DISCURSIVE CONSTRUCTIONS OF SOCIAL RESPONSIBILITY

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ABSTRACT

There is a widespread concern that the dental health care system in North America sustains an inequitable opportunity for accessing care. In response, the term *social responsibility* appeared in the dental literature, but it is not clear how it is understood and enacted, particularly within the context of a growing desire to enhance access to oral-health care through an affordable, equitable and practical system of delivery. Using an interpretive ethnographic approach, and the analytical and critical techniques of discourse analysis, I studied how 34 participants, comprising dental educators, dentists in private practice, and those in leadership and governance of dentistry, spoke about and accounted for social responsibility in relation to their sense of how the dental health care system operates or should operate and why they see and do things in one way and not another.

Competing professional, social, economic, and political views unveiled the moral and practical explanations the participants used to justify their position on social responsibility in dentistry. My findings reveal four competing discursive constructions of social responsibility in dentistry, situated within discursive spaces intersected by individual and collective notions of social responsibility on the one hand, and the acceptance and challenge of the status quo on the other. Each space occupies a range of accounts to explain, rationalize and justify particular viewpoints on social responsibility. The responsibility to treat pain, regardless of compensation, was a social responsibility that was held sacrosanct, and considered a widely accepted code among dentists generally and within dentistry in particular. It provided an agreed upon discursive space in talking and thinking about social responsibility. Problems emerged when particular discursive constructions of social responsibility took on a sense of what was considered so 'natural' and conclusive so as to be unassailable from any other position. There is an obvious tension between competing discourses and the associated constraints and challenges of accepted and dominant norms within dentistry, and the participants' sense of their rights and responsibilities.

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CHAPTER ONE

INTRODUCTION

The doctor was closing his bag now. He said,

"When do you think you can pay this bill?"

He said it even Kindly.

"When I have sold my pearl I will pay you," Kino said.

"You have a pearl? A good pearl?" the doctor asked with interest.

John Steinbeck, *The Pearl*

Refusing care to the poor

The impetus for this dissertation comes from a series of events that has essentially denied access to dental care for a particular segment of the population in British Columbia. In 1997, many dentists in B.C. chose to refuse what they considered inadequate reimbursements for patients on governmental social assistance—a reaction that was endorsed publicly at the time by the local dental association. Patients who had previously been treated at a reduced payment rate relative to non-assisted patients found themselves requiring basic care but being unable to afford it. They were placed in the adverse position of either having to do without care or to pay with money that would otherwise go to their basic necessities of daily living.

The refusal by dentists to treat patients on social assistance also affected my practice. While providing professional dental hygiene services for a private dental office in Vancouver, B.C., I was told by the proprietary dentist that I was to inform patients that he (which inevitably also meant me) would no longer see them unless they paid their fees up front. The dentist was asking patients to pay directly for the treatment received because he too was convinced that the reimbursement from the government was inadequate for the services he provided. In that office alone, the dentist's change in payment scheme affected at least 300 patients who felt that they could not meet the dentist's request for immediate payment.

There has been an ongoing dispute concerning dental fees for treatment of patients on social assistance between the Ministry of Human Resources (MHR) in the Provincial Government and the British Columbia Federation of Dental Societies (BCFDS) representing dentists. BCFDS recommended that dentists stop accepting new dental patients on social assistance until the Ministry agreed to a reimbursement plan according to the Dental Federation's Fee Guide (Dunnigan 1996). As a result, since 1997, patients on social assistance have difficulty identifying dental clinics that accept the Ministry's fees. This problem is seen as another manifestation of the long-standing difficulties in accessing dental care experienced by low-income groups, and those who are handicapped, homeless, institutionalized, or otherwise disenfranchised (Gelberg 1988; Locker & Leake 1993; MacEntee, Thorne, et. al. 1999; Milano & Seybold 2002; Miura, Yoshima, et al. 1997; Petersen 1990; Waldman 1995).

Yet, it has been suggested generally that dental services are, or at least should be, part of the basic fabric of the health care system, and that dentistry should be accessible to all, including the poor and the underprivileged (Canada 1995; Evans & Williamson 1978; Harmon 1993 92; Locker & Leake 1993). Indeed, this position appears to be in agreement with the idea of "health for all" that had widespread appeal as a fundamental right in Canada (Epp 1986). So, why does the dental profession insist on a system that offers such inequitable opportunity for care?

A brief historical overview of the Canadian health care system and the position of dentistry within it points to some of the issues affecting equitable access to dental care.

The Canadian Health care System

The Canadian health care system is founded on a social objective to reduce or eliminate the financial barriers to health care, and to help improve the health of Canadian citizens through equitable access (Crichton 1980). It is not *free* to society; it is funded from public taxes through a system of national health care insurance. The country's ten provinces and two territories each have a publicly funded insurance scheme connected nationally, resulting in a collective Medicare system. A constitutional arrangement allows each jurisdiction governing responsibility over health care, while national standards and financial support are arranged through a cost-sharing program determined at the federal level (Crichton, Hsu, et al. 1990).

The system permits physicians to operate a private practice with payment by the government on a fee-for-service basis negotiated through a fee schedule that varies from province to province. Charges are instituted primarily through an electronic billing system. The health services extend predominantly to hospital and medical care, although in some provinces peripheral services are offered through partial coverage (e.g. pharmaceuticals, massage therapy and chiropractic care). Each province governs its own health plan, with assistance from the federal government, which sets national policies and provides supplementary funding. The federal government is responsible also for services to registered Aboriginal peoples and to the military.

The Canada Health Act (1984) stipulates five "pillars" that all provincial health plans must uphold to receive federal supplements:

1. *Universality* — Coverage for all residents of the province;
2. *Comprehensiveness* — Coverage of all health services provided by hospitals, physicians and, where included in a province, additional services provided by other health care practitioners;
3. *Public Administration* — The plan must be administered on a non-profit scheme by a public authority who is responsible to the provincial government;
4. *Portability* — Canadian residents are entitled to full coverage when temporarily absent from their home province; and limited coverage as stipulated by each province for services outside of Canada;

5. *Accessibility* — All provincial plans must provide reasonable access to necessary care without discrimination based on income, health status or age.

In 2003, Canada was rated eighth (it was rated first in 1997 and has dropped steadily since) by the United Nations Development Program's Human Development Index, which measures life expectancy, educational attainment and adjusted income. However, it rates tenth of seventeen in the Human Poverty Index. This means that the degree of poverty in this country is greater than it should be given its level of development. Canada has the second highest rate of child poverty (21% of Canadian children live in poverty) compared to other industrialized countries (Centre for International Statistics 1998). Moreover, there is a growing body of related research that links poverty with health status (Feinstein 1993; Najman 1993; Roberge, Berthelot, et al. 1995). The research shows that the poor, compared to the affluent, have higher mortality rates, and experience more chronic medical conditions and symptoms of illness and disease (Kennedy, Kawachi, et al. 1996; Millar & Beaudet 1996). It is not just poverty, however, but also the relative gap between the rich and the poor, and the greater the gap the poorer the nation's health (Wilkinson 1996). Because of this, Canadians have generally always considered health and health care as, first and foremost, social concerns (Shillington, 1972).

Interestingly, however, oral health care has remained noticeably peripheral to the general health service. In order to understand why and how this happened it is important to trace briefly the history of the development of the health care

system under the umbrella of social security in Canada, and the influence of professional, economic, and political factors on it.

Origins of the social security concept

Health, it is argued, is a societal concern that, at the very least, affects an individual's capacity to function as a productive and contributing citizen, member of a family unit, and part of the socio-economic system (WHO 1999; UN 1973). Social security, therefore, represents a system of protection to individuals from social, political and economic problems. It is not a new concept. The provision of health care as a social security measure within an organized social system dates back to early Egyptian and Greek civilizations where physicians were hired by the state to treat its citizens without charge (Mirko 1998). During the European Middle Ages, the medieval church was instrumental in providing health and general care to those in need. The influence of Christian theological beliefs about helping the less fortunate through charitable acts provided a clear motivation for caring for the sick and poor, particularly since such acts ensured prospects of personal salvation (Owen 1965; Pemberton 1990). Some felt, however, that charitable activity in the shadow of self-interest (i.e. seeking personal salvation) marred a truly altruistic intent (Page 1996). Furthermore, the eligibility criteria for determining who would receive charity was also a topic of much debate. Some advocated an unconditional charity system while others insisted on a discretionary system to weed out fraudulent claims from healthier individuals, those of dubious character, and from the 'undeserving' poor—the infidels and excommunicates (Tierney 1959).

