Routledge
Taylor & Francis Group

Ethics & Behavior

ISSN: 1050-8422 (Print) 1532-7019 (Online) Journal homepage: http://www.tandfonline.com/loi/hebh20

Ethics, Changing Populations, and the Dental Profession

H. Barry Waldman, Marc Bernard Ackerman & Steven P. Perlman

To cite this article: H. Barry Waldman, Marc Bernard Ackerman & Steven P. Perlman (2015) Ethics, Changing Populations, and the Dental Profession, Ethics & Behavior, 25:3, 271-278, DOI: 10.1080/10508422.2014.921168

To link to this article: http://dx.doi.org/10.1080/10508422.2014.921168

Accepted author version posted online: 16 May 2014.
Published online: 15 Sep 2014.

ETHICS & BEHAVIOR, 25(3), 271–278

ISSN: 1050-8422 print / 1532-7019 online
DOI: 10.1080/10508422.2014.921168

Routledge
Taylor & Francis Group

COMMENTARY

Ethics, Changing Populations, and the Dental Profession

H. Barry Waldman
Department of General Dentistry
Stony Brook University

Marc Bernard Ackerman
Division of Medical Ethics
Harvard Medical School
Orthodontics
Boston Children's Hospital
Department of Developmental Biology
Harvard University School of Dental Medicine

Steven P. Perlman
Special Olympics
Special Smiles
Pediatric Dentistry
Boston University Goldman School of Dental Medicine

This review emphasizes the worldwide and U.S. evolving population demographics and the need for the dental profession to exercise its professional and ethical duty to expand its traditional patient base to provide needed services.

Keywords: ethics, professionalism, morality

INTRODUCTION

Most often one speaks of ethics in terms of an individual's behavior. Ethics, however, also reflects upon a group's actions or moral performance in a range of evolving circumstances. Although a

Correspondence should be addressed to H. Barry Waldman, Department of General Dentistry, School of Dental Medicine, Stony Brook University, Stony Brook, NY 11794. E-mail: hwaldman@stonybrook.edu

group is a totality of individuals, the performance of a small or even a large group may be quite different with the addition of the characteristics of one new member. For example,

> Safety experts recommend that newly licensed teenage drivers do not transport teenage passengers for the first 1,000 miles, or 6 months, of unsupervised driving. The risk of a fatal crash for a teen driver doubles with the presence of just one teen passenger. Each additional passenger increases the risk of a fatal crash. (New York Department of Health, 2013)

Similarly, the evolving setting within which a group finds itself may require the group to readdress its criteria for determining the morality of its activities.

A profession is defined as an occupation requiring a long and specialized course of higher education, and one that is governed by a special code of ethics (Gurley, 1961). Professions serve the public good. The American College of Dentists posits that there are four key features of a profession: (a) A profession must possess an important and exclusive expertise; (b) a profession must possess an internal and external structure, including a community of experts mutually recognizing one another's expertise and institutionalization of this relationship in a formal organization; (c) a profession's clients routinely grant its members extensive autonomy in practice of the profession; and (d) membership in a profession implies the acceptance by the member of a set of norms of professional practice or professional obligations (Brandhorst, 1971). A prerequisite for membership in the American Dental Association (ADA) is an individual's voluntary willingness to abide by the ADA Principles of Ethics and Code of Professional Conduct ("Advisory Opinions," 1981). The code is a written expression of the obligations arising from the implied contract between the dental profession and society. Five fundamental ethical principles make up the foundation of the ADA code: (a) patient autonomy, (b) nonmaleficence, (c) beneficence, (d) justice, and (e) veracity.

The modern theory of distributive justice according to Rawls is that all social primary goods, including liberty and opportunity and income and wealth, are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored (Rawls, 1971). Should access to healthcare be governed by the theory of distributive justice? As other authors have argued (Daniels, 1981), our contention is that healthcare professionals have an ethical responsibility to adhere to the principle of distributive justice and make sure that the least favored in the population have access to adequate healthcare. The aim of this review is to examine the trends in shifting population demographics and how these trends will shape existing inequalities in access to dental care.

WORLDWIDE POPULATION CHANGES

During periods when populations are (a) growing fairly slowly or (b) when most societies have populations that are relatively homogenous and growing at a reasonable constant and steady fashion, there may be limited need to reevaluate traditional values and perceptions of decency.

