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TABLE OF CONTENT

Editorial	3
Julian Warter	
Culture Differences and Trust	5
Paulo Finuras	
The Pre-M&A Stage: Understanding the Phases and Success Factors	13
Rachel Calipha, David Brock	
Life's a Box of... Conversations: The Company as a Language Network	35
Thomas D. Zweifel	
How Could We Turn a Good Idea Into an Effective Action? From Human Security to Interpersonal Securitization	43
Anton Carpinski	
Laughing Matters: When Humor is Meaningful	55
Hershey H. Friedman, Linda Weiser Friedman	
Inequities in the Romanian Society of Today	73
Melentina Toma	
Dental Healthcare Accessibility in Underprivileged Populations.....	81
Oana Isailă, Hostiuc Sorin	
Book Review	87
George Simons	
Book Review	89
George Simons	

DENTAL HEALTHCARE ACCESSIBILITY IN UNDERPRIVILEGED POPULATIONS

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Abstract

Underprivileged populations, a constant component of society, face distinct medical issues. The medical issues faced by patients from underprivileged groups has some particularities derived from specific economic and social particularities (food scarcity, decreased financial resources to access quality healthcare), risk factors (poor dieting, smoking) and a de-emphasis of prophylactic measures (due both to financial reasons as well as a lack of medical information); additionally, these factors are augmented by a healthcare system with insufficient resources, which tends to prioritize life-saving procedures. Dental healthcare is mostly private, and an optimal access to it requires significant financial resources; additionally, the public system is largely unknown to the masses and only insures a few basic dental procedures. The main aim of this paper is to perform an ethical analysis of the problem of access to dental healthcare (both prophylactic and therapeutic) in underprivileged patients (from a socio-economic point of view), depending on the type on the model dental practitioner-patient relationship.

Keywords: poverty; dental ethics; models of dental-patient relationship

Introduction

The relation between socio-economic status and personal health status is bidirectional – a lower socio-economic status decreases overall health and increases the burden of disease, while in the same time a poor health may decrease the chances of social and economic integration (Comber, Brunson, & Radburn, 2011; Grundy & Sloggett, 2003).

The National Institute of Statistics of Romania defines poverty as the related to “people whose income is so low that achieving a living standard considered acceptable in the society they are living in is impossible, and are facing multiple disadvantages such as unemployment, low income, poor living conditions, inadequate healthcare and have barriers in accessing education, culture, sport and leisure activities.”(Cuturela, Toma, Gheorghe, & Simion, 2018) According to the National Institute of Statistics, during 2018, in Romania, the rate of relative poverty was 23.5% (about 4.603.000 people).(Cuturela et al., 2018)

According to the Romanian Law concerning the prevention and punishment of all forms of discrimination “*an underprivileged community is that category of people who are either in a position of inequality compared to the majority of the population because of being identified as different compared to the majority, or are confronted with rejection and marginalization*”(Law nr. 116 concernig preventing and fighting against social

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marginalization, 2002). According to the same law “ (...) by discrimination we infer any difference, exclusion, restriction or preference made on race, nationality, ethnicity, language, religion, social class, beliefs, gender, sexual orientation, age, disability, non-transmissible chronic illness, HIV status, belonging to an underprivileged community or any other criteria which has as purpose and/or effect the restraining, the elimination of acknowledgment, use or effect, equally, of human rights and of the basic liberties or of legally accepted rights in the fields of politics, economics, society, culture as well as any other aspects of public life”(Law nr. 116 concerning preventing and fighting against social marginalization, 2002).

Social marginalization, in turn, is defined as “the peripheral social position of isolation of individuals or groups with limited access to economic, political, educational and communicational resources of the community. It is manifested through the absence of the minimum social requirements of living” (Law nr. 116 concerning preventing and fighting against social marginalization, 2002). According to the same law, regarding healthcare access “the access to healthcare for people who have the right to the minimal granted income is confirmed by local councils and assured in conditions established by the social healthcare insurance legislation”(Law nr. 116 concerning preventing and fighting against social marginalization, 2002), while another article enunciates that “for the people mentioned in article 16, it is mandatory for the local councils to provide them with adequate conditions for accessing all form of healthcare, including organizing social service unities in which the people can be cared for until their reinsertion in society.”(Law nr. 116 concerning preventing and fighting against social marginalization, 2002)

The Ethical Code of the Dental Physician analyses discrimination and access to emergency and non-emergency dental healthcare in the following articles: **Art. 14.** „The dental practitioner must listen to, examine and treat all people without discrimination”, **Art. 16.** (1) With the exception of emergency situations, the dentist has the right to refuse a patient due to personal or professional reasons; (2)It is considered a medical emergency if the patient requires immediate medical attention to manage pain, infection or bleeding; in **Art. 17.** - The dental practitioner cannot, without legitimate reason, interrupt an ongoing treatment without taking the necessary measures for the treatment to be continued by a colleague with the necessary competence; **Art. 19.** - (1)Prices must be settled tactfully and reasonably. It is required for the dentist to present an assessment of the costs to the patient before the treatment;(2) It is prohibited to discount dental prices in order to attract clients;(3) The dental practitioner can provide medical services free of charge”(The Code of Ethics of the Dental Physician, Decision 15, 2010). Regarding advertising, the same code states that “The dentist has to participate in the sanitary education of the population, supporting the application of prophylactic healthcare programs. The dentist who participates in such actions will avoid any personal advertising with the scope of attracting patients”(The Code of Ethics of the Dental Physician, Decision 15, 2010).