The 16th and 17th centuries also saw a division between the religious and secular segments of society, particularly within the context of economic activity. Calvinist theology introduced more positive, virtuous interpretations of entrepreneurial activity and the pursuit of wealth (Weber 1976). Financial betterment through honest hard work was considered righteous and honourable, thus changing the conceptions of poverty. Private and government sponsored charity rendered *carte blanche* were seen as systems that compromised accountability by sustaining dependence and discouraging responsibility as a productive member of society. Unfettered disbursements of charity were thought to breed slothful and immoral characteristics among the poor who were already seen by some as a burden on society. Thomas Hobbes, John Lock, Adam Smith and others were most influential in advocating minimal state and political involvement in personal, family and business matters. However, in the latter part of the Industrial Revolution (1870's and 1880's) the idea of the "common good" emerged, leading to a socio-political view that the state ought to "accept wider social responsibilities" (Humphreys 1995). There was increasing acceptance that the poor may be more than simply lazy and immoral and that they "could occasionally suffer misfortune which deserved help and guidance from their betters" (pg. 4). Several social, professional and religious associations or guilds also contributed voluntarily a set sum of money toward a form of protection that could provide assistance to its members who became incapacitated due to illness:

> If it should happen that any of the guild becomes infirm, bowed, blind, dumb, deaf, maimed or sick, whether with some lasting or only temporary sickness,

> and whether in old age or youth, or be so borne down by any other mishap that he has not the means of living, then for kindness sake, and for the soul's sake of the founders, it is ordained that each shall have out the goods of the guild, at the hands of the wardens, sevenpence every week; and everyone so being infirm, bowed, blind, dumb, deaf, maimed or sick, shall have that sevenpence as long as he lives (pg. 4).

In 1601, Britain passed the Elizabethan Poor Law allowing for a general taxation system to ensure medical care for the poor and infirm. Over time, societies developed more sophisticated arrangements, which today have evolved into publicly as well as privately funded health insurance schemes as a way to meet society's basic need to protect individuals from sickness.

The advent of a publicly financed system in Canada

The impetus for a publicly funded system in Canada came post World War II. Canada lagged other Western European countries in making health care economically accessible to its citizens (Wilensky 1975). The United States was ahead in thinking about and developing health insurance legislation, but never implemented it (Anderson 1972). Although the idea of publicly funded Canadian health insurance had been a topic of discussion since 1919, it was not established until 1968. Until then, cost was a significant barrier to accessing care. Initial conceptions of health insurance focused on its risk-sharing nature such that the poor would receive state subsidized care and the more affluent would be required to pay. Physicians did not object to such an arrangement provided it did not interfere with their private practice and fee structure (Torrance 1981). The Canadian Medical Association was uncomfortable with the idea of government or lay control of their endeavours, just as in the United Kingdom where the medical association struggled to prevent interference in professional matters by

organized third parties (Peterson 1978). Canadian doctors made a concerted effort to run for political office and doctors infiltrated local, provincial and federal health departments in order to influence related government policies (Taylor 1960).

During the early 1900's the Canadian government tended to favour a "market-ethos" and hesitated to intervene in the lives of citizens through any comprehensive social welfare mechanism (Bryden 1974). Torrance (1987) provides a comprehensive socio-historical overview of the subject. He adds that the government at the time was "a creature of the economic elite and was preoccupied with creating the conditions for economic growth" while "the resistance of individuals and corporations to taxation made it inconceivable to many government leaders that state resources could be found to finance social-welfare schemes" (pg. 19). The Great Depression, however, soon changed that. During the depression, poverty and poor living conditions gave rise to numerous communicable health problems that spread throughout the population. Poverty-stricken and ill people inundated the hospitals but could not pay the expenses; this also meant that doctors were not being paid. As a result, the government instituted medical relief plans to compensate doctors with at least some level of income (Torrance 1987). These desperate times influenced politicians to consider seriously the options for a government sponsored national health insurance system.

The Canadian Medical Association (CMA) reacted quickly by producing a report that established a number of principles they felt would be essential to a

health insurance program. Although the report did not object to governmental involvement in financing health insurance it made clear however that the profession would not allow any interference to disturb its professional autonomy. Professional control over the system was closely guarded. The change to a publicly financed system was said to infuse a stronger sense of humanity among Canadian doctors (Evans 1973). Doctors generally favoured government finances for patients who could not pay, but they opposed governmental control of the delivery of services as well as payment for services to patients who did not need public assistance. For example, the CMA wanted a non-political commission to administer any proposed system, with majority representation by physicians, as well as a payment method determined by the physicians. They insisted on control over fee schedules and compulsory coverage for those under a certain income level (Taylor 1987). Tensions between federal and provincial governments, professional demands, and a country in economic crisis due to the Depression, inevitably hindered social development and further progress in instituting a publicly financed health care system.

Publicly financed health insurance only became a reality when Saskatchewan, through the first social democratic elected provincial government in Canada, instituted legislation to establish such a program. It was established under a social philosophy that declares health care as an inalienable right not to be constrained by financial, political, professional, demographic, or any other factors (Taylor 1987). Within this system health care professionals were expected to act not opportunistically, but in primary consideration of the public

they serve (Barer & Evans 1992). Still, conflicts in values between the medical profession and governments over who should control the health care system and how physicians should be reimbursed continued. Moreover, the *a priori* social imperative of a national health care insurance drew criticism from some economists who believed that the government instituted this measure without considering its economic consequences (Detwiller 1972). Those who favoured the scheme maintained that the decision to include health care within the Canadian social system is rooted in moral rather than economic or political principles (Crichton 1980). The primary reason for national health insurance, it was argued, was to facilitate equity and access to hospital and medical services without constraints based on ability to pay. The understanding was that the goal of public policy in introducing a universal, comprehensive, and government administered system stems from the principle of equity above all else (Thatcher 1981).

Based on an extensive survey of universal health insurance in Canada, Thatcher (1981) shows that the system of national health insurance removed economic barriers to accessing health care, "not only for the poor, but for the working poor, for the thrifty immigrant saving to buy a house, for the farmer who had a bad harvest, the low-paid recent college graduate with a young family, the unemployed during a recession, and the retired on fixed incomes during inflation...(so that)...no Canadian citizen (had) to go begging to the welfare department to pay a hospital or doctor's bill" (pg. 1). Yet, from time to time, however, "deterrent" co-payment systems were introduced by some provinces to

reduce potential over-consumption of health services, but research suggested that all this did was deter the poor and socially disadvantaged from accessing services while overall utilization of services went unchanged (Stephens 1975). Health care in Canada, therefore, evolved under a *Social Security* system that encompasses also a range of welfare, unemployment, and pension schemes. Hence, much of the discourse in the literature on the development of publicly funded health care is situated clearly in fundamental notions of equal access and dignity.

Even so, on-going debates on the Canadian health care system focus heavily on the continuing escalation in health care costs, adequate reimbursements to health care providers, and the role of government in cost containment (Canada 1998). Media coverage on the state of the health care system in the late 1990s was replete with warnings of a "crisis" resulting from cost-cutting by governments, growing wait-lists and the dramatic decline of timely access to care (Sass 1999). The Canadian public is suspect of the government's ability to sustain Medicare, making it a passionate topic of political debate. Nevertheless, Canadians are considered to have the best health care system in the world in terms of universality, accessibility, comprehensiveness, portability, and public administration (Brown 1983; Peck 1999). However, health service funding continues to be presented as a "challenge" for governments facing increased deficits over time. There is always talk about containing costs and increasing efficiency toward improving quality of care. It is argued still, however, that equity and neither cost control nor professional autonomy should be the

governing principles to determine the health care system as a social security measure (Evans, Barer, et al. 1994).

Dental Health Care in Canada

Similar issues plague the dental health care system in Canada. There is mounting evidence that certain segments of the population (First Nations people, elders, low income groups, or those in poor health) are particularly disadvantaged from accessing dental services compared to medical services (CAPHD 2001; MacEntee et al. 2001). Apparently, decisions to visit dentists are strongly influenced by level of income, and are less likely to be made by frail elders and those with less education. More significantly, those without the means to pay feel unwelcome and rejected by some dental practices. Although the problem of access to care is not just about affordability, there has been very little done to resolve the problem of poverty and its impact on access to dentistry (Croucher 1988; Lewis 1992). It is embedded within the larger context of social, economic, professional and political agendas of the general health care system (Dummet 1971; Dussault 1981; Fox 1986; Freidson 1970). The recent disenfranchisement from dental care of those on social assistance in British Columbia is a striking example. The problem is due also in part to the fact that dental health care has not been a priority from the perspective of overall health care in Canada or in North America generally, where, essentially, it is left to the private enterprise of dentists (Evans & Williamson 1978; Evans & Law 1991; Locker & Leake 1993). Moreover, the problem of access to dental care is thought to be largely perpetuated by issues of professional, economic, educational,

political and policy decisions that place a low emphasis on public health concerns (Bagnall 1952; CDA 1996; Eggleston 1996; Feldstein 1988; Gullett 1952; Jamous & Peloille 1970; Larkin 1980; Madden 1965; Nash 1996; Spaeth 1990; Satcher 2000).

The dental health care system as it is currently structured is seen to give certain segments of the population an unfair advantage in access to care (Atchison 1997; Bolden, Henry, et al. 1993; Field & Jeffcoate 1995; Fredericks, Lobene, et al. 1980; Glassman, Miller, et al. 1996; Grembowski 1997; Gullett 1971; Harmon 1993; Harper 1994; MacEntee, Wiess, et al. 1991; Petersen 1990; Thaul, Lohr, et al. 1994). From a financial point-of-view, the contention is that dental care has been tied historically to service delivery through the fee-for-service private dental office, by which only the more economically stable individuals are served (Crichton, Hsu, et al. 1990; MacEntee, Weiss, et al. 1992; Millman 1993;Greenlick 1995; Stamm 1981).

