Dentistry’s social contract is at risk

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ABSTRACT

Background. The implications of the social contract for medicine and those it serves has been debated by bioethicists, political scientists, and physicians. Far less attention, however, has been given to dentistry’s social contract.

Methods. The existing literature from medicine is used to explore the social contract and the role of dentistry in today’s society, focusing on several areas of interest.

Results. The authors’ analysis discusses the history of the social contract and its implications for professionalism. The authors examine the failure of the dental profession to adequately address population needs and inequities in oral health, situating this in the context of an increasingly commodified, commercialized, cosmetically oriented, and proprietary culture in the profession. The authors highlight the important role of organized dentistry in facilitating change and renewing the social contract.

Conclusions. The authors conclude that reforms are necessary for dentistry to remain a profession.

Practical Implications. The authors’ findings may inform oral health policies and underscore the need for change among dental providers and organized dentistry to maintain dentistry’s professional status.

Key Words. Dentistry; social contract; professionalism; population health; ethics.

Scholars contend that medicine functions under a social contract that is less an explicit, written agreement and more an implicit, unspoken bond with society: an unwritten, dynamic, and ever-changing agreement, not enforceable by legal systems. The implications of the social contract for medicine and those it serves have been debated by bioethicists, political scientists, and physicians. Although there are certainly limitations to the social contract as a basis for the relationship between medicine and society, with some even arguing to abandon its use altogether, it remains useful in describing the mutual responsibilities between medicine and society. Far less attention, however, has been given to dentistry’s social contract. This might be explained given that dentistry in the United States and Canada has evolved independently from the rest of health care for a variety of social, economic, institutional, and administrative reasons. This is suprising in Canada, as the privately financed dental care system exists almost in complete distinction to the country’s prized universal health system.

In both countries, dentistry’s status and organization are becoming a focus of criticism, as more attention is placed on the unnatural separation of the “mouth” from the “body,” or “oral health” from “health,” plus the reality that private systems of care create significant barriers to access for many in need. These barriers to care, in turn, have serious and negative implications for people, families, health systems, and society more broadly. Although the profession historically mirrors medicine in its primary purpose to serve the public and people through the control and prevention of disease, the competing forces and interests between dentistry as a profession and a business demand that dentists and their associated institutions examine dentistry’s social contract and ask what the role of dentistry is in today’s society.

In this article, we explore this question using the existing literature in medicine as a guiding framework. In the first section, we discuss the history of the social contract in dentistry and its implications for professionalism. Next, we discuss the failure of the dental profession to adequately address inequities in oral health and access to care and its significance for the social contract.
explored. This is followed by a discussion of the implications of the social contract for an increasingly commercialized and cosmetic model of care. The penultimate section provides ideas on how the social contract may be renewed, exploring the role of organized dentistry in facilitating such changes. We conclude the article by noting the need for reform if dentistry wishes to remain a profession.

THE HISTORY OF PROFESSIONALISM AND THE SOCIAL CONTRACT

The concept of professionalism is closely tied to the values of medicine. Historically, physicians assumed the role of healers in society, treating the sick and those in ill health. Some argue that as health care delivery became increasingly complex, society demanded educational credentials for those wishing to serve the public in these roles, which, in part, gave rise to the modern medical profession. Dentistry was similar, and professional schools were eventually established to formally educate dental practitioners. Laypeople seeking assistance had to trust that these groups would use their knowledge in their best interest, placing the welfare of those they served above personal gain. In return for their expertise and altruism, professionals were granted special privileges by society, such as elevated status, prestige, and rewards, such as a protected marketplace and a relative monopoly secondary to restrictive professional licensure, among other things.

In fact, these privileges form the foundation of the social contract in medicine and dentistry. Some early social contract theorists posit that people consent to surrender some of their freedoms and submit to the authority of an expert in exchange for the protection of their existential rights. There must, in turn, be an implicit agreement that guarantees trust and respect between the two parties and preserves this confidence in the profession more broadly. Thus, by extension, a health care profession’s social contract, including dentistry’s, is a matter of social institutions and plays out in their many structural forms.