Barriers to accessibility

Dental procedures can be classified in basic procedures and supplemental procedures. In the basic procedure category are included: those needed to treat medical emergencies, to maintain proper phonatory and masticatory functions and some that are needed for the correction of significant esthetic deficiencies. Some authors include here preventive procedures (floriation, scaling, dental education) and additional procedures needed to attain these goals (such as dental X-Rays) (Ozar, Sokol, & Patthoff, 2018).

These basic procedures cannot be subjected to the laws of offer and demand, because basic dental healthcare procedures should be accessible to everyone. As a result, the price of these procedures cannot be inflated, they should be available for all people who need them, and dentists should offer them even though they specialize in procedures that are more

efficient from a financial standpoint (Benzian & van Palenstein Helderma, 2006; Frencken, Holmgren, & van Palestein Helderma, 2002). These procedures can be distributed according to the need, based on an altruistic model or on a model of social responsibility (Helderma & Benzian, 2006; Laloo, Myburgh, & Hobdell, 1999). Supplemental procedures are any other measures that the patient needs or require (such as cosmetic procedures). These can be analyzed through a model of demand and offer, yet without being a purely commercial one (as the dentist still has to respect professional and ethical requirements of the dental profession).

Underprivileged patients are confronted with numerous obstacles in accessing dental healthcare due to location, communication barriers, limited access to medical information regarding prophylaxis, the absence of financial resources. Regarding location, many patients live in either rural areas, with a very low density of dental practitioners, or in poor urban areas, again with limited proximity to quality dental healthcare. Sometimes, the dental practitioner does not live in the area that is served by him/her, therefore decreasing the access to emergency healthcare (which is not readily available, but rather possible only when the physician is in hours). The communication barrier is caused by a decreased understanding of the specialized jargon by the patient, which appears (1) when they are from different nationalities (an instance that increases everyday due to a net emigration of Romanian physician in Western Europe, and a net immigration of physicians from neighboring countries (such as Ukraine or Moldavia), but also from Asian and African countries in Romania, and (2) when there is a deficit in the usage of a linguistic apparatus that is not properly understood by the patients (not only regarding the forms of the wording, but also the actual meaning of the given information). It has to be emphasized here that physicians are fully responsible for giving the patients the correct information, and to check whether it is properly understood by them, and any deficit in this regard generates legal liability for the dental practitioner.

A lack of information regarding prophylaxis, associated with a lack of material resources makes this group less prone to identify early dental pathologies which, not treated in due time, lead to major issues increasing the overall costs.

Some of the above-mentioned barriers can be decreased by specific actions implemented by the dental practitioners, or which may depend, in a variable degree, by their actions (or inactions). The first main action that can be taken by the physician is to obtain a proper informed consent for each procedure, based on a proper information (correct from a medical point of view, but also performed taking into account the psychology and intellectual capacity of the patient), a satisfactory understanding of the information that is given by the physician (that should be checked by the physician repeatedly while discussing with the patient), and while fully respecting the autonomy of the patient in the decision-making process (Hostiuc & Buda, 2018).

A second action is for the physician to *eliminate communication barriers*. To earn the patient's trust and to eliminate barriers in communication, the physician should (1) understand the social context of the patient – giving the necessary attention to the living conditions and spiritual values of the person, since that is the basis of their needs and medical expectations; (2) reserve enough time for a proper discussion with the patient, regarding not only the procedure, but also other issues the patient deems important; (3) have empathy, which brings closer the patient to the physician (in particular) and the dental profession (in general), and it significantly increases therapeutic compliance and trust (Slote, 2007); (4) avoid moralist attitudes - the role of the doctor is to make people better, to understand and accept the particularities of particular cases in order to manage them in a given socio-economical context and not to judge the decisions of the patient, decisions which have been imposed by their unfortunate social or economic status; (5) overcome social distances - the doctor must

not display a pretentious and superior attitude and attire, as underprivileged people feel stigmatized anyway and elements that could accentuate this notion and alienate the patient by having their trust in the doctor diminish must be avoided; (5) favor direct, personal contact with the patients, by not mediating the relation between these two parties through a third one, even if it is a healthcare staff, as it might create a false impression that the medic belongs to 'another world', a foreign one that has nothing to do with the patient must be eliminated(Loignon et al., 2010).