Many see the problems stemming from the development of dental health care and educational policies around the priorities of professionals, rather than those in need of care (Becker, Greer, et al. 1961; Croucher 1988; Freidson 1983; Fox 1986; Larkin 1983; Lewis 1992; Light 1988; Ludmerer 1985; Shugars, O'Neil, et al. 1991). There is mounting documentation that elements of autonomy, professional power, status, control and income are key factors in influencing the health care environment (Baszanger 1985; Capilouto 1995; Daniel 1983; Foucault 1975; Johnson 1972; Larson 1977; Macdonald 1995). It is argued that

the professions have emerged as products of an industrial society dominated by the market place (Goode 1960; Polanyi 1957; Stein 1996).

The literature on the development and evolution of the dental profession—its struggle for recognition, political power, professional autonomy, and its fee-for-service delivery structure—points also to the ensuing inequities within the dental health care environment (Forbes 1985; Greenlick 1995; Gullett 1971; Locker & Leake 1993; Manga 1997; Williams, Butters, et al. 1990). It indicates that the evolution of the dental health care system has been shaped predominantly by entrepreneurial goals that claim sole control over the delivery and scope of dental service (Barker & O'Neil 1992; Davis 1980; Jamous & Peloille 1970; Larkin 1980) with the intent of preserving professional autonomy along with financial control (Daniel 1983; Dussault 1981; Johnson 1972). At one point it was suggested, "the efficacy of the...College of Dental Surgeons, the educational system, indeed the whole structure of the dental industry and profession, is to be judged by their effects on private practice and by what takes place in the context of private practice" (House 1970). Studies conducted in the late sixties revealed that financial success dominated the ambitions of dental students (Linn 1968; Parrish 1968), and that the dental profession attracted materialistically oriented individuals (Crowder 1966). Sherlock and Morris (1972) summarized this view with the comment that "students are highly motivated to achieve economic and professional status; but (that) they adopt a rhetoric of altruism in order not to disclose these motives." Today, the delivery of dental health care is said to be

geared primarily toward those who can pay while those who are less advantaged are deprived of a comprehensive, high quality services.

The connection between health, oral health and quality of life

Quality of life is a complex and multidimensional concept that has been associated in recent years with the outcome of health care. It refers usually to a mix of biological, psychological and social dimensions of illness from the perspective of the patient (O'Boyle 1997). Its influence on physical functions, emotions, cognitive awareness, life satisfaction and economic status has caught the attention of researchers interested particularly in chronic disease. More recently, the term "health-related quality of life" has emerged to focus on "the value assigned to the duration of life as modified by the social opportunities, perceptions, functional states and impairments that are influenced by disease, injuries, treatments or policy" (Patrick & Erickson 1993). There is no agreement, however, on how this relates specifically to basic care, and, like the expansive 1947 WHO definition of health, it is said to have little practical value for public policy (Evans, Barer, et al. 1994). Nonetheless, the concept of health-related quality of life does have practical meaning within the specific confines of oral health care (Slade 1997). Researchers are finding that oral health is an essential part of the daily comfort, hygiene and general health of older adults (MacEntee, Hole, et al. 1997), and oral health care a constant concern for caregivers in long-term facilities (MacEntee, Thorne, et al. 1999). The literature indicates that it is increasingly more difficult to justify the separation of oral health care from other health services (Damiano, Shugars and Johnson 1992; Dharamsi and MacEntee

2002; Evans and Williamson 1978; Field and Jeffcoate 1995; Locker and Leake 1993).

Despite the apparent insignificance of tooth-loss, a defective dentition can in fact disturb eating, speaking, general appearance and comfort and it can precipitate serious illness (Reisine 1988; Cushing, Sheiham, et al. 1986; Locker & Grushka 1987). Sick-leave is attributed more to dental problems than to most other disorders (Hollister & Weintraub 1993). Dental caries in children disturbs their growth and ability to thrive (Acs, Lodoline, et al. 1992; Ayhan, Suskan, et al. 1996). The Provincial Health Officer in British Columbia disclosed recently that dental treatments are the most common hospital-based surgical procedures, usually involving general anaesthesia, for children under 14 years of age in the province (Provincial Health Officer's Annual Report, 1997). In addition, there is also some evidence linking poor oral hygiene and periodontal disease with coronary heart disease, although a causal relationship has not been established (Mattila, Valtonen, et al. 1995; Beck, Garcia, et al. 1996; Joshipura, Rimm, et al. 1996; Howell, Ridker, et al. 2001). Furthermore, the evidence is mounting that dental health problems are more prevalent, and the consequences more serious, among lower income groups (Charette 1993; Miller, Brunelle, et al. 1987; Szqejda, 1960).

If oral health is an integral part of individual health then to the degree health care matters it must include oral health care. It cannot be a privilege only accorded to a select few. Yet, dental services continue to remain excluded from the protected set of services for which "the fair distribution of benefits and

burdens in society" is a critical principle (Cupit 1998). Consequently, those who cannot access oral health care because of poverty, disability or any socio-economic factors are effectively barred from the reciprocity of communal benefits and burdens (Bolden, Henry, et al. 1993). It has been argued, therefore, that the public good of health care cannot be left to the whim, or distributed in the interest of some powerful group of owners or practitioners (Walzer 1983).

A request for social responsibility

The question that many are now asking is what is the dental profession's responsibility towards impoverished children and adults, towards frail elders, the developmentally disabled, and towards minorities and populations with extraordinary health needs? There is a call for universal access to basic dental services at an affordable cost. It is being suggested that dental profession must develop a more socially responsible curriculum, and that health policies need to reflect a commitment to social responsibility (Formicola 1993; Gershen 1993). The basic premise underlying the discussions on social responsibility is that the dental profession exists to provide health care to everyone, not just those who can pay for service. As a result, over the past decade, requests have surfaced for the adoption of an ethic of "social responsibility" to effect change in the existing philosophy of dental practice, and for health policies and dental education to reflect a commitment to this principle (Barker & O'Neil 1992; Boyd 1993; DePaola 1994; Durbin 1992; Entwistle 1992; Field & Jeffcoate 1995; Gershen 1993; Woolfolk 1993).

Research Questions

Although the term "social responsibility" has appeared in the dental literature, it is not clear how this concept is understood or how it is to be enacted in dentistry, particularly in light of the recent events in B.C. There is no clear view at present of how *social responsibility* is interpreted within the dental health arena. There is a sense that if we are to effect positive change we should know how dentists think about *social responsibility*, and how they position themselves in relation to it (Bolden, Henry, et al. 1993; Durbin 1992; Entwistle 1992; Field 1995; Formicola 1988; Glassman, Miller, et al. 1996; Grembowski 1997; Harmon 1993; Shugars, O'Neil, et al. 1991; Williams, Butters, et al. 1990; Woolfolk 1993).

The following research questions, therefore, form the basis of my study:

1. ***How do dental educators and practitioners understand and talk about social responsibility in relation to issues of access to dental health care?***

2. ***What discursive constructions are invoked as individuals rationalize their position(s) in relation to social responsibility in dental health care?***

I anticipated that these questions would be addressed differently depending on one's values, beliefs, and intentions in relation to the provision of dental health care. I wanted to know, therefore, how the idea of social responsibility is considered within dentistry, how its expression and understanding relates to the issues of access to dental care. I wanted to know how dentists position themselves in relation to a social responsibility for those who cannot normally access dental health care, and how they justify and rationalize their position. The

different ways in which people attend to social responsibility and their expressions and understanding of it will influence and shape the boundaries that define what is acceptable and unacceptable within the community of professional dental practice.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

"As far as the laws of mathematics refer to reality, they are not certain; and as far as they are certain, they do not refer to reality"

Albert Einstein

Knowledge, Understanding, and Methodology

In this chapter, I review the historical, philosophical and practical concerns that accompany research. My aim is to provide a background and rationale for my research approach. The following questions guide my review: What is science? What makes the scientific endeavour legitimate? What meaning can a scientist, social or natural, give to a phenomenon that non-scientists cannot give? Where does the idea of science come from and why do we do it? What passes for knowledge in society? How is knowledge developed, transmitted, and maintained in social settings? How do we know something? What is the relationship between the knower and the known? How is knowledge identified among scholars and scientists? What might represent the evidence that produces knowledge? How should this evidence be gathered and represented? Who decides what is true and what is false, what is real, what is fact or fiction, what is subjective or objective?

This chapter, therefore, explores the nature of *knowledge* and *science* within our society, concerning what and how anything is taken to be known. I will focus on the social factors that influence the understanding, production and discovery of knowledge, and its dissemination, distribution, and application. I trace the social ideas of science and knowledge within a historical context, which I read through the works of Appleby et al (1996), Denzin (1997), Gadamer (1975), Schutz (1970), and Seidman (1998). These writers present the very idea of science as contestable. They look at social theory as a critical and interpretive endeavour within a philosophical, scientific and moral imperative. They examine the deep-seated tension between the scientific, philosophical and moral approaches to research. Although science seems to have developed as a moral vehicle to human emancipation, it is not this moral imperative that is in question. What is in question is the distinction between subjective and objective notions of knowledge, and the ways science represents the world.

