JOURNAL OF DENTAL HUMANITIES

VOLUME 3: ISSUES 1/2 WINTER/SPRING 2019

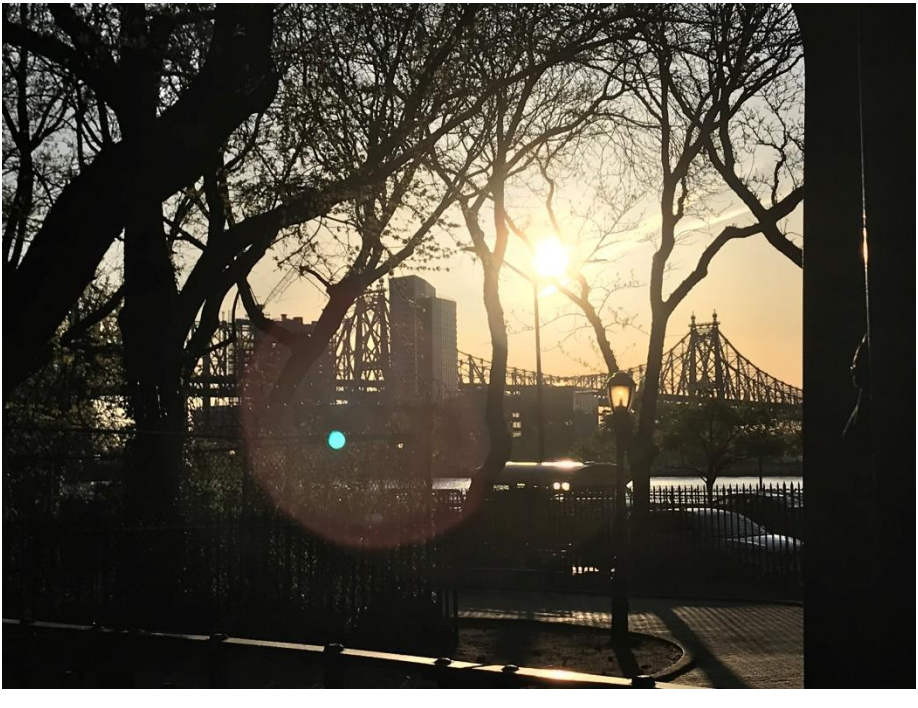
JOURNAL OF DENTAL HUMANITIES

The Journal of Dental Humanities is dedicated to presenting thought provoking material connecting dentistry to the humanities, and the social sciences. The journal places a priority on publishing quality material that supports the objective of dental professionals who seek to provide a patient-centered approach to health care. The mission purpose of the Journal of Dental Humanities aligns with the position that a functional democracy requires ethical, highly skilled professionals who are engaged, active members within their community and the larger society.

EDITORIAL BOARD

ISSN 2573-8844

CONTENTS



EDITORIAL: IS IT TIME TO RESTORE THE ADA ETHICAL CODE'S LOST KEY SENTENCE?

ROBERT P. IOVINO, D.D.S., M.A.

"A dentist has the general obligation to provide care to those in need." The words of this brief unambiguous imperative cut right to the quick; when teaching dental ethics over the past decade plus, I have witnessed the impact these exact words can have as their meaning resonates and unfolds in the minds of young dental student professionals. Positioned for over twenty-five plus years, at various locations, within the *ADA Principles of Ethics and Code of Professional Conduct (ADA Code)*[1], this "care imperative" conveyed the essential fact that professional dentists have "positive" obligations. Unlike members of the general public, who can essentially fulfill their "negative" social obligations by simply folding their hands,[2] incumbent upon every licensed dentist is the duty to actually perform by participating, in some way, in providing public service (Service both to their individual patients and the public at large.).

Properly understood, the demands of this care imperative are reasonable not onerous. This is because "general" positive obligations remain unspecified, meaning their selection and actual performance is

[1] American Dental Association. "American Dental Association Principles of Ethics and Code of Professional Conduct, With official advisory opinions revised to May 1992" the "care imperative" was prominently position in the Code's fourth paragraph. Subsequent to the adoption of the five current ethical principles into the ADA Code in October 1996 the "care imperative" was contained in Advisory Opinion 4.1.A. The "care imperative" was eliminated in November 2018.

[2] Thereby avoiding the performance of prohibited actions. For an excellent review of the concepts of "negative", "positive," and limited "special positive" duties/obligations see Patricia Smith's *Liberalism and Affirmative Obligation,* Oxford University Press, 1998 .

at the discretion of each and every practitioner. Importantly, however, always opting out of the performance of this duty to participate in providing needed care is not a viable option for an ethical dentist. Understood in such a way, the presence of this imperative within the *ADA Code* provided educators with the perfect platform to build upon by which to convey to dental students the essence behind the complex fluid concept of licensed professionalism.[3]

Ironically, subsequent to the November 2018 revision of the ADA Code aimed at protecting the just interests of the handicapped, this impactful "care imperative" was eliminated.[4] While periodic revision of the ADA Code is essential, and the stipulation of the obligation to provide care can still be found elsewhere within the text of the current ADA Code, the elimination of what I considered the Code's most remarkable complete sentence is unfortunate at best. At worst, the care imperative's elimination can be misconstrued as additional evidence of a tone-deaf profession incapable, or unwilling, to adequately respond to critics challenging the dental profession to provide access to needed care to *all* marginalized individuals. Such misconceptions can be the harbinger of untoward consequences.

