of Americans, but with priority consideration of children; access in such a manner that major barriers are destroyed; and parents, no matter their economic status, ethnicity, or cultural circumstance, can be assured their children will be treated justly by society in that they will have an equal opportunity, with other children, for good oral health. The profession must search for the "bold,

new solutions" the *RWJ Report* of 2002 said dentistry was not thinking about. Inherited assumptions about how the delivery system has been structured in the past must be challenged, and a workforce and delivery system must be created that meets society's expectations; expectations that include all of our children reaching adulthood with good oral health.

The Greek philosopher Heraclitus recognized it more than 2,500 years ago when he said, "Nothing endures but change."

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Change is occurring and is challenging the profession. Change will continue. The environment is one of continual change. Health care reform is occurring. Society will not stand idly by while a significant number of children do not have adequate access to oral health care while a significant number of dentists refuse to treat children with public insurance; and while major oral health disparities exist between the poor and the economically advantaged. The question is whether or not the profession will be the leader of creative, effective change, or whether it will continue to be content to react to change not liked or wanted. It is instructional to realize that the same skeptical reaction the profession is having to adding new members to the dental team is not dissimilar to that which dentistry had as a profession with the introduction of dental hygienists in the

early 20th century.³⁶ Yet, dental hygienists are now respected, important, and valued members of the oral health workforce.

Dentistry needs thoughtful, committed, courageous leadership from members of the profession. Dentistry must distinguish itself by being a true profession, a profession that can be trusted to place the welfare of society first and foremost in all of its deliberations; by being faithful to the covenant that exists with society; by creating a more effective and less expensive way to ensure oral health care for all of our children; and by not only meeting but exceeding societal expectations. ■■■■

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