I have divided this chapter into two sections. First, I study what historians refer to as "the Scientific Revolution" and its "enlightened" perspective of science and knowledge. I explore select aspects of the sociology of knowledge using a limited number of sources (Bauman 1978; Hekman 1986; Hesse 1980; Kecskemeti 1952; Outhwaite 1996). I briefly examine various conceptions of knowledge. I trace its roots, both theoretical and practical; how it is produced and distributed, its power, its ownership and its use to construct distinct subjects and objects and different scientific practices. As I waded through the literature in this exploration I sought to understand various social theories about relationships

between knowledge(s), truth(s), belief(s), method(s) and society. My purpose, however, is not to examine the technical details of different social theories, nor to advance a new historical perspective on their development. Rather, I wish to sketch a compact overview of what is commonly accepted as the history of the development of ideas about knowledge. My purpose in the first section is to lay the foundations for a deeper analysis of the *epistemological* and *ontological* bases necessary for understanding the differences between natural and social science approaches to research.[1]

In the second section I explore the works of Albert Schutz and Hans-Georg Gadamer. Through them I hope to gain a deeper appreciation and understanding of philosophical foundations for developing a viable research project. They are particularly helpful for epistemological reasons because they present a specific understanding of science and the nature of knowledge from a societal view-point. Schutz and Gadamer are referred to as anti-foundationalists (Hekman 1986). All anti-foundationalists posit that Enlightenment or positivist ideas of knowledge and

[1] Most researchers recognize that they bring to their research a set of assumptions (a world-view). These assumptions are influenced by what Guba and Lincoln (1988) call "axiomatic" concerns (i.e. widely accepted principles). Creswell has adapted and advanced these axioms (1998, p. 75). He explains that there are five conditions that guide research. I have included my interpretation of each condition in brackets: 1) Ontological (What is the nature of reality? What is the meaning of existence? Is reality subjective and multiple, socially constructed and interpretive, or is it something that exists independent of our perception of it, waiting to be discovered?) 2) Epistemological (What is the nature of knowledge and justification? What does it mean to know? What is the relation between the knower and the known? Is knowledge found through the senses, only that which is observable and generalizable, or is it perspectival, intersubjective, contextual and essentially interpretive?) 3) Axiological (What role do one's values play? Are bias and prejudice to be controlled in pursuit of pure knowledge, or are they accepted as inevitable and inherent in experience? Whose truth/ethic is privileged? Who is in power and who is marginalized? 4) Rhetorical (What is the nature and role of language? Is it to be formal and distanced to the third person, or is it to be in first person and metaphoric? Is it evocative or impersonal? Which discourse is privileged?) 5) Methodological (What is the process or method of knowing? How should research proceed? What tools/instruments are necessary, if any? Is a measuring stick required to count the frequency of occurrences, or is the researcher the instrument who negotiates and co-creates? Is the 'data' captured and displayed, or is 'information' co-constructed and interpreted?).

science are incommensurable with the study of the human social world. Schutz and Gadamer have advanced seminal ideas in this area. Both studied Edmund Husserl and Martin Heidegger and both have pursued the task of unpacking the phenomenon of understanding. Although Schutz and Gadamer enter the debate with a presupposition (who does not?), what is important is that, unlike foundationalists, they question the absolutism of Enlightenment conceptions of science. I acknowledge that this is a familiar, established debate. Yet, it is still addressed in current social science literature (Alcoff & Potter 1993; Charmaz 1995; Denzin 1997; Mills 1997). My purpose in studying this debate is to recognize its traditional, historical origins, and to identify theoretical foundations for my research on social responsibility.

Schutz has been credited with laying the foundations for examining the creation of knowledge in society from a social phenomenological view-point. Schutz focuses his attention on the taken-for-granted, routine aspects of life, which we live out without the need for justification (Schutz 1962). Studying the taken-for-granted views of others, the world, and ourselves in general can provide insight into the cognitive stance we take toward what we do as people, researchers, institutions, etc.

Gadamer's work will be helpful to explore what kind of insights and truths can be found in the social sciences (Gadamer 1975). What I find critical in Gadamer's writings is his view that the distinction between subjective and objective knowledge is based on an erroneous epistemology. Using

hermeneutics[2], Gadamer maintains that to transcend the Enlightenment's concept of truth and method for examining the nature of knowledge requires a move from an epistemological to an ontological foundation.

The Advent of Inquiry

Science, as a system of knowledge, plays a substantial role in changing the way in which the world is seen and understood. The scientific revolution[3] (1500-1700) in Western Civilization is seen as having made eminent the idea of "systematic inquiry" and "reason," and the "scientific method" in developing the

[2] The term is commonly understood to refer to the theory and practice of interpretation. Friedrich Schleiermacher (1768-1834), recognized for advancing hermeneutic theory, defined it as the art of understanding classical, biblical and legal texts (Schwandt, 1997, p. 62). Wilhelm Dilthey (1833-1911) extended Schleiermacher's concept to encompass the epistemology and methodology of the social sciences (Van Manen, 1990, pp. 179-181). Since Dilthey, the concept was associated with a particular methodological approach until Martin Heidegger (1889-1976) tied it to ontology. Gadamer took Heidegger's notion and developed it to explain the universal aspect of interpretation through Being. For Gadamer, hermeneutics is not to do with methodology or epistemology (understanding as social science method) but ontology (understanding as a mode of being). Gadamer insists that we cannot separate ourselves from the meaning of a text. He sees hermeneutics as the philosophical exploration of the character and fundamental conditions of all understanding (1975, p. xiii). For a thorough definition and theoretical variance on hermeneutics see Schwandt (1997), Van Manen (1990), and Bleicher (1980).

[3] Shapin (1996) argues that we do not fully appreciate our taken-for-granted assumptions of what we know as "the scientific revolution". Recently, historians have contested its representation. Essentially, the idea of "the Scientific Revolution" is primarily understood and explained as a conceptual shift in ways of thinking about knowing our world. It happened somewhere between the late sixteenth to early eighteenth century. It is explained as a radical change in the conceptual lens of Western forefathers. Understanding "the Scientific Revolution" in this way is now a commonly accepted part of Western tradition. However, we fail to consider problematic aspects of this view. First, the terms "science" and "scientist" were not introduced into the English language until the Nineteenth Century, before which "natural philosophy" and "natural knowledge" were used (Cohen, 1994). Shapin (1996) states that the phrase "the Scientific Revolution" was introduced in 1939 by Alexandre Koyre, before which it was never studied as an event, nor was it a specific object of historical inquiry (pg. 2). Shapin challenges traditional scholarship on "the Scientific Revolution." He provides a cogent thesis disputing the claims of legitimacy in professing that there was such a revolution, that it marked a clear break between old and new ways of thinking, and a coherent and unambiguous transition to experimentalism and the identification of a particular "scientific method" for producing authentic accounts of the world. Shapin insists on situating traditional understanding of the scientific revolution in a broader cultural and social context that takes account of religious, political and economic patterns. My aim is not to enter Shapin's debate, but to argue in general that what we consider 'accepted' ways of 'knowing' change over time and such changes affect concepts of science in particular, and knowledge in general.

concepts of *objective* knowledge and truth (Gay 1973; Wilson 1996). It is believed that the European world-view of knowledge and reality was profoundly affected when Copernicus (1473-1543) declared that the sun was at the centre of the solar system. A new language had been developed to reveal the secrets of creation. Unlike religious scriptures, which required interpretation, the language of physics and mathematics were seen as pure, objective, and logical, providing the tools that allowed scientists to "see" the truth. One such tool, for example, was Galileo's (1564-1642) telescope, which enabled the "seeing" of Copernicus' theory. Knowledge about the universe was no longer considered the exclusive purview of the Church. Science[4] gave rise to religious scepticism. It changed the ownership and privilege over claims to knowledge and truth. Science's usurpation of knowledge entailed a decrease in power and control for the Church, the monarchy and prevailing aristocracy.

The Enlightenment era can be seen as emancipatory. Science liberated society from the hegemonic practices of the Church. The concept of knowledge took on a different meaning. It was now based in science, but not without a price. The legitimating power of science led to a struggle over differing ideas of truth. Supporters of science paid a high price for their sacrilegious views. They faced exile, imprisonment, and execution. Francis Bacon, for example, was not unmindful of this. He made sure to present science as necessary in understanding God's creation. Without negating Copernicus and Galileo, and in

[4] Keeping in mind Shapin's (1996) thesis (see note 4), I use the term very loosely (i.e. not as a coherent, widely accepted concept), unlike Bauman (1978), Hekman (1986), Hesse (1980) and others whom I have cited in my study of the Enlightenment era.

keeping with the existing authority over knowledge, which could render accusations of blasphemy, Bacon (1561-1626) carefully confirmed, "God hath framed the mind of man as a mirror or glass capable of the image of the universal world, and joyful to receive the impression thereof" (Bacon 1605). Thus, science, according to Bacon, is presented as merely a tool to cleanse the human intellect of the mind's "idols" of sheer opinion, ideology, and self-interest that contaminate the quest for "true" knowledge. Scientists began to see life-saving value in combining scientific theory within a religious context.