---

[3] "Ism" at the end of a word denotes an ideology. The respective point / counterpoint polar positions of Milton Friedman on medical licensure (See Friedman's *Capitalism and Freedom,* The University of Chicago Press, 1962.), and the "professionalization of a profession" of Louis Menand (See Menand's *Marketplace of Ideas* – Norton 2010*),* offer a perfect portal through which to introduce to an audience competing varied concepts of "professionalism." Select interdisciplinary readings in the humanities are essential in elucidating what society expects and depends upon from licensed professionals.

[4] American Dental Association. "American Dental Association Principles of Ethics & Code of Professional Conduct, With official advisory opinions revised to November 2018." Accessed 1 December 2018. <https://www.ada.org/~/media/ADA/Member%20Center/Ethics/Code_Of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en>

Now when teaching dental ethics, one must reference recent old editions of the code and encourage students to reflect on both the meaning of and the loss of this key sentence. How much easier it would be if the "care imperative" was reinstated. Accordingly, I ask: Is it time for concerned dentists and dental educators to petition the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA) to reinstate the "care imperative" word-for-word once again into the text of the ADA Code?[5]

[5] For an in-depth discussion of the importance of the care imperative and its position within the ADA Code, please see "Location and the Choice of Principles Matter: Refocusing the American Dental Association's Ethical Code on Public Service" on page 7 of this issue of the Journal of Dental Humanities.

COMMENTARY: DID *THE ATLANTIC* GET "THE TRUTH ABOUT DENTISTRY" RIGHT?

STEVEN D. LONDON, D.D.S., PH.D.

The Atlantic published an article by Ferris Jabr in the May 2019 issue, titled "The Truth About Dentistry: It's much less scientific – and more prone to gratuitous procedures – then you may think."[1] Clearly, the goal of the article was to convince the reader that "The Truth About Dentistry" is that dentistry is not a profession to be trusted in the best case, or one prone to overtreatment with methods and procedures that do not have adequate scientific evidence as to their effectiveness in the worst case. Needless to say, the article elicited a strong response from the profession, with the American Dental Association president, Dr. Jeffrey M. Cole, issuing a statement stating that "the overwhelming majority of dentists are ethical practitioners, and that's why dentists are consistently ranked among the most honest and ethical professionals". In regard to the unethical practitioner featured in the article, Dr. Cole further states that "every profession unfortunately has some individuals with questionable ethics, and that this is true in journalism as it is in dentistry". He concludes that "it is unfair to paint an entire profession with such a broad and negative brush."

[1] Jabr, F. "The Truth About Dentistry: It's much less scientific – and more prone to gratuitous procedures – then you may think." *The Atlantic*, 2019, (4), 70.

A careful read reveals that the article is actually two articles in one. The first is a story of an unscrupulous dentist who has for years been overtreating his patients on a regular basis. This fact came to light when the practice is purchased by a young dentist who realizes that the majority of patients have had procedures that were clearly unnecessary including excessive endodontic and prosthodontic procedures. This story ends with the young dentist suing for misrepresentation and breach of contract, and with 10 former patients suing the unscrupulous provider for fraud, deceit, battery, financial elder abuse and dental malpractice. This is clearly a story of an unethical dental provider. Unfortunately, concerning other health professions, such a story is not unique.

The second story is what I call "a review of the dental profession" where Jaber makes the following points:

- Patients have a fraught relationship with dentists as authority figures;
- Dentists are often dismissed as "not real doctors" but rather "mechanics for the mouth";
- Many patients fear dentists. In support of this Jaber states that "for more than a century, dentistry has been half-jokingly compared to torture";
- Patients both dread dental procedures and belittle their medical significance.

Wow, what a clearly biased way to characterize the dental profession! To make matters worse, Jaber further states that "the uneasy relationship between dentist and patient is further complicated by an unfortunate reality:

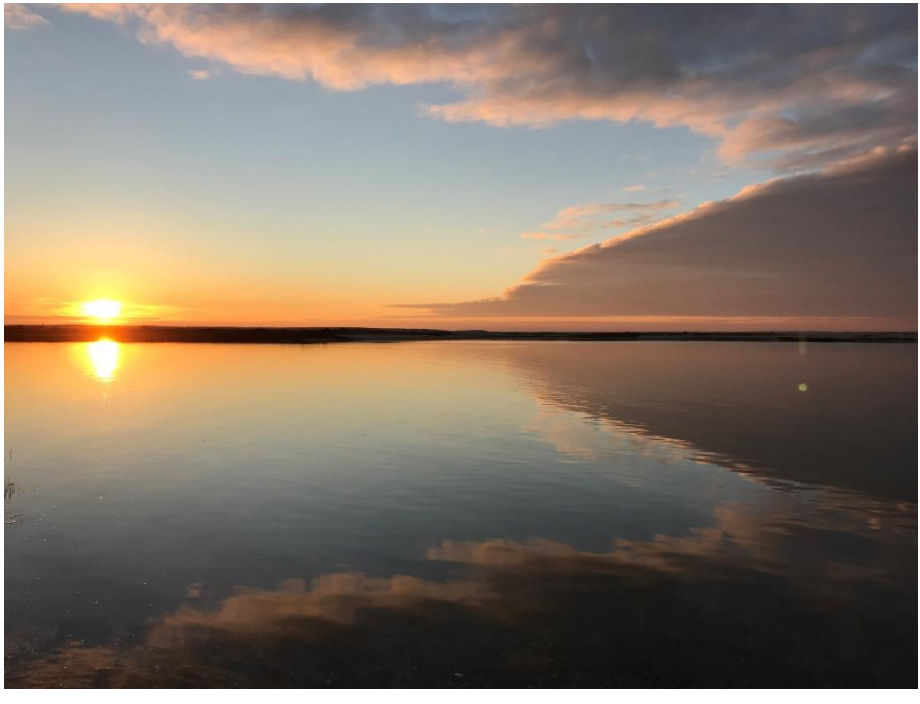
- Common dental procedures are not always as safe, effective, or durable as we are meant to believe;
- As a profession, dentistry has not yet applied the same level of self-scrutiny as medicine or embraced as sweeping an emphasis on scientific evidence;