> Yet we no longer live in such a world. The twenty-first century—following a century of global and regional intermixing borne by technological change and economic integration—is a time when diverse and rapid population shifts are taking place across the globe. (Goldstone, 2012, p. 12)

Around the world, very young and very old age groups are increasing rapidly and urban populations are expanding dramatically. "At the same time, migration and the political boundaries left from the days of imperialism and colonialism have produced numerous multiethnic societies with shifting ethnic or religious composition" (Goldstone, 2012).

U.S. POPULATION CHANGES

> The term 'minority,' at least as used to describe racial and ethnic groups in the United States, may need to be retired or rethought soon: by the end of this decade, according to Census Bureau projections, no single racial or ethnic group will constitute a majority of children under 18. And in about three decades, no single group will constitute a majority of the country as a whole. (Cooper, 2012, p. A20)

Indeed, worldwide developments are an increasing reality in the United States. For example, the role of the decline of the White majority in the United States and the importance of minority ethnic groups was a factor in electing the nation's first non-White president.

> . . . in 2008 almost one in four voters were minorities, up from just over one in five in 2004. Moreover, shifts in minority populations were concentrated in electorally crucial 'battleground' states . . . demographic change and differential ethnic voter turnout will have major implications for the future of American politics. (Kaufmann & Toft, 2012, p. 13)

The Hispanic population is projected to "more than double, from 53.3 million in 2012 to 128.8 million in 2060. Consequently, by the end of the period, nearly one in three U.S. residents would be Hispanic, up from about one in six today" (U.S. Census Bureau, 2012).

In addition, according to Census Bureau projections:

> the population age 65 and older is expected to more than double between 2012 and 2060, from 43.1 million to 92.0 million. The older population would represent just over one in five U.S. residents by the end of the period, up from one in seven today. The increase in the number of the "oldest old" would be even more dramatic—those 85 and older are projected to more than triple from 5.9 million to 18.2 million, reaching 4.3 percent of the total population. (U.S. Census Bureau, 2012)

During this period, the proportion of children younger than 15 years of age is projected to remain at approximately 20% of the population. By contrast, the working-age population (18–64) is expected to increase from 197 million to 239 million, whereas its share of the total population declines from 62.7% to 56.9% —a major factor when considering the need to support the costs of providing services for the dramatic increases associated with the needs of the geriatric population, for example, public pension and health and social services (U.S. Census Bureau, 2012).

The projected increases in governmental spending for the elderly in coming decades are sobering. Annual public benefits to the elderly as a percentage of the gross domestic product are forecasted to rise through 2040 by 11% in the United States to an overall level of 20% (Haas, 2012). "If current trends continue, by 2030 Medicare and Social Security will require nearly half of all federal income tax dollars. By 2040, they will require nearly two thirds of this revenue" (Haas, 2012, p. 51). Although the magnitude of these forecasts is almost beyond belief, as a result of significantly smaller proportions of working age adults in other counties, the reality is that compared to other major countries the aging crisis in the United States is less acute.

IMMIGRANTS

The world of today and even more the world of tomorrow will be a world of people on the move.

> The proximity of very young populations in Central and Northern Latin American, North Africa and the Middle East, and South Asia to richer but rapidly aging populations in North America, Europe and far eastern Asia, will create enormous forces pulling labor migrants from developing countries into the rich world. (Goldstone, 2012)

HOW DOES ALL THIS APPLY TO MORALITY AND THE DENTAL PROFESSION?

The answer to the question may be to substitute the words "dental practitioners" for "national candidates" in the following quotation.

> The election of Barack Obama as the first African-American multi-ethnic president with the '. . . strong support among blacks, Hispanics, and other fast-growing minorities suggest that future national candidates need to pay greater attention to the issues embraced by minorities as they become players in the electorate.' (Frey, 2012, p. 149)

Morality (and its related series of synonyms—ethics, principles, decency, honesty, and integrity) is closely associated with the historical concepts of a "profession," that is, a "solemn declaration," "meaning an occupation (in which one) professes to be skilled in" thereby assuming the protection of others ("Profession," 2013). By extension, one may suppose that a health practitioner's concern is to address the needs of the public. In actuality, however, the concern for the care of others is inescapably intertwined with the realities of economics of both the practitioner and the individuals in the public.

Some Examples

As a first example, in mid-April 2013, the lead headline of the *ADA News* announced that "baby boomers boost utilization: older patients show raise in dental expenditures" (Soderlund, 2013, p. 1). However, the following paragraphs of the column emphasized a different story.