Science during this time was seen as a quest for pure knowledge. It was a quest for objectivity, free from interpretation and social conditioning (Hesse 1980). Bacon called for a scientific method of observation, measurement and experimentation in search for absolute truth as God had created and laid down for discovery by "man"[5]. Following Bacon's foundation, the tools for such discovery were continuously refined and objectified—an endeavour critical to the Enlightenment project. Rene Descartes (1596-1650) called for the "certainty and self-evidence" of mathematics to explain how the universe "truly" functioned (Hamilton 1994). John Locke (1632-1704) asserted that empiricism, the doctrine that all knowledge originates in the senses, is the only true way to come to know the world as God created it. Newton (1642-1727) introduced the theory of gravity and the laws of motion that govern nature as it functions perfectly and

[5] Feminist theorists have long asserted that epistemic privilege was exclusive to men during the Enlightenment era, thus placing women and their knowledge and role in scientific endeavours in a subordinate, if not non-existent, position. Proper science, feminist theories maintain, is a gendered product, with its genesis in masculine conceptions of knowledge, resulting invariably in a male controlled production of scientific culture (for a cogent thesis of the feminist critique of science, see Elvi Whittaker's, Decolonizing Knowledge: Towards a Feminist Ethic and Methodology, in J.S. Grewal and H. Johnston eds., *The India-Canada Relationship* (New Delhi: Sage, 1994) pp. 345-65.

predictably, as only God had once understood it. Eventually, however, scientists and philosophers struggled to defend the rationality of human beings and endeavoured to prove that humans exist independently of any metaphysical force. The ensuing scientific revolution challenged the status quo and carved a path for the Enlightenment era (1700-1789)—an intellectual movement credited with introducing scientific and secularist thought over religion, and challenging the Church as sole authority over knowledge and truth.

The 18th century also saw the construction of social science based on the principles of the Enlightenment (Cohen 1994). During this time Henri Saint-Simon (1760-1825), the founder of French Socialism, popularized the term "positivism" from the French words *positive* and *system* or *theory* (Kohl 1992). Positivists "contend that there is a reality *out there* to be studied, captured, and understood..." (Denzin 1994). Scientists of the Enlightenment era asserted that we must be free of the uncertainties of time, place, history and culture if we are to know about our social and natural world (Gay 1973). Truth and reason were understood to be permanent, and not affected by history and culture. Sir Francis Bacon provided a foundation upon which all knowledge was to be discovered and explained, declaring that "truth is not to be sought in the good fortune of any particular conjuncture of time, which is uncertain, but in the light of nature and experience, which is eternal (1970, p. 93). The prevailing belief was that we could use rational, empirical principles to understand social interaction, just as empiricism allowed the discovery of the natural world. Auguste Comte (1798-1857), regarded as the founder of modern social science and credited with

advancing a philosophical theory of positivism, reaffirmed that true knowledge is discoverable and measurable through demonstrable scientific laws established through controlled experiment. Only in this way, he argued, we can *objectively* explain various phenomena, both within the realms of the social and natural world (Boyd, Gasper, et al. 1991). Human beings were to be studied not as "historical, cultural beings, but ... free from the distortions or prejudices of particular times and places" (Hekman 1986). The search for truth and knowledge, therefore, had to follow the deductive, nomothetic, empirical[6] approach and the aim was to *find* the scientific laws that governed human beings and their behaviours. Chinn (Chinn & Kramer 1991) refers to this as the *Received View* of science.

The Received View

Essentially, the Received View posits that the world is made up of absolute truths existing independently from human consciousness. It is available for discovery within a causal and factual form. Consequently, the philosopher/ scientist/researcher is seen as an independent observer of a truth "out there". The observer is seen as having no influence on the observed so long as the appropriate measurement tools are used. Science, in this view, is clearly associated with the quantification of facts or data. A reductionist approach to problem solving predominates. Theories are formulated and tested

[6]The term empirical here needs clarification. In Enlightenment thought the term "empiricist" is understood to mean that " ... the data of experience are the foundation of all knowledge claims and that only empirical observations (not reason) can be trusted" (Schwandt 1997, pp. 36-37). However, explains Schwandt, when a qualitative researcher conducts empirical research, the data of experience (what the researcher saw or heard) is a relational referent that provides one aspect of interpretation. This is different from taking an empiricist orientation.

experimentally to verify or falsify different hypotheses. Statistical tests based on probabilistic theory are used extensively to prove relationships between measured variables. The goal is to discern the numerical regularities of behaviour, that is, counting the number of events and measuring the extent of the behaviours being studied. The intent is to develop generalizations to control and predict precisely the phenomenon studied. Science, in this view, is seen as a tool to discover the laws that govern the universe and, ultimately, to command all natural and social phenomena (Cohen 1994; Jacox & Webster 1992).

The "scientification" and "factualization" of knowledge is understood to have had a profound affect on eighteenth century society's view of reality and human progress (Smith 1796; Hume 1876; de Condorcet 1796). Positivistic science acquired such epistemic privilege in the eighteenth century that society came to learn and accept its tenets unquestioningly, always trying to displace taken-for-granted, common sense ideas with unquestionable scientific knowledge (Giddens 1976). The Enlightenment's concept of a social world based on scientific reason was greatly influenced by the social turmoil prevalent at the time. The perceived social consequences were freedom, equality and social change from a society governed by religious culture that dominated the masses with a heavy hegemonic hand. There was a prevailing prejudice manifest within existing social conditions that differentiated sharply between those privileged by their ties to the Church and related aristocracy and the oppressed peasant class. This inspired a struggle for equality and democracy, a struggle that was conceived to be won only through the objectivity and impartiality of a science

regarded to be accessible to all. The scientific view of society was a vehicle to challenge the Judeo-Christian culture of the time and its social hierarchy of inequality and intolerance (Seidman 1998). The inalienable, *measurable* truths produced through science, against ones produced through divine revelation, came to be applied to people and their situations. "Hard data" would eventually democratize society—influencing policy formation, social change, economic affairs, and military and taxation endeavours (Holzner & Marx 1979). Science was seen as providing a level playing field, each person equal before the other, allowing for no social privileges, regardless of royal status or proclamation of divine inspiration. Thus, Enlightenment's science, as a new moral imperative and a way of knowing what was true and what was false in an objective manner, played a significant role in social change toward secularism and individualism.

The Revolutionary View

The Enlightenment's concepts of science soon began to change within some circles. Although not entirely devoid of a movement toward some sort of objectivity and universalism, thoughts about the interpretive nature of knowledge began to emerge very early during the Enlightenment. In his *Critique of Pure Reason* (1781), Kant, following the work of Plato, favoured the idea of human reason as the final arbiter of the origin of knowledge. Unlike Locke and Hume, who favoured empirical experience as the sole source of knowledge, arguing that pure knowledge begins and ends with sense-experience free of subjective interpretation, Kant asserted that we do not simply experience the world as it presents itself to us, as the empiricists claimed, but we interpret it *also*. The pre-

eminence of the Received View, therefore, did not go unchallenged by those who did not see empirically founded knowledge simply as an objective progression toward "the truth."

In contrast to the Received View, which asserts that the meaning and truth of scientific theories are absolute and that empirical facts exist regardless of personal views, there began to emerge a *Revolutionary View* (Chinn & Kramer 1991). Science was seen to be deeply influenced by social forces, and the influence of culture and social environment an integral part of human reality (Sampson 1980). The Revolutionary View attempts to institute that truth is established within a social context, influencing how people act in certain situations and derive meaning from it. Inspired by the German intellectual tradition[7], supporters of this alternate view saw an inherent flaw in the strict, deductive approach to the acquisition of knowledge, particularly in the social sciences, and they argued that the history of science is an essential, yet ignored, element within the Received View (Tesch 1990). They argued that the behaviour of people should be understood through the meanings behind people's actions and intentions. In other words, reality is distilled through a conceptual lens to see the world from a particular standpoint.

The social significance of science was a problem that many prominent theorists attempted to address. The philosophy of science emerged as a

[7] The word "science" in the English language has a much narrower meaning than in German. For example, to ask if the social sciences are really a science, or *Wissenschaft*, would be inappropriate in German, states Outhwaite (1996, p.85): "If an English speaker tells me my work in sociology is not really science, I prepare for a philosophical discussion; if a German speaker says it's not *Wissenschaft*, I recoil from the insult." The point here is not to explain the different meanings of the word more so than to highlight the philosophical differences in approaching the concept.

significant aspect within social theory (Outhwaite 1996). Karl Marx (1818-1883), Frederich Nietzsche (1844-1900), Georg Simmel (1858-1918), Max Weber (1864-1920), Max Scheler (1874-1928), and Karl Mannheim (1887-1947), among others, produced sharp criticisms against the prevailing concepts of empirical inquiry and its goals of pure knowledge, untainted by the human mind. In general, they rejected the claims that science, as a practice of discovery of a world independent of our senses, can represent the absolute reality of all phenomena, whether natural or social. Yet, neither did they entirely abandon the idea of empirical rationality and its causal explanations as the foundation of knowledge. Nor did they abstain from seeking some form of "true" knowledge. Using Hegel's (1770-1831) idea that subjectivity was an inherent part of cognition and that objective knowledge is derived through subjectivity, Marx, Weber, Mannheim, Dilthey and other contemporaries were convinced that interpretation and science could merge to reveal the truth underlying all social situations (Bauman 1978).