- Many standard treatments, to say nothing of all the recent innovations and *cosmetic extravagances* (my emphasis), are likewise not well substantiated by research.

Each story within the article could function as a standalone piece. However, with the case of the unscrupulous dentist is interweaved with Jaber's contention that the dental profession has a weak scientific foundation, we have a very strong **opinion piece** against the contemporary practice of dentistry in the United States. But I don't think that the average reader will realize that this article is, in fact, the opinion of the author. I am not quite sure why the editors of the *The Atlantic* felt that this article deserved publication. Dr. Cole, the ADA president, insinuated that this was an example of unethical journalism in his response, but I am more concerned with the broader issue of why specific acts of unscrupulous dentistry can result in a degeneration of the entire profession. Unfortunately, this phenomenon is not new. In 1997, William Ecenburger published a "Special Report" in the *Reader's Digest* titled "How Dentists Rip Us Off" in which he travels across the country posing as recently moved into one of 50 areas across the United States seeking a new dentist to continue his care.[2] In fact, he was doing investigative journalism and he found a broad range of treatment plans ranging from minimal to extensive with associated wide range of costs.

I would like to encourage a discussion among our readers of how our profession is viewed by the public, and why such all-encompassing and derogatory coverage of the profession seems to be evident in the popular literature over at least the past twenty years.

[2] Ecenburger, W. "How Dentists Rip Us Off." *Reader's Digest*, 1997, February, 50.



LOCATION AND THE CHOICE OF PRINCIPLES MATTER: REFOCUSING THE AMERICAN DENTAL ASSOCIATION'S ETHICAL CODE ON PUBLIC SERVICE

ROBERT P. IOVINO, D.D.S., M.A.

Abstract:

The American Dental Association's *Principles of Ethics & Code of Professional Conduct* (*ADA Code*) is a concise, user-friendly document. Understandably, the architects and custodians of the *ADA Code* can take justifiable pride in their continually "evolving" document's versatile design and content. However, there remains an important assessment of the *ADA Code* that begs to be made. When critically evaluating the effectiveness of the ADA ethical code, it is important to distinguish between just how well the code "reads," from how inadequately it is actually often "taught" & "utilized."

This report details the devaluation, and ultimate elimination, of a long-standing "public service/care" imperative from within the *ADA Code*. This action, considered in the light of the critique of principlism by the scholars Beckwith and Callahan, supports my thesis: From a pedological standpoint, especially when imparting the duty for public service, when properly structuring the *ADA Code* -- location & the choice of ethical principles matter.

Introduction:

> "A dentist has the general obligation to provide care to those in need."[1]

For more than a quarter of a century this exactly worded "care" imperative was arguably the American Dental Association's *Principles of Ethics and Code of Professional Conduct* **(***ADA Code*) most remarkable sentence. Though once prominently featured in the ADA ethical code, the emphasis placed on this imperative has been progressively diminished. The explanation for this is my thesis: From a pedological standpoint, especially when imparting the duty for public service, when properly structuring the *ADA Code* -- location & the choice of ethical principles matter.

In the 1992 edition of the *ADA Code* this "care" imperative was spotlighted in the Code's 4th paragraph.[2] (See Appendix A.) It resided in an advisory opinion, under the, then, common sense first ADA ethical principle of "service to the public." (The 1992 ADA Code's first principle section heading, in its complete form, reads: "Service to the Public and Quality of Care.") Consequent to the 1996 major reorganization of the code, coinciding with the adoption of the current five, philosophically derived, "biomedical," ADA principles, this remarkable sentence was essentially hidden. The "care" imperative was buried deep within the text of the *ADA Code*, as part of Advisory Opinion 4.A.1 - patients with bloodborne pathogens – organized under the fourth ADA principle "justice." (See Appendix B.) Ironically, as a

---

[1] American Dental Association. "American Dental Association Principles of Ethics & Code of Professional Conduct, With official advisory opinions revised to November 2018." Accessed 1 December 2018. Hereafter simply referred to as the "care" imperative. <https://www.ada.org/~/media/ADA/Member%20Center/Ethics/Code_Of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en>

[2] American Dental Association. "American Dental Association Principles of Ethics and Code of Professional Conduct, With official advisory opinions revised to May 1992."

direct result of the November 2018 revised update of the *ADA Code*[3], aimed at protecting the just interests of the handicapped, the "care" imperative was eliminated.