Dentistry’s contract with society is partly explicit, found in legislation, codes of ethics, and mandates of licensing, among other things. However, like medicine’s social contract, it still remains mostly implicit, and because society has chosen to use the concept of a “profession” for organizing the delivery of care, professionalism itself best serves as the basis for the implicitness of the social contract, delineating reciprocal rights and obligations between a health care profession and society. On the 1 hand, the dental profession and its members are granted respect, trust, the privilege to self-regulate, and a relative monopoly, setting the conditions by which dentists can earn generous financial compensation. On the other hand, the dental profession and its members promise to be fair, competent, knowledgeable, and compassionate; to self-regulate well; to address the concerns of society; and to altruistically serve the public.

The latter promises—to address the concerns of society and to altruistically serve the public—reflect a commitment to social responsibility (that is, a commitment to advocate and work for the happiness, health, and prosperity of a community and its members), which necessarily includes serving the community and its people. Indeed, because professions exist at the behest of society, professions that fail to respond to the social contract risk losing their designation as professions. For instance, maintains that altruism, more than any other professional responsibility, separates dentistry from being considered a trade or occupation. The current approach to dental care arguably violates these responsibilities, by privileging those who are better off in terms of access, such as the wealthy and those with private insurance. This model of care is remarkably unjust, entrenching broader inequities in society, and holds serious implications for the profession at large.

SOCIAL INEQUITIES AND THE NEED TO TREAT THE UNDERSERVED

The primary factors that shape a population’s health are not determined by medical treatments and lifestyle choices, but rather by the conditions in which people live and work. These social determinants also predict and shape a person’s oral health. Perhaps unsurprisingly then, the social determinants of health manifest more prominently in those societies that privilege the financing and delivery of dental services through private means, such as in Canada and the United States, where those with the greatest needs face the greatest structural barriers to care. In these systems of care, untreated oral disease, dental pain, and tooth loss disproportionately impact the most vulnerable members of society: those with less income, lower levels of education, and greater levels of food and housing insecurity.
These vulnerable populations disproportionately rely on charity, community health clinics, hospitals, and dental schools for care,17 arguably suggesting that the profession maintains a separate social contract for a subset of the population, an arrangement that is morally indefensible and almost certainly unsustainable. The American Dental Association18(p3) recognized these problems more than a decade ago when it acknowledged that to maintain the public trust, “the profession must find ways to provide care for those in need, regardless of their financial wherewithal or the challenges they present.” Nonetheless, there is little evidence that things have substantively improved for the worst off in society. Income and education gradients in oral health persist15; the geographic distribution of dentists continues to favor affluent communities19; and cost remains a major barrier for those with the greatest need for care.15

Beemsterboer14(p1,212) claims that this stems from “an erosion of social consciousness in [dentistry’s] professionalism.” Indeed, dentists can hold negative stereotypes and misconceptions about the poor,20 and health professionals generally have little appreciation for the day-to-day challenges of their lowest-income patients, which can negatively affect how they care for such patients.21 But worse yet, moral agency has been shown to decrease as one’s personal wealth or status increases (an enigmatic challenge in health care generally as dentists tend to accumulate wealth and status as part of the social contract), which augments the cognitive bias that personal choices are primary in determining life circumstances.22 This may explain, at least in part, the dental profession’s tendency to attribute poor oral health as a moral failing or as a reflection of personal responsibility23 despite substantial evidence that individual choices are heavily constrained by social circumstances (that is, the social determinants of health).

Of course, many dental professionals do offer pro bono work to those less fortunate, or they support tax incentives to encourage pro bono care for marginalized communities.24 Although such efforts are laudable, charity and volunteerism are not a substitute for a sustainable system designed to provide ongoing care.9 Charitable dentistry risks becoming the basic and legitimate standard of care for vulnerable populations, despite its inability to meet the sometimes dire needs of such groups, particularly as it is rarely comprehensive and tends to be episodic at best.20 Volunteer dentistry also risks “ghettoizing” those living in poverty by failing to integrate them into daily practice,25 further alienating the marginalized in an already unjust system. Together, such acts can actually mask system failures that would otherwise not be tolerated by the general public, placating necessary policy responses that better address societal needs.25 In this way, charity and volunteer work can stifle reforms necessary to address access problems, as well as solutions framed within the social determinants of health. Ultimately, it is arguable that, if a health profession does not adequately meet the existential needs of the most vulnerable with reasonable and equitable care, the profession risks losing its trust, status, and designation with society.

