COMMENTARY

From Exceptionalism to Essentialism in Dentistry

Lisa Simon

Keywords: Health Equity, Oral Health, History of Dentistry, Access to Care, Health Care Policy.

In his article, Cajee[1] juxtaposes the response of the dental profession to Dr. Painless Parker's dental franchises and self-promotion in the 1930s with his posthumous exoneration in 1979, when advertising by dentists had become widespread. Cajee follows this evolution of the field from a self-regulating profession to a lucrative but externally regulated industry.

Yet in 1932, when Painless Parker's license to practice dentistry was first challenged, dentistry was already more market-driven and deregulated than medical care. The first dental school in the US, founded in Maryland by a group of physicians, had existed for 92 years, marking in many ways the first branch point separating medicine from dentistry, and delaying dental education's adoption of a residency model of care delivery and professional identity formation. It had been three years since a group of Texas schoolteachers created the first American medical insurance model; the system of discounts and incentives that has come to be called dental insurance would not emerge until the post-World War II period.[2] Though perceived as repellent at the time, Painless Parker's mercenary approach to dental practice is a direct link between dentistry's origin as the trade of the barber-surgeon and the now-standard commercialization of oral healthcare. The siloization of dentistry as a profession independent of the rest of healthcare, with dental care treated as a benefit rather than a necessity, makes the field more vulnerable to deregulation and deprofessionalization.

The impact of this separation and its shaping of the modern dental delivery system are not merely historical curiosities. In the midst of a profoundly unequal medical system, oral health outcomes remain some of the most inequitable and unjust. Americans report more frequent financial barriers to dental care than any other health need.[3] One third of Americans lack any form of dental coverage.[4] Medicare beneficiaries have the lowest rates of dental insurance of any demographic, and Medicaid is not required to provide dental coverage for adults.[5] Low rates of public insurance acceptance by dentists, as well as a dental workforce that is strikingly less diverse than the American population, further worsen access.[6] Without dental care, patients with toothaches often seek relief in the emergency department, making up more than 1% of all ED visits nationally, but where palliation with an antibiotic and opioid prescription is all that is commonly available.[7]

Though corporate-run group practices make up a growing share of the dental market, more than 90% of dental practices are still run by one or a few dentists, who also make up the constituents of most professional dental associations.[8] As Cajee notes, owner-dentists can be motivated by the same ethically questionable financial incentives as corporations or venture capitalists. The fee-for-service reimbursement system that is still near-universal in dentistry rewards more invasive and costly interventions over preventive models of

Lisa Simon, M.D., D.M.D., *is a fellow in oral health and medicine integration at the Harvard School of Dental Medicine, a resident in internal medicine at Brigham and Women's Hospital, and a faculty affiliate at the Harvard Medical School Center for Primary Care.*

The Journal of Law, Medicine & Ethics, 49 (2021): 89-91. © 2021 The Author(s)
DOI: https://doi.org/10.1017/jme.2021.14

management independent of benefit to patients. Shifts to value-based payment models that are becoming standard in the rest of the healthcare system remain rare in dentistry, due to slow adoption of quality metrics and diagnostic codes, but primarily a reticence to change on the part of most dental practitioners.[9]

Although most Americans receive their dental care in the private practice setting, governmental, legislative, and health systems changes are making progress in reconciling dental delivery with wider health policy trends. The Health Resources and Services Administration (HRSA) implemented an Oral Health Strategic Framework from 2014 to 2017, the first goal of which was to integrate oral health delivery into primary care, and which resulted in increased funding for health center dental programs, dental schools, and integration pilots.[10] Private payers with sufficient subscriber bases, such as Kaiser Permanente, have demonstrated the feasibility of using more integrated dental practices to identify unmet preventive health service needs, such as providing flu vaccines during a visit.[11] Oregon's Medicaid Coordinated Care Organizations (CCOs) are funding dental delivery as part of capitated payments for overall health maintenance, rather than a fee-for-service carveout. Even Medicaid ACOs that continue to fund dental care through parallel fee-for-service systems, such as Massachusetts, are implementing oral health quality metrics that put the onus for compliance on the medical system, bypassing dentist reluctance. A commonality of these integrative initiatives is their origin outside of dentistry itself, representing in some ways a shift towards external professional regulation just as potentially transformative as venture capital-owned dental practices.

Initiatives to reintegrate oral healthcare back into the broader healthcare system are often justified by claiming that doing so will improve health outcomes for patients with chronic conditions such as diabetes or during pregnancy, or will ultimately result in cost savings for payers. Yet studies have been at best inconclusive.[12] That the pain, shame, and suffering caused by poor oral health impacts well-being should be intuitive; the fact that this is not considered sufficient justification for more robust dental infrastructure and access is a testament to the completeness of the historical rupture between dentistry and medicine.

Painless Parker was known to wear a necklace of 357 teeth that he claimed to have extracted in a single day. There are modern echoes of such dehumanizing sensationalism in newspaper aerial photographs of the volunteer dental clinics held in gymnasia or on race tracks across the country, where thousands wait hours for a free tooth extraction conducted on folding chairs.

Much of the resistance for legislation that could increase oral health equity in the US has come from organized dentistry, which has waged state and national campaigns to prevent the adoption of mid-level dental providers,[13] prevent the development of a single-payer health system, and to keep dental coverage out of Medicare.[14] Yet in the midst of the COVID-19 pandemic, the American Dental Association released a statement affirming that dentistry was essential care, urging state regulators to allow dental practices to reopen with minimal restrictions after several months of imposed closures.[15] While such a move was at least in part economically motivated to increase revenues for struggling member dentists, the rapid rebound in dental volume, at rates far greater than other ambulatory services, suggests that the public is also eager for dental care.[16]

Dentistry is at an ethical crossroads of its own making, made more extreme by the neoliberal market forces described by Cajee. Is dental care a valuable commodity on the open market, or essential health care? The conclusions reached by the profession and by the public will drive the future of oral health.