All Progress is not Straight Forward

The very early 1990's will be remembered as the near highwater mark for many ideal theories. In the real world the Berlin Wall had tumbled, and certain scholars optimistically considered the triumphant global spread of liberal democracy to be a real possibility.[4] In the Academy, John Rawls was in the process of expounding how and why his landmark ideal social contract theory "Justice as Fairness," was political not metaphysical.[5] [6] While Tom Beauchamp and David Childress's foundational four principles method (aka principlism, a mid-level philosophical theory), introduced in 1979, served as the dominant, and arguably the ideal, way by which to do health care ethics.[7]

Such heady times coincided with a growing dissatisfaction with the 1992 version of the ADA code of ethics. By 1994, maintaining that the *ADA Code* had "failed,"[8] the ADA Council on Ethics, assisted by the Chicago Loyola based philosopher/ethicist David Ozar among others, embarked on a two-year project to significantly revise, and

---

[3] American Dental Association. "American Dental Association Principles of Ethics & Code of Professional Conduct, With official advisory opinions revised to November 2018." Accessed 1 December 2018. Hereafter simply referred to as the "care" imperative. <https://www.ada.org/~/media/ADA/Member%20Center/Ethics/Code_Of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en>

[4] Fukuyama, Francis. "The End of History." *The National Interest,* No.16. Summer 1989.

[5] Rawls, John. "Justice as fairness: political not metaphysical." *Philosophy & Public Affairs.* Vol. 14 Number 3. Summer 1985.

[6] Rawls, John. *Political Liberalism.* Columbia University Press, 1993.

[7] Beauchamp, T.L. and J.F. Childress. *Principles of Biomedical Ethics*. New York: Oxford University Press; 1979.

[8] ADA Principles of Ethics, Code of Professional Conduct revamp OK'd by House. ADA News. 1996;27(19):24.

improve, the ADA Code.[9] They envisioned a revised code that would serve to "teach," not a code resembling legislation. Their effort culminated in October 1996 when the ADA House of Delegates passed Resolution 59H and the ADA code assumed its current familiar "easier to use" five "biomedical" principle-based-format.

However, the process of "enunciating" professional guidelines and streamlining the organization of the ADA code around the new five ethical principles, came at a price. In his comments on principlism, Francis Beckwith, Professor of Philosophy and Church-State Studies, at Baylor University essentially explains. Beckwith notes: "the principles central to principlism, such as autonomy and justice, are almost all procedural in their application;" and such principles "commit the relevant medical personal and institution to as minimal an understanding of the human person and her good as possible."[10] How true; justice is a complex, abstract principle. Lost in *ADA Code's* 1996 revision was the emphasis, and value, the profession back in 1992 placed on the personal responsibility, or duty, every dentist has to provide quality "care"[11] and "service to the public."[12]

[9] ADA Code of Ethics Approved for Revision. ADA News. Spaeth, Dennis, June 24th, 1996, p.3.

[10] Francis Beckwith. "Dignity Never Been Photographed" in Ethics & Medicine, Summer 2010.

[11] The duties of "public service" and "care" are somewhat hidden in the current ADA ethical principles beneficence and justice. Over time these duties have now been clearly stated in the current ADA Code's Preamble and Introduction. Unfortunately, given the emphasis placed on problem-solving exercises utilizing the five ADA "biomedical" ethical principles, the Introduction and Preamble components of the ADA Code too often, essentially, go unnoticed.

[12] Implicit with a broad understanding of the 1992 ADA Ethical Code's first principle.

A Focused Critical Look at the 1996 Version of the ADA Code to Date

The current ADA ethical code is a concise, user-friendly document. However, while the *ADA Code* delineates the lofty aspirational goals of the profession, sections of the *ADA Code* appear to favor the interest of member dentists over the interest of the general public. A clause in the *ADA Code* that permits a dentist considerable discretion in the selection of their patients is a frequently cited example of such professional self-interest. In counterpoint: To its' credit, while celebrating the Codes 150th Anniversary, the ADA utilized its five ethical principles to tout the profession's "patient first promise."[13] This represented a wonderful idea, and it remains a great public-service message. However, despite the priority allocated to patient-interests, the question remains: Who is to provide needed care for the many disadvantaged individuals who are not fortunate to be selected by dentists to be their patients?

To what factors might we ascribe this apparent collective near-sightedness? Arguably, for one, counterintuitively, the current *ADA Code's* de-facto quick, dentist/user-friendly, principle-based problem-solving method, works too well. The main objection Daniel Callahan, the founder of the Hasting's Center (The Hasting's Center is the world's first bioethics research center. It is located on the Hudson River opposite West Point in Garrison, New York.) has to principlism is that the principles "have served most effectively a kind of blocking function. By providing a relatively easy method to solve many ethical problems, and by being only too well adapted to Anglo-American culture, principlism has in practice (if not necessarily in its theory) *short-circuited* (my emphasis) the opening up of larger, more important issues."[14]

[13] "Ethics: The 5 promises ADA dentists make to their patients." American Dental Association. Accessed 1 December 2018 <https://www.mouthhealthy.org/en/az-topics/e/ethics-and-dentistry>

[14] Callahan, Daniel. *The Roots of Bioethics.* Oxford University Press, 2012, p.19.