**COMMODIFICATION, COMMERCIALISM, ENTREPRENEURIALISM, AND COSMETIC DENTISTRY**

The social contract in dentistry is predicated on the notion of inequality between the parties, assuming a power differential or asymmetry of information between dentists and patients, and inequality among people, as the social contract is, in part, meant to privilege care for those most in need. Given such inequality, health care cannot be considered a commodity of the marketplace, as it fails to adhere to the basic economic principles necessary for marketplace transactions, such as information symmetry and equal choice.7,9,26 And yet, the commodification and commercialization of dentistry has driven a rise in entrepreneurialism among dentists in what is deceptively viewed as a competitive marketplace.7 Dentistry, as a profession, however, does not operate within a competitive marketplace; society has granted it a monopoly over its services as part of the social contract. This system is the opposite of free market economics given that it, by definition, is anticompetitive and driven by a service to the community rather than the individual.7

But by framing dentistry as a commodity and commercial enterprise and the profession as operating within the confines of a free market system, there is an uncritical propagation of a business-minded ethos that arguably justifies care only for those who can afford recommended treatment. In this way, dentistry privileges more affluent communities and those patients with private dental insurance, thereby diminishing oral health as a social good.11 Bertolami27(p423) argues that dentists have “avoided practicing in both rural areas and the inner city just as they have
avoided faculty positions and public sector careers as a result of these misguided market signals, artificially inflating their incomes by discounting the social costs of their decisions.

Dentists’ behaviors today are sometimes more consistent with professionals who exhibit the freedoms of a businessperson, yet the foundations of professionalism are mismatched with those of a business. The values that guide dentistry as a business are profit, competition, maximizing personal good, free enterprise, and individual choice. The values underlying dentistry as a profession, on the other hand, are fostering human prosperity and flourishment, cooperation among stakeholders, maximizing social good, justice, and equality. These conflicting philosophies have fueled a growing tension between the proprietary and professional cultures of dentistry. In turn, there is growing concern and evidence that dentists are adopting business approaches to patient care that are grounded more in financial considerations than patient health and an unnecessarily competitive professional environment in which dentists more often view other dentists as competitors rather than colleagues. Such tensions may help explain dentists’ continued frustration with efforts to improve the oral health of low-income people, often expressing feelings of being imposed on to provide services at lower costs or even at a financial loss. Many dentists also feel compelled to provide “dentistry for the poor” that does not reach the standards of “regular dentistry.”

However, from a fiduciary perspective, what qualifies as regular dentistry in a proprietary culture is not necessarily synonymous with what qualifies as regular dentistry in a professional culture. This, of course, is a symptom of a larger feature in dentistry today: its willingness to embrace larger cultural shifts in the United States and Canada involving a preoccupation with self-image, particularly apparent in a fixation with straight, white teeth. This cultural shift has occurred alongside a broader social trend that ascribes the structural to the individual and a deference to competitive markets to distribute social goods. In many ways, the rise of commercialism, competitiveness, and cosmetic dentistry in the United States and Canada reflects these broader social trends during the past 3 decades. If dentists continue to focus resources on issues of vanity over existential needs, the general public may increasingly view dentistry as something other than a profession, nullifying the need for a social contract and ultimately leading to the loss of dentistry’s status as a regulated health profession.

OPPORTUNITIES FOR A RENEWED SOCIAL CONTRACT

There are already indications that society is beginning to question its social contract with dentistry. Functions traditionally reserved for dentists are now being performed by others; for instance, hygienists have seen an expanded purview of their responsibilities and, in the United States, dental therapists are now providing care to select underserved areas. In some jurisdictions, physicians are permitted to apply fluoride varnish and conduct routine oral examinations, and direct-to-consumer orthodontics avoids the traditional patient-provider relationship altogether. These changes show, at least to some degree, a dismantling of dentistry’s monopoly in what may be a sign that society is reconsidering its social contract with dentistry.

Meaningful reforms—not simply tinkering with the existing apparatus—are necessary if dentists intend to maintain or possibly regain their status as professionals, and this likely begins with formal dental education. A greater emphasis must be placed on recruiting future practitioners who view their profession as a means through which to serve both people and their community. This may require a rethinking of the admissions process; less emphasis on academic records from applicants and a greater weight given to lived experience and social consciousness. The education of dental students must also contend with actualizing the social determinants in terms of how they shape population and individual health profiles.