Karl Marx introduced the root proposition that consciousness is determined by social being ((Berger & Luckmann 1967). He argued that humanity was plagued with false concepts and ideas rooted in the material world. His aim was to dispel the ideology that sustained the wealthy at the expense of the poor (Giddens 1976). He rejected the idea of immutable laws forever governing society, whether from God or from a particular form of science. Instead he argued that reality is socially and historically determined and embedded in powerful creations of particular social and economic structures which coercively

cause a type of false consciousness above which one had to endeavour to rise (Sayer 1979). Marx did not reject an empirical vehicle for realizing truth; rather he formulated the role of empirical rationality in affecting social change for the oppressed. Nietzsche (1844-1900) too challenged the enlightenment ideal of science with the view that people do not discover nature, but they imagine and define it. He introduced what many postmodernists consider a liberating view of truth, that is, the legitimacy of each individual's sense of reality independent of concepts put forth by any "higher authority," whether it is religion or science (Nietzsche 1882). The French and German sociologists Emile Durkheim (1858-1917) and Max Weber (1864-1920), although influenced by empirical/causal ideas, considered social explanations of society. Durkheim rooted the study of society in cultural beliefs and in human behaviour. He maintained that social structures, however, gave rise to social *facts* that constrained one's behaviour irrespective of one's will. For Durkheim, the social scientist had to access social reality as "it actually is" and the only way to do this is to recognize and place aside one's own interests and preconceptions, that is, to maintain "value neutrality" (Durkheim 1966). Weber too remained influenced by empiricism, never entirely abandoning his conviction in reason and science. He saw science as a vehicle to expose ignorance and superstition (Seidman 1998, pg. 83). However, more so than Marx and Durkheim, Weber emphasized an interpretive social science and asserted, "human action is subjectively related in meaning to the behaviour of others" (Weber 1981, pg. 159). He also provided a clear definition of *social* action, stating, "action is social in so far as, by virtue of the

subjective meaning attached to it by the acting individual, it takes account of the behaviour of others and is thereby oriented in its course" (Weber 1947, pg. 88). Weber made a clear distinction between positivist science and the interpretivist nature of human beings, arguing that science too was influenced by human values (Holton 1996). Weber's interest in the idea of "understanding" from the point of view of others was, nonetheless, secondary to his primary goal of seeking causal explanations of social action.

For the most part, early German intellectuals have been criticized for adopting, in one way or another, implicitly or otherwise, the distinct paradigm of the Enlightenment. Although they introduced interpretivism as key to human nature, they tended toward a "true" science of society. The strive for *true consciousness*, as with Marx, or the insistence on *value freedom*, as with Weber, or the transcendental hope for *pure consciousness*, as with Husserl's (1859-1938) phenomenology[8], all hint at a quest for some form of absolute knowledge. As such, they are trapped within a form of the Enlightenment's positivistic epistemology (Bauman 1978; Hekman 1986). Critics argue that to posit knowledge in the social sciences as necessarily subjective (although equally valid) not only accepts the existence of objective knowledge, it continues to lend further legitimacy to Bacon's ideas of the two kinds of knowledge, one pure and the other tainted (Hekman 1986).

[8] Phenomenology is a diverse philosophy with different points of departure. It is founded in the work of Edmund Husserl's (1859-1938) transcendentalism. It has been heavily influenced by the existential philosophy of Maurice Merleau-Ponty (1908-1961), and by the hermeneutic thought of Martin Heidegger (1889-1976). In short, phenomenologists attempt to render a thoughtful description of ordinary conscious experience of everyday life (Schwandt 1997). It is concerned with a cognitive reality that manifests in processes of subjective human experiences (Wagner 1970).

To escape this quagmire, some avoided the epistemological issues surrounding the idea of subjective and objective knowledge (Hesse 1980). Karl Mannheim's work, argues Hekman (1986), comes close to developing an interpretive understanding of knowledge and method, "purged of the Enlightenment's distinction between objective and subjective knowledge (providing) a new foundation for the social sciences that is not susceptible to the errors attendant on the association of truth with scientific method" (Hekman 1986). Mannheim examines the concepts of meaning, understanding and knowledge in pursuit of a methodology for the cultural sciences that enables one to "emancipate oneself from the methodological principles of natural science" due to disparate views between the two (Kecskemeti 1952). Nevertheless, Mannheim himself questioned the truth claims of his theory: If all social knowledge is historically and socially relative then so is his own claim. Consequently, he posited truth claims within the social context of those who express and accept them.

Essentially, social theorists of the twentieth century are divided into two camps: one focuses on the empirical relation between knowledge and social factors, and the other on social origins of common-sense or everyday knowledge (Hekman 1986). The former is rooted in the Enlightenment tradition based in a positivist epistemology, and the latter in phenomenology. The Americans largely adopted a positivist approach, while the Europeans took more of a Marxist/materialist view. It was the German school, however, that was particularly

influential in giving rise to a significant conceptual shift among sociologists of knowledge concerning subjective and objective knowledge.

The concept of subjective knowledge has taken on more significance in the recent past. From having a minor role in relation to objective knowledge (a foundational position of the Enlightenment), the nineteenth and twentieth centuries saw the rise of subjectivity (anti-foundational thought) as a fundamental aspect of social science (Hesse 1980). Some anti-foundational theorists tried to move away from the distinction between subjective and objective altogether, indicating that this only reinforced epistemological assumptions based on foundational thought (Hekman 1986).

Four distinctive concepts of the relation between factual statements and values have emerged over time (Outhwaite 1996). First, is an enduring Comtean positivism carried through from the French Durkheimian School. This is followed by the Marxist materialist concept of criticism, which has evolved in various directions by individuals such as Georg Lukác (1885-1971), Theodor Adorno (1903-1969), Max Horkheimer (1895-1973), Jean-Paul Sartre (1905-1980), Louis Althusser (1918-1990), Jurgen Habermas (1929-) and others. German historicism gave rise to a third conception of the relationship between facts and values. The idea is that history can only be understood in terms of the world view prevalent during various historical periods. If so, social scientists cannot really transcend their own historical lenses to view the past. Thus, historical inquiry becomes no more than a reinterpretation of the past within a present paradigm. The fourth concept, states Outhwaite, is based in Weber's distinction between

"value-relation" and "value judgment." According to Weber, the social scientist should be able to discern a social phenomenon from a variety of possible evaluative standpoints, particularly between what is scientifically grounded and that of personal evaluation (Outhwaite 1996, pg. 99). In arguing for a "value free science" Weber sought a critical role for science in value clarification (Holzner & Marx 1979). Such a role, according to Weber, intended to exorcise value judgment and instate an ethical use of science.

Although a diverse range of schools of thought have emerged they all share a concern with interpretive knowledge. In his cogent thesis, *The Structure of Scientific Revolutions*, Thomas Kuhn argues that the interpretive nature is deeply and undeniably embedded in science. Science is a product of a community of practitioners who construct a specified, shared understanding, language, and method of knowledge, its properties and uses, and its epistemic privileges (Kuhn 1970). Science, says Kuhn, comes from a culture that gives rise to epistemically privileged world-views, or *paradigms*, to provide accepted ideas of knowledge and reality at any give time in history. Such is the nature of the scientific episteme and related paradigm shifts, that is, a ground of thoughts on which at a particular time some statements – and not others – will count as knowledge (Macdonnell 1986). Accordingly, various critics of the Enlightenment disputed its tenets and were seen as proponents of *counter*-Enlightenment (Seidman 1998). Some held true to spirituality and intuition, holding fast to religion and tradition, and some defended egalitarian values tied to an agrarian social system. The

common ground shared by these critics was an aversion to secularization and scientification of society under the guise of social progress.

I have provided a very dense overview of the historical roots of both the natural and social science models of inquiry currently available. I have highlighted the basic ideas that evolved within the classical period regarding the sociology of knowledge. My purpose was to acknowledge the foundation necessary for a deeper analysis of the epistemological and ontological bases for understanding the differences between natural and social science methods to research. One basic criticism of social theory, suggests Turner (1996, pg. 11), is that it has not resolved the problem of explanation and interpretation. We continue to seek better ways to explain and understand the nature of knowledge and the self within society. Social theory has undergone numerous transformations over time and theorists continue to struggle to understand better the shared problems of social life. Moreover, recent theoretical developments have only added to the problem, particularly because some theorists claim originality for their work without fully understanding previous formulations of social theory within a long established tradition in the human sciences (Turner 1996).