Nowhere are the "short-circuited" ramifications of how the code is "utilized and taught" more profound and consequential than in the areas of public service and professional ethics education. Unfortunately, there is a limited amount of time allocated to teaching ethics, both, in a dental school's curriculum, and, in the area of post-graduate continuing education. Accordingly, time allocated to the study of professional ethics is often dedicated, nearly exclusively, to clinical problem-solving exercises utilizing the "relatively easy" problem solving method afforded by the 5 ADA ethical principles. As Callahan essentially predicts, frequently omitted, in the classroom, and many busy dentists chairside problem-solving rush, is any nuanced consideration of the important issues touched upon in the content of the *ADA Code's* Introduction, Preamble, and Section 4's mention of the broader concept of justice.

Significantly, such oversight and alleged self-interest on the part of America's dentists has not gone unnoticed. For example: In his 2012 Senate Healthcare Subcommittee report, titled *Dental Crisis in America*, Bernard Sanders cautioned: "The oral health care system in America is currently designed around the needs of dentists rather than the needs of those who are underserved."[15] More recently, Mary Otto, journalist and author of the acclaimed book *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America* (The New Press 2017), has become a prominent voice calling on the dental profession in America to devote more attention and time to the delivery of needed dental care as a public service. Otto, echoes Senator Sanders sentiment, writing, "the separate, carefully guarded, largely private system that provides dental care in America can be enormously difficult to reach for those without mobility or money."[16] An internet search will confirm that Otto's report has garnered significant attention to the critical issue of oral healthcare access.

---

[15] Sanders, Bernard. *Dental crisis in America: the need to expand access.* Subcommittee on primary health and aging, U.S. Senate committee on health, education, labor & pensions. 29 February 2012. Accessed 1 December 2018. <https://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>

[16] Otto, Mary. *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America.* The New Press, 2017, pp. viii-ix.

Essentially, dentists all across America are being challenged to focus their attention on those individuals who find themselves outside the current dental care delivery system looking in. The outstanding questions become: How will the American Dental Association respond? Is it once again time for the ADA to re-emphasize in its ethical code the special obligation its' member dentists have to work with all stakeholders involved to provide service/care to *all members of the public*?

Location Matters: Refocusing the ADA Code's Call to Public Service

It can be correctly claimed that a renewed call to public service in the *ADA Code* has already occurred. Credit largely an almost decade long effort, spearheaded by Dr. Frank Catalanotto, and the ADEA, whose 2004 committee report promoted the idea that "the oral health care system must serve the common good."[17] Unfortunately, half a decade would pass before the ADA Code was as a result revised. This is a classic example how institutional right actions are often undertaken only once they become a derivative response to highly publicized wrongs. To explain: In 2007 national news services widely reported the untimely tragic death of twelve-year-old Deamonte Driver from complications related directly to a serious dental infection. In 2009 the ADA added the following "advocacy" clause to the ADA Code's Preamble: "Each dentist should share in providing advocacy to and care of the underserved. It is urged that the dentist meet this goal, subject to individual circumstances."

[17] Catalanotto, Frank. "A Welcome to the Workshop on "Professional Promises: Hopes and Gaps in Access to Oral Health Care."" *Journal of Dental Education,* Vol.70, Number 11, 2006, p.1120. Accessed 1 December 2018. <http://www.jdentaled.org/content/jde/70/11/1120.full.pdf>

Undoubtedly, the addition of the "advocacy" clause to the *ADA Code* represents a positive step. Unfortunately, the clause's location in the Code's Preamble, for all-intent-and purposes, arguably, renders the clause largely invisible, and mostly ineffective. To reiterate: the utility of the current *ADA Code* resides in its de-facto user-friendly quick problem-solving method; which in-turn depends on the "prima facie" nature, and use, of the 5 ADA ethical principles. All-too-often, whenever the *ADA Code* is discussed, or utilized, in the class room, continuing education course, or clinic, the near-exclusive focus of all participants is directed towards the code's principles.

Two related questions now come to mind: First: Is it now time to, counterintuitively, slow down the code's problem-solving method? Second: Is now time to introduce a new ADA ethical principle, and thereby refocus and sharpen the attention the profession places on matters concerning the common-good/public service and distributive justice?

Principles Matter: It's time for a 6th Principle of Dental Ethics

Restoring the "care imperative," and placing it in an up-front position in the *ADA Code*, would be an excellent way to start. Positioning the "care imperative" as an Advisory Opinion immediately under the previously proposed ADA ethical principle of "respect for human dignity"[18] [19] (Enumerated as the" "first" of six co-equal ADA ethical principles.) would re-emphasize our profession's commitment to public service. Certainly, enlisting a high percentage of ADA members, and the general public into the cause of providing needed oral health care as an essential public good, is consistent with

[18] Iovino, Robert. "Revising the American Dental Association Principles of Ethics and Code of Professional Conduct: Adding "Respect for Human Dignity" as the sixth principle of dental ethics to accommodate advances in genetic science." *JADA*, Dec. 2016. Accessed 1 December 2018. <https://jada.ada.org/article/S0002-8177(16)30753-X/pdf>

[19] Iovino, Robert. "Response to Dr. Burla." *JADA*, April 2017. Accessed 1 December 2018. <https://jada.ada.org/article/S0002-8177(17)30146-0/pdf>

recognizing the dignity of all individuals. Alternatively, we could simply restore "service to the public" as the first of, what would be, 6 co-equal ADA principles.