Dental education today often fails to expose students to addressing the social determinants of oral health. As argued, dentists tend to view oral health responsibilities through the lens of the person, and this ideology is consistent with viewing the obligations inherent in the social contract only at the level of the person rather than the community. More to this point, cognitive bias toward and negative stereotypes about the poor tend to worsen as social status and wealth increases, and this must be understood by educators and leaders if the profession wishes to reform the system in a more equitable manner and regain or maintain the public trust. Given all of these issues, a much greater focus on addressing and understanding the social determinants of health in educational, clinical, political, and professional settings is warranted.
Dentists and dental organizations can and must play a critical role in creating a new model to improve health outcomes through access to care. Dental organizations have been reluctant to mandate solutions that would assuage the existing access challenge, such as obligatory service for new graduates to treat underserved areas or the creation of a robust dental safety net through public clinics. Instead, professional recommendations rely almost exclusively on increasing public expenditures (that is, increasing service fees), a politically expedient solution that simply shifts the onus of responsibility from dentists to the government. However, if the leadership within the dental community will not offer novel solutions to address access challenges in dentistry today beyond financial remuneration, society—ostensibly represented through its government—will remedy the problem with its own policy solutions.

Dentists and dental organizations must offer a willingness to reimagine how dental care is organized, financed, and delivered. For instance, the La Cascada Declaration, published in 2017 by several leading experts in oral health, highlights many possible areas for reform, suggesting several radical measures they argue are essential to maintain the profession’s public trust. Although controversial, La Cascada offers a transformative vision away from traditional dentistry, arguing for an ideological and cultural shift in the profession. We agree with several of the La Cascada propositions, such as the need to challenge corporate and financial influence over clinical and research decisions, increasing the focus on social determinants and population health in the education of dentists, and a call for increased social spending to reduce inequities. Other tenets of the manifesto are less persuasive, however; namely, a focus on dissuading dentists from performing most dental procedures and a call to reduce the growth in dental specializations. Nevertheless, the value of the declaration is in inviting a conversation in dentistry that is long overdue, allowing the profession an opportunity to wrestle with its social obligations and what dentistry will mean in this century.

We further propose that several other solutions exist to strengthen the social contract. For instance, bringing dentistry closer to the field of medicine (educationally, administratively, and socioculturally) may help remove the unnatural separation of the mouth from the body and better address normative needs (that is, oral disease and systemic health), thereby making dentistry more professional in the eyes of the public. As well, regulatory bodies can demand changes to dental school curricula with a greater emphasis on societal health and prevention, a reconfiguring of the workforce and its provider types, in which graduates are expected or obligated to practice in relation to population needs, and even changes to remuneration methods.

Finally, the profession must also reevaluate the priority afforded to cosmetic concerns. Professions exist to address existential threats—the treatment of disease, the relief of pain, the elimination of infection, and so forth. A distinction may be necessary for dentists who treat needs that pertain to an existential vulnerability (which may or may not include some esthetics in today’s society) and those who treat cosmetic concerns for purposes of vanity. These are difficult issues to address, but they will only be resolved if dentists show the commitment to honestly formulate a renewed social contract with society.

CONCLUSIONS
We have discussed the social contract in dentistry and its implications for professionalism. It is arguable that the commodification of dentistry, a rise in commercialism and entrepreneurialism, and the growing demand for cosmetic dentistry have nurtured an environment that favors those with greater resources, largely at the expense of those with the greatest need for care, including the poor and the uninsured. Not surprisingly then, social and economic gradients in oral health have persisted, and these oral health inequities may become increasingly more evident as social demands for meeting basic needs and even the perfect smile intensify.

We have also discussed several ideas for reform, most of which amount to a recognition of social responsibility as a core tenet of the social contract. In short, we believe that leadership and the rank-and-file membership of dentistry must become far more engaged with the societal norms and expectations associated with professionalism and engage in forthright discussions of solutions that challenge conventional wisdom and recent developments in dentistry. If dentists and their leaders are unwilling or unable to renew their social contract, choosing to maintain the status quo, it is conceivable that dentistry will lose its existing authority over addressing the oral health needs of society.
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