Common-Sense Knowledge: The Social Construction of Reality

For the most part, the researcher's aim for studying society during the eighteenth and nineteenth century was to understand and to describe precisely how it works. Social scientists understood that their endeavour was aimed at

producing a better, more real understanding of society than the layperson on the street. The layperson functioned through common-sense, which, most social scientists argued, was antithetical to scientific thought. Staunch positivists tried to eliminate common-sense in search for scientific truth, while interpretivists subsumed it under "the actor's view-point." Understanding the actor's view-point, social scientist's claimed, led to the *real* reasons behind people's acts. Presumably, this reality transcended common-sense ways of acting. However, the layperson may argue that if common-sense were so inferior in its legitimacy for day-to-day living, then we, as an intelligent species would not adhere to it so closely, and we would conduct ourselves in a scientific mode, that is, with the attitude that what we identify as real is only real if we have hard evidence for it. This raises the question, what is common-sense? Alfred Schutz took up the task of exploring this question.

Alfred Schutz (1899-1959) bridged the ideas of the classical sociologists Karl Marx and Max Weber and the European phenomenologist Edmund Husserl with the work of American pragmatists William James and George Herbert Mead (Wagner 1970). Schutz has been credited with developing a systematic and comprehensive theory of the "common-sense, everyday world." His aim was to lay the foundations of a phenomenological sociology which examines "how we come to interpret others and their actions; with the complex ways in which we understand those with whom we interact; and the ways in which we interpret our own actions and those of others within a social context" (Bernstein 1976).

Schutz focused his study on the "life-world," a concept within phenomenology referring to the total sphere of everyday experiences, orientations, and actions through which individuals pursue their interests and daily affairs by dealing with people, planning and acting on various plans, events and objects (Schutz 1970). We live our life-world through the "natural attitude," explains Schutz (1970). We accept without question that there *is* a social world and that we communicate with each other meaningfully, accepting tacitly that there are certain principles in place, which are true for day-to-day living. This is "common-sense." Within our "common-sense world" we act and react, we form relations and come to terms with the actions of others and our own. We deal with customs and laws and cultures. We encounter limitations and opportunities. As we carry on day-to-day we do not question the reality of various encounters, whether it be with others or with nature or objects. We accept unreflectively that who we are and what we do is natural and true to our experience. Schutz states:

> The world of everyday life is taken for granted by our common-sense thinking and thus receives the accent of reality as long as our practical experiences prove the unity and congruity of this world as valid. Even more, this reality seems to us to be the natural one, and we are not ready to abandon our attitude toward it without having experienced a specific shock which compels us to break through the limits of these 'finite' provinces of meaning and to shift the accent of reality to another one (1962, pgs. 343-4).

Schutz explains that our being in the life-world is affected by our "biographical situation," that is, we are uniquely affected by the baggage that is given to us by family and friends and by socio-cultural relations that act as the guiding elements of social life. In this baggage I accumulate my "stock of knowledge at hand." This stock is made of "typifications of the common-sense

world." The notion of common-sense is based on a perspective world view dependent upon a shared, socially constructed system of meaning. It contains concepts that have been handed down to me by my parents, teachers and society. I take some concepts as given, and I interpret and reinterpret others, yet naturally guided by "common-sense." This stock of knowledge subsequently affects what and how I experience my life-world. The lens through which I see the world and act in it is specific to my accumulated experiences and knowledge. My "biographically determined situation" and my "stock of knowledge at hand" permit me to decide what and how I see the world—my "natural attitude." Although my experiences are unique to me and I accumulate a stock of knowledge subjectively, I do not exist alone and outside of social influences. My biographical situation, my natural attitude and my stock of knowledge are generated within and out of a socially informed environment. Thus, I can appreciate the necessary element of intersubjectivity that makes up my life-world.

Schutz's social phenomenology sought to explore and explain how meaning is derived in the social world. His goal was to examine the creation of knowledge in society. He defined knowledge as everything that we, as members of a particular social group, claim to know. He asked the question: what do we know and what is the social basis of this knowledge? In his pursuit to answer these questions Schutz provides a valuable insight into social reality. Unlike Husserl, Schutz searched for the notion of understanding in human activity, as did Heidegger. Aspects of Schutz's work have a striking parallel to Hans-Georg Gadamer's hermeneutics. Although each have a different point of departure, the

former in epistemology and the latter in ontology, the two complement each other toward a more fruitful position on concepts of science, understanding, knowledge, and human nature.

Hermeneutics, Language and the Social Sciences

How is understanding possible, asks Gadamer in his major work, *Truth and Method* (Gadamer 1975). Hermeneutics, is his answer. Hermeneutics, as summarized in footnote two, is generally defined as the art and craft of interpretation (Kohl, 1992, p. 30). Friedrich Schleiermacher (1768-1834), who is recognized as having advanced the idea of hermeneutics, sees it as an orientation toward the hidden meanings in all things, i.e. text, music, art, speech, cultural practices, etc. (Schleiermacher 1977). The word hidden, however, connotes a pre-existing phenomenon inherent in an object. Thus, hermeneutics, according to Schleiermacher, is a "technology" for interpretation toward finding the "true" meaning of things, particularly sacred texts. It is a struggle against misunderstanding (Van Manen 1990). This original understanding of hermeneutics takes an objective stance. Positive hermeneuticians, for example, will seek the meaning of a thing/object as it is seen to exist in the thing itself, independent of the interpreter's consciousness of it.

Gadamer, however, sees hermeneutics as understanding through interpretation, an inevitable aspect of being human. All understanding is interpretational. The two are interdependent if not one and the same. There is no objective distance between the self and that which is understood. All

interpretations remain open and incomplete. Gadamer's approach to hermeneutics is decidedly philosophical. He does not provide a method for obtaining knowledge (Gadamer 1975). More importantly, it is not based in the more common debate of subjective versus objective knowledge. Rather, it is based in linguistics. Thus, to understand the hermeneutic experience one needs to delve into the activity of language and conversation. To summarize Gadamer's general position on hermeneutics, it is ontological (understanding is a necessary aspect of Being), universal (understanding is an essential part of all human activity), and conversational (interpretation is dialogic, that is, an interaction between the interpreter and that interpreted). Through these three fundamental aspects of his approach to hermeneutics, Gadamer builds his thesis on truth and method.

Gadamer's thesis deals with the quest for a better understanding of the social/human sciences. He asks, "what kind of insight and what kind of truth" do the social sciences offer (Gadamer 1975). Unlike most contemporary debates that focus on methods, and on disputes over the legitimacy of the natural over the human sciences and vice-versa, Gadamer states at the outset:

> The hermeneutics developed here is not, therefore, a methodology of the human sciences, but an attempt to understand what the human sciences truly are, beyond their methodological self-consciousness, and what connects them with the totality of our experience of the world (Gadamer 1975, pg. xiii).

Gadamer's journey into hermeneutics explores the connection between philosophy and social science, taking ontology as the starting point. Gadamer analyzes the works of both Husserl and Heidegger who form the stepping-stones

for his work. He is careful to avoid, however, their absolutist tendencies. In order to do this he grounds his analysis in language and in time (Hekman 1986).

For Gadamer, Husserl provides, for the first time, the beginnings to a dependable thesis against objectivism. Knowledge, as we tend to see it, is in understanding, says Husserl. Understanding provides meaning. All of this is an act of consciousness. In everyday life, meanings are created out of the influence of history, culture, and motives. As such, meanings are not inherent in objects that exist independent of our being. Thus, meanings of things are in interpretation. But, interpretation is tainted by history and culture. True meaning, argues Husserl, requires a purification process from the "germs of relativism" (Bauman 1978). Husserl's aim is to return to the essence of things. To find the essence and true meaning, requires, for Husserl, a journey into another world—a world of pure consciousness. In his quest to understand the nature of knowledge, Husserl finds that he has to abandon the interpretive world that he knows for a world of spirit, or what he termed, "transcendental subjectivity." For Gadamer, this transcendental journey leads to idealism. Thus, he finds that Husserl's transcendental approach fails to achieve the stated goal. For Gadamer, the notion of reality lies not in a realm of ideas that transcend everyday life nor within a subjective-objective dichotomy (Gadamer 1975).

Gadamer turns to Martin Heidegger (1889-1976), where the question of understanding is sought within one's being. Understanding becomes an issue that is derived from being *in* the world. Its basis is ontological, not methodological, nor epistemological (Bauman 1978). Unlike Husserl, who

embarks on a transcendental journey to pure understanding, Heidegger insists that consciousness cannot emancipate itself from the world. Heidegger maintains that,

> "to 'prove' the existence of an external world is to overlook the *a priori* nature of Being-in-the-world... Rocks and trees do not depend on man for their occurrence in the universe, but reality, which is merely a mode of man's interpretation of the world, does depend on man's existence" (Gelven 1970).

For Heidegger, hermeneutics is part of the nature of being. Understanding, therefore, is a mode of being rather than a mode of knowledge or method. Heidegger's project is not concerned with designing a method through which one resolves the complexities of interpretation. Nor is he concerned with ways to identify the primacy of one interpretation over another. Rather, he is concerned with the question: "what, in the human mode of being-in-the-world, determines both the possibility and the actuality of understanding?" (Bauman 1978). His ultimate answer is existence in the world. Thus, we do not need to transcend our worldly existence to make sense of the phenomenon of understanding. Truth lies not in the spirit world but here in the earthly world. On earth we express ourselves primarily through language, which plays a critical part in the constitution of meaning.