The introduction of either proposed 6th principle into the *ADA Code*, and, by extension, into the code's de-facto problem-solving method, will have multiple positive effects. The concise user-friendly form of the principle-based *ADA Code* is preserved, while simultaneously addressing Beckwith and Callahan's concerns regarding principlism's shortcomings. Either principle will facilitate the profession's active participation in a civic discourse refocused on human values. Either principle can serve as the foundation for additional new guidelines relating to the ethical use of developing advanced technologies, and efforts promoting public service and social justice. (Both of the proposed new principles ["respect for human dignity" and "service to the public"] are mutually compatible with, and supportive of, the current ADA principle – justice.)

In addition: The complex nature of either new principle is to be welcomed. The complex nature of either new 6th ethical principle will *selectively* serve to slow down, and effectively repair the "short-circuit" in, the *ADA Code's* problem-solving method. Additional time spent unpacking the obligations inherent in either 6th principle will encourage the consideration of previously overlooked critical issues. "Good actions" are likely to follow.

PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT

WITH OFFICIAL ADVISORY OPINIONS REVISED TO MAY 1992

The ethical statements which have historically been subscribed to by the dental profession have had the benefit of the patient as their primary goal. Recognition of this goal, and of the education and training of a dentist, has resulted in society affording to the profession the privilege and obligation of self-government. The Association calls upon members of the profession to be caring and fair in their contact with patients. Although the structure of society may change, the overriding obligation of the dentist will always remain the duty to provide quality care in a competent and timely manner. All members must protect and preserve the high standards of oral health care provided to the public by the profession. They must strive to improve the care delivered—through education, training, research and, most of all, adherence to a stringent code of ethics, structured to meet the needs of the patient.

PRINCIPLE – SECTION 1

SERVICE TO THE PUBLIC AND QUALITY OF CARE.

The dentist's primary professional obligation shall be service to the public. The competent and timely delivery of quality care within the bounds of the clinical circumstances presented by the patient, with due consideration being given to the needs and desires of the patient, shall be the most important aspect of that obligation.

CODE OF PROFESSIONAL CONDUCT

1-A. PATIENT SELECTION.

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex, or national origin.

ADVISORY OPINION

1. A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

1-B. PATIENT RECORDS.

Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient.

ADVISORY OPINIONS

1. A dentist has the ethical

Section 4 PRINCIPLE: JUSTICE ("fairness"). The dentist has a duty to treat people fairly.

This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

CODE OF PROFESSIONAL CONDUCT

4.A. PATIENT SELECTION.

While dentist, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, gender, sexual orientation or gender identity or national origin.

ADVISORY OPINION

4.A.1. PATIENTS WITH BLOODBORNE PATHOGENS.

A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual is infected with Human

Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, the individual dentist should determine if he or she has the need of another's skills, knowledge, equipment or experience. The dentist should also determine, after consultation with the patient's physician, if appropriate, if the patient's health status would be significantly compromised by the provision of dental treatment.

4.B. EMERGENCY SERVICE.

MORE THAN 3 MILLION CHILDREN HAD UNMET DENTAL NEEDS DUE TO COST IN 2017: WHAT'S AT FAULT?

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.[1] AND STEVEN P. PERLMAN, D.D.S., M.SC.D., D.H.L.(HON.)[2]

"**Some people think that people are entitled to health care as a matter of right, whether they work or not. This is just absurd as saying that food, clothing and shelter are a matter of right – one step further then that is a revolutionary system boarding on Communism."** (Emphasis added) (1971)[3]

- Dr. E.R. Annis, former president of the American Medical Association.

"… more than 50 years after passage of Medicaid (the federal health insurance program designed to support health care for poor children and people with disabilities), almost two decades following passage of the Children's Health Insurance Program, and six years after the introduction of the Affordable Care Act (Obamacare), approximately 28% of children in the U.S (20.3 million children) still do not have full access to essential health services."[4]

- 3.3 million children are uninsured.

---

[1] SUNY Distinguished Teaching Professor, Department of General Dentistry, Stony Brook University.

[2] Global Clinical Director, Special Olympics, Special Smiles, Clinical Professor of Pediatric Dentistry, the Boston University Goldman School of Dental Medicine.

[3] Annis, E.R. *The New York Times*, October 4, 1971; Waldman, H.B., "Health care delivery and a need to re-evaluate the Daniel Boone mystique." *New York Journal of Dentistry*, 42(6) June-July 1972.

[4] Redlener, I., Gracy, D., Walto, D. "Unfinished business: More than 20 million children in the U.S. still lack sufficient access to essential health care." Children's Health Fund. Accessed 14 December 2018. <https://www.childrenshealthfund.org/wp-content/uploads/2016/11/Unfinished-Business-Final_.pdf>

- 10.3 million children are insured but missing timely, well child checkups (indicative of lack of access to primary care).
- 6.7 million children on Medicaid/CHIP have access to primary care but have unmet needs for pediatric subspecialty care.
- More than 3 million children had unmet dental needs due to costs. In addition, it has been more than five years since 4.9 million children had a dental visit or never had a dental visit. (Table 1)[5]

Barriers

Financial barriers refer to costs such as high copays, high deductibles and unaffordable prescription drug prices. The Children's Health Fund estimates that there are over 13.1 million children whose families report they were either unable or having problems paying medical bills. Provider-based barriers also contribute to the financial burden when clinics or providers won't accept certain forms of insurance or create environments that promote insurance stigma. Non-financial barriers most often take the form of either geographic or informational barriers.