Dentistry is at an ethical crossroads of its own making, made more extreme by the neoliberal market forces described by Cajee. Is dental care a valuable commodity on the open market, or essential health care? The conclusions reached by the profession and by the public will drive the future of oral health.

Note

The author has no conflicts to disclose.

References

1. N. Cajee, "Disruptures in the Dental Ethos: Neoliberal Logic at Work," *Journal of Law, Medicine & Ethics* 49, no. 1 (2021): 77-88.
2. L. Simon, "Overcoming Historical Separation between Oral and General Health Care: Interprofessional Collaboration for

The Journal of Law, Medicine & Ethics, 49 (2021): 89-91. © 2021 The Author(s)

Promoting Health Equity," *The AMA Journal of Ethics* 18, no. 9 (2016): 941–949, doi:10.1001/journalofethics.2016.18.9.pfor1-1609.
3. M. Vujicic, T. Buchmueller, and R. Klein, "Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services," *Health Affairs* 35, no. 12 (2016): 2176–2182, doi:10.1377/hlthaff.2016.0800.
4. National Association of Dental Plans, "2019 NADP Dental Benefits Report," (NADP: Dallas, TX, 2019), *available at* <https://knowledge.nadp.org/products/2019-dental-benefits-report-provider-networks> (last visited January 21, 2021.)
5. A. Willink, N. S. Reed, B. Swenor, L. Leinbach, E. H. DuGoff, and K. Davis, "Dental, Vision, And Hearing Services: Access, Spending, And Coverage For Medicare Beneficiaries," *Health Affairs* 39, no. 2 (2020): 297–304, doi:10.1377/hlthaff.2019.00451.
6. E. A. Mertz, C. D. Wides, A. M. Kottek, J. M. Calvo, and P. E. Gates, "Underrepresented Minority Dentists: Quantifying Their Numbers And Characterizing The Communities They Serve," *Health Affairs* 35, no. 12 (2016): 2190–2199, doi:10.1377/HLTHAFF.2016.1122.
7. A. Veerasathpurush, S. Rampa, M. K. Lee, A. Veerajalandhar, and R. P. Nalliah, "Hospital-Based Emergency Department Visits Involving Dental Conditions: Profile and Predictors of Poor Outcomes and Resource Utilization," *Journal of the American Dental Association* 145, no. 4 (2014): 331–337, doi:10.14219/jada.2014.7.
8. K. Nasseh, J. R. Bowblis, M. Vujicic, and S. S. Huang, "Consolidation in the Dental Industry: A Closer Look at Dental Payers and Providers," *International Journal of Health Economics and Management* 20, no. 2 (2019): 145-162, doi:10.1007/s10754-019-09274-x.
9. E. M. Obadan-Udoh, J. M. Calvo, S. Panwar, et al., "Unintended Consequences and Challenges of Quality Measurements in Dentistry," *BMC Oral Health* 19, no. 1 (2019): 38, doi:10.1186/s12903-019-0726-4.
10. United States Department of Health and Human Services, Oral Health Coordinating Committee, "Oral Health Strategic Framework, 2014-2017" (Washington: DHHS, 2019).
11. J. Snyder, "Kaiser Permanente: Integrated Value Based Care Model," in *Evolving the Dental Public Health Landscape: Interprofessional Practice and Value-Based Care* (San Antonio: American Institute of Dental Public Health, 2019).
12. H. W. Elani, L. Simon, S. Ticku et al., "Does Providing Dental Services Reduce Overall Health Care Costs? A Systematic Review of the Literature," *Journal of the American Dental Association* 149, no. 8 (2018): 696–703, doi:10.1016/j.adaj.2018.03.023; W. Liu, Y. Cao, L. Dong L, et al., "Periodontal Therapy for Primary or Secondary Prevention of Cardiovascular Disease in People with Periodontitis," *Cochrane Database of Systematic Reviews* 12 (2019), doi:10.1002/14651858.CD009197.pub4; S. P. Engebretson, L. G. Hyman, B. S. Michalowicz, et al., "The Effect of Nonsurgical Periodontal Therapy on Hemoglobin A1c Levels in Persons with Type 2 Diabetes and Chronic Periodontitis: A Randomized Clinical Trial," *JAMA* 310, no. 23 (2013): 2523–32, doi:10.1001/jama.2013.282431.
13. L. Simon, R. B. Donoff, and B. Friedland, "Dental Therapy in the United States: Are Developments at the State Level A Reason for Optimism or a Cause for Concern?" *Journal of Public Health Dentistry* (2020), doi:10.1111/jphd.12388.
14. American Dental Association, "Current Policies, Adopted 1954-2019," (2020), *available at* <https://www.ada.org/~/media/ADA/Member%20Center/Members/current_policies.pdf> (last visited January 21, 2021).
15. M. B. Versaci, " ADA: Dentistry is Essential Health Care," *ADA News*, *available at* <https://www.ada.org/en/publications/ada-news/2020-archive/october/ada-dentistry-is-essential-health-care> (last visited January 21, 2021).
16. ADA Health Policy Institute, "COVID-19: Economic Impact on Dental Practices Week of September 7: Report," (ADA: Chicago, IL, 2020).

The Journal of Law, Medicine & Ethics, 49 (2021): 89-91. © 2021 The Author(s)

https://doi.org/10.1017/jme.2021.14 Published online by Cambridge University Press