- Americans aren't spending any more on dental care than they were 5 years ago.
- After decades of steady growth, national dental expenditures began to slow in the 2000s, years before the economy soured.
- Once the great recession hit in 2008, national dental expenditures leveled off and have remained flat ever since.
- The rising proportion of those older than 65 could significantly increase dental expenditures, "buoying up the dental economy for years to come" (Soderlund, 2013, pp. 1, 4).

Unfortunately, waiting decades for the dramatic increase in the number of seniors to increase dramatically and boost the economics of dentistry is not a viable option for current practitioners. Similarly, reliance solely on emphasizing efforts to increase the use of services by the traditional consumers of oral health care may have its limitations.

Second, consider the fact that almost half of youngsters and teenagers (ages 5–17 years) were reported to have had no expenditures for dental services in 2010, followed by two thirds

of younger adults (18–44 years) and more than half of the population 45 years and older with no spending for dental care. Among other demographic cohorts, dental expenditures were reported by a smaller percentage of

- Men than women
- Minority groups, in particular Hispanics, than White non-Hispanics
- Middle income and poor populations than higher income populations (Agency for Health Care Research and Quality, 2012). Nearly one in four children live in poverty, ranging from 13.1% in North Dakota to 34.7% in Mississippi (Blow, 2013).
- Residents in nonmetropolitan statistical areas than those in metropolitan statistical areas.
- Uninsured individuals than privately insured and government covered program groups.
- Residents of the Southern Region than in all other census regions (Agency for Health Care Research and Quality, 2012).

Third, as to expenditures, an estimated almost 60% of the population (183.9 million individuals) reported no expenditures for dental services. Among those who spent money for services, the average individual expended $666 in 2010 with a median expenditure of $236, which would indicate that of those who spent money for care, half expended a relatively small amount of money (i.e., less than $236) and half (or possibly a small component) expended a much greater amount of money to raise the overall national mean level to $666 (Agency for Health Care Research and Quality, 2012).

Fourth, how we pay for dental services is another problem. Out-of-pocket spending represented 44% of all dental service costs. By contrast, out-of-pocket spending represented 14% for all health care expenditures for the total population (including 17% of the costs for individuals younger than 18, 15% for the 18–64 population, and 12% for the 65 and older population; Carper & Machlin, 2013). In essence, spending for dental services "is felt" to a greater extent than for total health services.

- Private insurance does not cover 54% of dental expenses (Carper & Machlin, 2013).
- Medicaid provided 6% of all expenditures for dental services. However, it represented 42% of costs for children younger than 5 years, 21% for the Hispanic population, 38% for the poor population, and 73% for the 65 and older population with public insurance (Agency for Health Care Research and Quality, 2012).
- Studies suggest that fewer than 25% of all dentists accept Medicaid patients and fewer than 10% have at least 30% of their practice represented by Medicaid beneficiaries (Friedman, 2012).

Yes, there are explanations, including inadequate fee schedules and byzantine bureaucratic impediments. However, from the prospective of the public, the results are limitations in the availability of dentists to provide access to care. "More than 4 million children aged 17 and younger had unmet dental needs in 2011 because their families could not afford dental care" (Palmer, 2013).

Fifth, approximately 56.7 million people living in the United States in 2010 (18.7% of the population) had some kind of disability. About 12.6%, or 38.3 million people, had a severe disability. This number has continued to increase and will grow as the expanding aging population reaches their 70s, 80s, 90s, and beyond (Brault, 2012). In 2010, almost 29% of individuals with disabilities (many of whom are dependent upon the Medicaid program for care) did not obtain dental

services because of cost (National Center for Health Statistics, 2012). Also, Medicaid dentists are "so hard to find" (Otto, 2007, para. 5).

Sixth, there have been dental profession demographic changes. Regarding dental school graduates, between 2001 and 2010 the continuing increase in the proportion of female representation among graduates from 37.5% to 45.3% was the major demographic change. During the same period, the proportion representations among graduates included the following:

- Non-Hispanic White—decreased from 62% to 58.4%.
- Asian—decreased from 26.5% to 25%.
- Hispanic—increased from 4.9% to 6.1%.
- Black—increased from 4.9% to 5.5%.
- Native American—increased from 0.6% to 0.7%. (American Dental Association, 2012).

Compared to the general population, Asian students were overrepresented among graduates and other minorities continued to be underrepresented among dental school graduates during the past decade.