Geographic barriers include issues of transportation, such as a lack of a car or poor public transit options, and federal - designated Health Professional Shortage Areas (HPSAs) where the number of health professionals in a given geographical area is insufficient for that population's healthcare needs. It is estimated that over 14 million children live in HSPAs.

[5] Summary of Health Statistics. National Health Survey 2017. U.S. Department of Health & Human Services. Table C-11a. National Center for Health Statistics. Accessed 13 December 2018. <https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_C-11.pdf>

Informational barriers include parents' lack of health literacy, dauntingly complex language used in information about coverage eligibility and accessing care, and parents' limited English proficiency.[6]

Some history

> "**Responsibility for obtaining medical care is essentially a private matter. Attempts by government to assume this responsibility on behalf of the individual represent a form of paternalism that fosters dependence and immaturity and are an unwarranted intrusion on the freedom of the individual to run his life as he wishes."** (1971)[7]

In the 1960s, organized dentistry attempted to cope with the onrush of demands for social change and more effective utilization of health care. In 1962, the Association of American Dentists (AAD) was organized "…for the defense of freedom, dignity and integrity of dentistry."[8] It was the AAD's belief that "…recent federal laws had opened to engulf the private practice of dentistry. The political and economic foundations are being laid for the socialization of our profession …"[9] The American Dental Association (ADA) is in "… adamant opposition to any legislation which would provide health care costs under the Social Security system (i.e. Medicare) …"[10] In early 1965, the ADA joined the American Medical Association (AMA) in calling for expansion and modification of the then existing Kerr-Mills

---

[6] Redlener, I., Gracy, D., Walto, D. "Unfinished business: More than 20 million children in the U.S. still lack sufficient access to essential health care." Children's Health Fund. Accessed 14 December 2018. <https://www.childrenshealthfund.org/wp-content/uploads/2016/11/Unfinished-Business-Final_.pdf>

[7] Anonymous; in Waldman, H.B., 1972. op cit.

[8] Association of Association of American Dentists, Newsletter, 1963, May; in Waldman, H.B. "The response of the dental profession to change in the organization of health care – a commentary." *American Journals of Public Health* 1973;63(12):17-20.

[9] Association of Association of American Dentists, Newsletter, 1963, July; in Waldman, H.B., ibid.

[10] ADA Newsletter. March 1, 1965; in Waldman, H.B. ibid.

legislation (which created the Medical Assistance for the Aged program – a forerunner of the Medicaid program). The states would be given power to decide which patients needed financial assistance. The federal government would provide matching funds to the states for the program. Local dental societies underscored the need for limitation in services benefits under the then proposed Medicare program.

The "fear" of government involvement and with it the socialization of private dental practices had taken hold of the profession. "Social progress was indeed the temper of the land. Instead of remaining on the defensive and permitting things to happen, the dental profession was ready to move public opinion in its favor. By supporting a minor step (mandating dental services for children based on economic need) it might preserve private practices."[11]

Today's realities

We are not addressing the needs of our children's oral health and it is taking the toll on them in school and later in life.

> "According to the Centers for Disease Control, tooth decay is among the most common chronic conditions of childhood. One in 5 children, aged five to 11, and 1 in 7 children, aged 12 to 19, have at least one untreated cavity. These numbers are higher for children from minority and low-income families. African-American and Hispanic children are more likely than white children to have cavities in their primary (baby) teeth and are twice as likely as white children to have untreated cavities. The disparity in untreated cavities continues into the teen years."[12]

- The U.S. Surgeon General, in 2000, estimated that more than 51 million school hours were lost annually due to dental-related illnesses. More recent studies confirm these earlier

[11] Waldman, H.B., ibid.

[12] Fielding, J. "Tooth decay disproportionally affects low-income kids with limited access to dental care." *U.S. News & World Report.* "Take care of children's teeth." 9 November 2016. Accessed 15 December 2018. <https://ph.ucla.edu/news/news-item/2016/nov/us-news-world-report-take-care-childrens-teeth>

findings. Children with poor oral health status were nearly 3 times more likely ... than were their counterparts to miss school as a result of dental pain.