The validity of the main models of dental physician-patient relationship in underprivileged persons.

The equitable distribution of resources on a populational level in dentistry is made using four main models: depending on the need, a partially altruist model, through the concept of social responsibility and by the law of offer and demand.

The model of distribution depending on need is in limited use, being applicable only for procedures that are state funded, which are a very small percentage from the total dental procedures carried out nationally nowadays.

The model based on a partial altruism considers that is needed a partial redistribution of the financial benefits of dental practice (ideally toward people disadvantaged to the lottery of life, based on the principle of Rawlsian justice) (Rawls, 2009). According to this principle, dental practitioners have a duty to be altruistic(Steinmann, Sykora, & Wiesing, 2009), at least in some circumstances (Holden, 2013). Jos Welie argues that this altruism is important as there is an important imbalance between the dental practitioner and the patient, disequilibrium that is caused not only by a differential of medical knowledge, but also by needs (the patient has a significantly higher need – medical, than the physician – financial or scientific). Basically, there is an increased risk for the physician to attach a higher value on the financial part of his profession, that deemphasizes the intrinsic value of the results of his profession (to make the patients better)(Welie, 2006). This altruism allows a better positioning of the dental practitioner as a professional and not only as a commercial provider of services. This issue has been analyzed, as an example, in kindergartens, where the educators, fed up of staying after hours because parents could not make it in time to take their children, have imposed a financial penalty for those who were late. As a result of this action, parents began to be late more often, as they considered it normal, the educators being paid for it. Therefore, a taxation of an altruistic practice from a professional that was abused and which was seen as a form of discouragement, generated a commercialization of the practice from the parents(Sandel, 2009). This partial altruism is specifically detailed in the Code of Ethics of the Dental Practitioners, where is stated that “The dental physician can give free medical care”, without however for this practice to be used as an anti-trust practice, the same Code saying that “It is forbidden to give discounts to attract clientele”(The Code of Ethics of the Dental Physician, Decision 15, 2010). This altruism is only *partial*, as it is not reasonable to ask from a dental physician (or any other type of professional) to be unable to provide his/her means of subsistence only in order to act virtuously, and by that to solve a system problem, such as the problem of limited access to oral healthcare(Ozar et al., 2018), and optional, as this altruism cannot be imposed to a professional, who uses material (costly) resources and his own time to treat the patients.

According to the model of social responsibility, the access to the dental practitioner is highly dependent on the economic status of the patient, which causes a direct correlation between socio-economic disparities and inequalities in providing dental healthcare. Based on this concept, dental physicians have a moral obligation to provide free medical care in emergencies, irrespective of the financial possibilities of their patients. Therefore, as an example, if the patient has dental pain or a dental abscess, the treatment should not be

conditioned by the possibility to pay (Welie, 2006). This of course, does not mean that the dental professional should not be reimbursed, if possible. Also, upon this model, dental professionals have a moral obligation not to select patients depending on their financial resources, or upon other potentially discriminatory criteria. This does not mean that patients are not allowed to preselect themselves, depending on their known financial resources, by analyzing the estimated costs of the treatment (which they should know before beginning the treatment).

According to the law of offer and demand, which is prevalent in the private system (even though often not so conspicuous), dental professionals provide services, that are solicited by their patients, depending on their needs, and mediated by a cost-benefit analysis. This model does not optimize dental care at a populational level because (1) not everybody needing dental procedures can afford them and (2) not everybody can afford the best dental procedures for their particular disorders. This model is very advantageous for the professionals, which may be able to maximize their financial benefits in relation with the time and resources spent, but also depending on the financial resources of their patients. To minimize the risk of situations in which the patients will benefit from suboptimal treatments, dental professionals are obliged to respect some ethical principles that (1) insure a minimal protection of the patients, and (2) limit somehow the liberties of the dental practitioners in a purely commercial market. For example, the articles from the Code of Ethics of the Dental Physician regarding advertising are trying to limit potential anti-trust practices, by limiting the way financially potent dental practices use advertising for promotional purposes, while allowing at the same time a fair playground for less financially potent dental practices (including dental physicians at the beginning of their carrier).

From the four above mentioned models, it is obvious that the last one generates a suboptimal model for providing dental care to underprivileged patients, not only by limiting the access to curative treatments, but especially through a lack of information regarding preventive dental care. Therefore, at least where is the most widely used, it should be associated with populational, educational programs, directed toward the maximization of preventive measures, which overall decrease the cost of dental care significantly.

Conclusions

There are numerous factors influencing dental care for underprivileged populations, which should be analyzed, and specific measure should be taken to provide optimal dental healthcare reported to a specific cost standard.

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