Regarding dentists, in 2010, 80.3% of the 175,000 dentists were non-Hispanic Whites, 19.7% were members of minority groups (13.7% Asian, 5.7% Hispanic, and 0.3% Black; U.S. Census Bureau, 2013). The shortage of Hispanic dentists has been emphasized previously by the National Hispanic Medical Association (2012).

OVERVIEW AND COMMENTARY

What is unique about the dental profession that requires particular emphasis on the need to expand its definition of ethics? Physicians and the increasing numbers of allied health professionals function in interrelated arrangements (ranging from large group practices to hospital settings) with associated demands for services by varied population groups. In addition, government regulations require hospitals that receive federal funds to provide care of individuals despite their inability to pay for services.

By contrast, generations of dentists have carried out their professional activities in solo or small practice arrangements with little to no personal pressure to care for particularly underserved populations. For example, the Medicaid program is a critical avenue for the care of individuals with limited incomes and/or disabilities. Although dental services are required for children under the Early Period Screening, Diagnostic and Treatment component of the Medicaid program, coverage for adult dental services is optional. According to a 2010 report, "twenty-two states provided no dental coverage for adults or limited that coverage to emergency or trauma services only. In other states services may be limited to one examination and cleaning per year, or a cap may be placed on the dollar amount of service that will be covered in a given year" (Wall, 2012). As a consequence of limitations in reimbursements, bureaucratic delays, and related factors, about 25% of dentists accept Medicaid patients (Friedman, 2012; Pew Charitable Trust, 2013).

Nevertheless, the excuse that "no single profession can remedy inadequate health care" must not be viewed as the rationale not to initiate changes to make inroads into the overall need for care.

In the past, dentists waited in their operatories for patients "to find them" with limited attention to the happenings beyond the proverbial walls of one's practice. In more recent years, many dentists have advertised to attract a targeted demographic of patients from the community in proximity to their offices. Even more adventurist practitioners sign contracts with various third-party entities, including HMOs, DMOs, PPOs, and numbers of other capitated and management systems.

Each of these arrangements has a commonality—availability of finances for the "usual patients" (middle- and upper-class populations). In addition, some practitioners "have ventured" into the Medicaid program and the care of individuals with severe disabilities. However, as the 2013 ADA report indicated, "Americans aren't spending any more on dental care than they were 5 years ago" (Soderlund, 2013).

These events are occurring at a time when the patient population for dental services is undergoing dramatic changes, at a time that the profile of dental students and the general profession no longer reflects the current and future profiles of the general population. Some have argued that political pressure arising from an underserved population base may result in the development of the midlevel provider track, sending streams of intermediate practitioners to provide access to care for these underserved populations.

Alternatively, the dental profession could demonstrate its sense of morality and join in an effort to first direct and then provide the needed care for the changing base of the population. The concept of professionalism must be the bedrock of any healing art that seeks to be called a profession. It has been posited that there are three types of evidence-based dissatisfaction with American healthcare today (Coulehan & Williams, 2003). First, today's doctors are excellent technicians but lack skill in the range of clinical judgment and ethical decision making. The results from a recent study of all dental schools in the United States indicated that

> little time is devoted to ethics insurrection in the formal curriculum . . . (respondents suggested) the need for ethics to be more fully integrated across the curriculum, including carryover into the clinical years; the need to assess and ensure competence; the need for faculty development; and the need for more attention to method of instruction. (Lantz, Bebeau, & Zarkowski, 2011, p. 1295)

Second, today's doctors are not meeting patients' expectations in the realm of interpersonal communication, continuity of care, access, and advocacy. Third, today's doctors are socialized during their formal training not to espouse values traditionally associated with medical virtue. In essence, medicine and dentistry have devolved into the guilds rather than professions. It is time for a grassroots effort among veteran dentists to accept the mantle of caring for all corners of the population, and by doing so they may once again reassert that dentistry is a profession steeped in morality and virtue.

REFERENCES

Advisory Opinions to the ADA Principles of Ethics and Code of Professional Conduct. Council on Bylaws and Judicial Affairs. (1981). *Journal of the American Dental Association*, *103*, 253.