- Children who reported having recent tooth pain were four times more likely to have a low grade point average – below the median GPA of 2.8 – when compared to children without oral pain. This affects academic achievement, employment opportunities and earning potential.[13]
- Poor dental health is also driving up costs to American taxpayers. The American Dental Association reports that overall spending on dental care increased from $50 billion in 1990 to $113 billion in 2014.[14] And during this same period the share of total U.S. dental care funded by public sources soared from 2 percent to 11 percent. One major contributor to this increase has been more children getting dental care from Medicaid and through the Children's Health Insurance Program.[15]
- There is an uneven distribution of dentists nationwide which means many areas do not have an adequate supply of these practitioners. As a result, access to care is constrained for people in these communities regardless of income or insurance coverage.
- The relatively small number of dentists who participate in Medicaid means that many low-income people are not receiving dental care.[16]

---

[13] Fielding, J. "Tooth decay disproportionally affects low-income kids with limited access to dental care." *U.S. News & World Report.* "Take care of children's teeth." 9 November 2016. Accessed 15 December 2018. <https://ph.ucla.edu/news/news-item/2016/nov/us-news-world-report-take-care-childrens-teeth>

[14] Soderlund, K. "Dental spending remains stagnant." *ADA News*. 15 February 2016. Accessed 15 December 2018. <https://www.ada.org/en/publications/ada-news/2016-archive/february/dental-spending-remains-stagnant>

[15]"Action for Dental Health: Bringing Disease Prevention into Communities: A Statement from the American Dental Association." December 2013. Accessed 15 December 2018. <https://www.ada.org/en/~/media/ADA/Public%20Programs/Files/bringing-disease-prevention-to-communities_adh >

[16] Pew Trust. "In search of dental care: Two types of dentist shortages limit children's access to care." Accessed 15 December 2018. <https://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2013/insearchofdentalcarepdf.pdf>

- How we pay for dental services is a major problem. Out-of-pocket spending represents 44% of all dental service costs. By contrast, out-of-pocket spending constituted 14% of all health care expenditures (including 17% of the costs for youngsters less than 18 years of age). In essence, spending for dental services "is felt" to a greater extent than for total health services.
- "The Affordable Care Act (ACA) specifies that dental care for children is an 'Essential Health Benefit.' That may sound like having some sort of dental coverage—insurance or otherwise—is required for kids by law. But what it really means that pediatric dental coverage must be *available* for purchase in the ACA Marketplace. Parents don't have to purchase dental insurance under federal law. In the federal and state run Marketplaces, pediatric dental plans are available as part of a health care plan, as a bundled offer or as a stand-alone plan. In the federal Marketplace, you cannot purchase a stand-alone dental plan without purchasing health care insurance. Stand-alone dental plans are not covered by federal subsidies."[17]

[17] Carper, K. and S.R. Machlin. "National Health Care Expenditures in the U.S. Civilian Noninstitutional Population 2010." Medical Expenditures Panel Survey Statistical Brief #396, January 2013. Agency for Healthcare Research and Quality, Rockville, M.D. DentalPlans.com. Affordable Care Act and dental care: children. Accessed 17 December 2018. <https://www.dentalplans.com/affordable-care-act/children-dentalcare>

What does this all have to do with humanities and ethics?

The "boogieman scare" (an imaginary monster that children believe hides under the bed or in the closet to scare people[18]) of government intervention in the private practice of medicine and dentistry (eventually leading to socialism and communism) permeated the development of national approaches to health care issues after the assassination of President Kennedy. These issues continue today as: 1) the federal government deals with the dramatic changes to health services in an era of evolving national demographics, and 2) the dental (and medical) professions come to terms with an increasing commercialization of practice settings with the decreasing solo practice arrangements (once the bulwark of dental practice). It seems that somewhere along the way the bedrock of the relations between the patients and providers has been suppressed by third parties (insurance companies and government) and now further depersonalized by the commercial chains that permeate the fabric of dental practice. These development have been at a cost to the foundations of our profession -- **the humanities and ethics** and the means to ensure the oral health services for the **3 million children (and others) unable to afford the care.**

[18] Urban Dictionary. "The boogieman." Accessed 18 December 2018. <https://www.urbandictionary.com/define.php?term=the%20boogieman>

Table 1. Unmet dental needs due to cost for children 2-17 years by selected characteristics: 2017[19]

	Number (in 000s)	Percent
Total	**3,010**	**4.6%**
Male	1,559	4.6
Female	1,451	4.5
Age		
2-4 yrs	223	1.9
5-11	1,196	4.1
12-17	1,590	6.4
Race & ethnicity		
White	2,271	4.7
Black	472	4.9
Asian	96	2.5
2+ races	146	4.5
Hispanic	1,149	7.0
Economics		
Poor	812	7.3
Near poor	972	6.0
Not poor	1,121	3.0
Parental education		
Less than H.S. diploma	511	7.4
High school diploma *	672	6.4
More than H.S. diploma	1,676	3.6
Insurance		
Private	1,071	2.9
Gov't programs	1,089	4.6
No insurance	747	22.1
Regional		
Northeast	362	3.1
Midwest	638	4.5
South	1,260	5.2
West	750	4.8

*Or General Educational Development diploma

[19] Summary of Health Statistics. National Health Survey 2017. U.S. Department of Health & Human Services. Table C-11a. National Center for Health Statistics. Accessed 13 December 2018. <https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_C-11.pdf>

The Journal of Dental Humanities is published quarterly. All correspondence may be addressed to:

Journal of Dental Humanities
351 Meetinghouse Lane
Southampton, New York 11968

Telephone – (631) 283-5626

www.journalofdentalhumanities.com

Original material may be submitted for review and possible publication. Please send submissions via email to rpiovino@gmail.com . Materials submitted for review must not have been previously published or currently under review for publication elsewhere.

Submissions of interest will undergo a blind review process.

Journal of Dental Humanities
351 Meetinghouse Lane
Southampton, N.Y. 11968