Agency for Health Care Research and Quality. (2012). *Medical expenditure panel survey: 2010*. Available from http://meps.ahrq.gov

American Dental Association. (2012). *2010-2011 Survey of Dental Education. Academic programs, enrollment and graduates—Vol. 1*. Retrieved from ttp://www.ada.org/sections/professionalResources/pdfs/survey_ed_vol1.pdf

Blow, C. M. (2013, October 26). Billionaires' row and welfare lines. *The New York Times*, p. A21.
Brandhorst, O. W. (1971). *The American College of Dentists: Its history, organization, objectives, and how it functions*. Bethesda, MD: American College of Dentists.
Brault, M. W. (2012). Americans with Disabilities: 2010. *Current Population Reports* (P70-131). Retrieved from http://www.census.gov/prod/2012pubs
Carper, K., & Machlin, S. (2013, January). *National health care expenses in the U.S. civilian noninstitutionalized population, 2010* (Statistical Brief No. 396). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.meps.ahrq.gov/mepsweb/data_files/publications/st396/stat396.pdf
Cooper, M. (2012, December 12). Census officials, citing increasing diversity, say U.S., will be a 'plurality nation.' *The New York Times*, p. A20.
Coulehan, J., & Williams, P. C. (2003). Conflicting professional values in medical education. *Cambridge Quarterly of Healthcare Ethics*, *12*, 7–20.
Daniels, N. (1981). Health-care needs and distributive justice. *Philosophy and Public Affairs*, *10*, 146–179.
Frey W. H. (2012). Racial demographics and the 2008 election in the United States. In J. A. Goldstone, E. P. Kaufmann, & M. D. Toft (Eds.), *Political demography* (pp. 149–158). New York, NY: Paradigm.
Friedman, E. (2012, February 9). Access to dental care: A national scandal. *Hospitals & Health Networks Daily*. Retrieved from http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=2540006049
Goldstone, J. A. (2012). A theory of political demography. In J. A. Goldstone, E. P. Kaufmann, & M. D. Toft (Eds.), *Political demography* (pp. 10–28). New York, NY: Paradigm.
Gurley, J. E. (1961). *The evolution of professional ethics in dentistry*. St. Louis, MO: American College of Dentists.
Haas, M. L. (2012). America's golden years. In J. A. Goldstone, E. P. Kaufmann, & M. D. Toft (Eds.), *Political demography* (pp. 49–62). New York, NY: Paradigm.
Kaufmann, E. P., & Toft, M. D. (2012). Introduction. In J. A. Goldstone, E. P. Kaufmann, & M. D. Toft (Eds.), *Political demography* (pp. 3–9). New York, NY: Paradigm.
Lantz, M. S., Bebeau, M. J., & Zarkowski, P. (2011). *Journal of Dental Education*, *75*, 1295–1309.
National Center for Health Statistics. (2012). The status of ethics teaching in U.S. dental schools. *Health, United States, 2011: With special feature on socioeconomic status and health*. Hyattsville, MD: Author. Retrieved from http://www.cdc.gov/nchs/data/hus/hus11.pdf
National Hispanic Medical Association. (2012). Diversity in the health professions. Shortage of Hispanic dentists. Retrieved from http://www.slideshare.net/dentistryinfo/shortage-of-hispanic-dentists
New York Department of Health. (2013). Teen drivers and passengers safety, teens ages 15 to 19 years. Retrieved from http://www.health.ny.gov/prevention/injury_prevention/children/fact_sheets/teens_15-19_years/teen_drivers_passenger_safety_15-19_years.htm
Otto, M. (2007, February 28). For want of a dentist. *The Washington Post*. Retrieved from http://www.washingtonpost.com/
Palmer, C. (2013, March 21). Children's dental visits, unmet need: Data from 2011 National Health Interview Survey. *ADA News*. Retrieved from http://www.ada.org/news/8420.aspx
Pew Charitable Trust. (2013). *In search of dental care: Two types of dentist shortages limit children's access to care*. Retrieved from http://www.pewstates.org
Profession. (n.d.). In *Online Etymology Dictionary*. Retrieved from http://www.etymonline.com/index.php?term=profession
Rawls J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press.
Soderlund, K. (2013). Baby boomers boost utilization: Older patients show rise in dental expenditures. *American Dental Association News*, *44*, 1, 4.
U. S. Census Bureau. (2012, December 12). U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb12-243.html
U.S. Census Bureau. (2013). *2012 statistical abstract of the United States*. Retrieved from http://www.census.gov/compendia/statab/2012edition.html
Wall, T. P. (2012). *American Dental Association: Health policy analysis series—Dental Medicaid*. Web site: http://www.ADA.org/en/science-research/health-policy-institute