One central aspect in Gadamer's hermeneutics is the idea of prejudice, which is presumed in all understanding. When interpreting an experience Gadamer stresses the importance of reflective examination of one's bias or prejudice. His aim is to encourage a reflection of things we take for granted. He states that,

> ... understanding achieves its full potentiality only when the fore-meanings that it uses are not arbitrary. Thus it is quite right for the interpreter not to approach the text directly, relying solely on the fore-meaning at once available to him, but rather to examine explicitly the legitimacy, i.e. the origin and validity, of the fore-meanings present within him (Gadamer 1975).

The idea of prejudice is inherent in Being and cannot be overcome, or held at bay as was attempted in Enlightenment thought. The fundamental prejudice of the enlightenment, argues Gadamer, is the prejudice against prejudice itself. Prejudice is a fundamental arm of reason. Thus, reason cannot transcend time and space, for it is in and of humanness existing only in concrete, historical terms, always dependent on the given circumstance in which it operates (Gadamer 1975).

For Gadamer, the concepts of truth and prejudice are interdependent and need to be examined thoroughly. Once prejudice is brought to the fore and recognized, albeit in a limited fashion, understanding is enhanced. This, Gadamer sees, as the "undeniable task of critical reason" (1975, pg. 246). According to Gadamer, the social sciences have, willingly or unwillingly, assumed natural scientific methods and in doing so have dichotomized the relation between truth and prejudice. Thus, some social scientists have not been able to abandon objectivist tendencies. Moreover, such tendencies fail to acknowledge the effectual inevitability of historical awareness that is inherent in the understanding process (Gadamer 1975). The historical element of experience and understanding is discarded in Enlightenment objectivism, which leads to a distortion of the idea of knowledge. The insistence on repeatability of experience in the natural scientific method removes all historical elements from

experience and this renders the notion of generalization a weak form of understanding (Gadamer 1975). However, Gadamer is careful not to fall into the trap of historicism.

Historicists maintain that to understand the past one must see it through the lens of the past, that is, in terms of the historical horizon of past events (Hekman 1986). This, Gadamer asserts, is not possible. The lens that we develop over time demand a perspective through which seeing alone becomes seeing something in a particular way (Nietzsche 1967). Our lens can, however, allow for a "fusing of horizons," states Gadamer. The term "horizon" is taken to mean the "range of vision that includes everything that can be seen from a particular vantage point" (Gadamer 1975). Also, one's horizon is framed by the prejudices of the time. We always interpret our experiences from a particular viewpoint. We understand the world around us through the conceptual lens we have developed. We cannot see the world without the lens. It is permanent. It cannot be removed to achieve objectivity. Understanding from another's point-of-view, then, requires Gadamer's "fusing of horizons." It is an idea developed from both Husserl and Nietzsche, and it requires

> an eye turned in no particular direction, in which the active and interpreting forces, through which alone seeing becomes seeing something ... these always demand of the eye an absurdity and a nonsense. There is only a perspective seeing, only a perspective 'knowing'; and the more affects we allow to speak about one thing, the more eyes, different eyes, we use to observe one thing, the more complete our 'concept' of this thing, our 'objectivity', be (Nietzsche 1967).

Gadamer appeals to the idea of aesthetic experience to show the limitation of Enlightenment concepts of truth and method for the social sciences. He

argues that when we experience art we take a cognitive stance that is incongruous with natural scientific methods. The aesthetic experience of art, for example, induces a peculiar mode of understanding. Such an understanding is first a self-understanding. To understand art through aesthetic experience requires an understanding of the self in relation to what is understood (Gadamer 1975). Art, literature, play and other forms of aesthetic experience are representations or reproductions of ways in which we see our world. Embedded in these representations is the hermeneutic. Science too, Gadamer concludes, is a mode of reproduction of our world, thus, it is hermeneutical.

Hermeneutics, says Gadamer, is an integral part of being human. Moreover, it is full of bias and motive. We pay attention to certain aspects of our world while we hold in the background other aspects and ignore yet other aspects. Moreover, we are historical beings, which makes it inconceivable to place understanding in a timeless, generalized, and absolute cage. Evidently, Gadamer's hermeneutics is not grounded in epistemology. As stated earlier, it is grounded in ontology. Thus, to study hermeneutics is to study "Being" and the study of "Being" calls for a study of language (Gadamer 1975). Language is the key to understanding for, as Heidegger states, "language is the House of Being" (Hekman 1986). Gadamer is careful, however, not to reify language. Thus, not everything is language. But it is through language that we become acquainted with an intersubjective world. In human communication, language unfolds in the sharing of common meaning (Gadamer 1975; Berger & Luckmann 1967). Within

the social "sciences" all understanding is linguistic and it is the medium of language through which Gadamer embarks on his journey into truth and method.

Central to Enlightenment thought is the belief that to distinguish between truth and falsity we need sound criteria in our methods. A key criterion here is the guarding against prejudice. Gadamer, as presented above, puts forth a defensible position that prejudice, that is, our situatedness in history and time, is a precondition of truth (Hekman 1986). Prejudice is part and parcel of Being. Methodological guidelines, no matter how refined, cannot achieve truth. Truth exists insofar as it resonates accepted meaning within common understanding explicated through language. Thus, Gadamer's most striking argument is that we do not speak a language more so than it speaks us:

> Strictly speaking, it is not a matter of our making use of words when we speak. Though we 'use' words, it is not in the sense that we put a given tool to use as we please. Words themselves prescribe the only ways in which we can put them to use. One refers to that as proper 'usage' – something which does not depend on us, but rather we on it, since we are not allowed to violate it (cited in Hekman 1986, pg. 119).

My intention in this chapter was to engage in a reflective composition that shared with the reader my evolving breadth and depth of understanding of the nature of knowledge and science within our society. I have drawn heavily on resources that themselves provide summaries of many of the philosophical concepts of scientific reasoning. If anything, I have surely realized that I know very little and take much for granted. This is only a first, rather vicarious step to examine the deep-seated tension between the "scientific", philosophical, and moral approaches to research. I cannot but continue to confront the ideas of "science" and "research", particularly through the works of Albert Schutz, Hans-

Georg Gadamer, and Norman Denzin. I realize that I am just beginning my learning.

In the next chapter I focus on methodology. It is not my intention here to defend the choice of using a qualitative over a quantitative approach, as it seems customary to do in "basic science" disciplines. It would be inappropriate, just as it would be inconceivable for a researcher using quantitative techniques to defend that choice over a qualitative approach. I will, however, take an educative position and trace the history and theoretical relevance of qualitative approaches to inquiry for the benefit of those who come from a positivist perspective where established theories and hypotheses are tested deductively and results are expressed in numerical forms using statistical analysis to identify and attempt to determine causal relationships between measured variables.

Thus, I will present the most recent work by Denzin (1997) whose focus, I believe, parallels important aspects of the work of both Schutz and Gadamer. Denzin explores ethnographic practices for the twenty-first century. He argues for a new moral discourse of our world, and a new ethic of inquiry. To paraphrase Denzin, this discourse uses ethnography through literary journalism, performance art, and other *discursive practices*[9] for studying our world in ways that produce a new ethic of inquiry. This new ethic is grounded in human experience; it

[9] Schwandt (1997) explains that the phrase *discursive practice* refers to particular ways of writing, talking about, and doing *something* within a defined ethical, social and political framework. This *something* could be a certain research practice within a particular discipline, for example. A specific jargon is used and regarded as understandable and valuable to the users. To refer to qualitative research as a set of discursive practices is to acknowledge that its language is in part constitutive of its meaning and significance, which, in turn, is reflective of its practitioners' intentions. Accepted ways of writing and speaking and doing (discursive practices) within particular settings are influenced by social, historical and political factors (see Schwandt 1997, pg. 31).

promotes universal human solidarity; it is committed to human justice; it is, in essence, a moral discourse of the contemporary world, lending itself to "messy" texts[10]; it provides a 'research' vehicle for the collection and telling of multiple versions of truth; and most importantly, it brings ethnography closer to a set of critical, journalistic practices which not only awaken the moral imperative, but call for actions that transform less humane to more compassionate ways of being. Within the new ethic of inquiry, the "writer can no longer presume to be able to present an objective, non-contested account of the other's experience" (Denzin 1997, pg. xiii).

[10] The concept of "messy text" refers to an eclectic form of writing committed to cultural criticism; it is seen as many sided, multivoiced, open-ended, devoid of abstract theorizing, and without closure (Denzin 1997, pgs. xvii, 224-27). Messy texts acknowledge the idea that writing is inscriptive--a way of "framing reality"--thus, it tries to resist an imposition of one version of what is while favouring multiple realities wherein no single interpretation is privileged (Clough 1992; Lee & Ackerman 1994; Marcus 1994; Trinh 1992).

CHAPTER THREE

METHODOLOGICAL CONSIDERATIONS

"A study belongs to the human (sciences) only if its object becomes accessible to us through the attitude which is founded on the relation between life, expression, and understanding."

Wilhelm Dilthey

Undoubtedly, the "true" definition of science has been a long-standing topic of dispute among scholars. Different camps have emerged upholding different philosophies of science: positivists, functionalists, structuralists, feminists, relativists, interpretivists, constructivists, phenomenologists, realists, materialists, post-modernists, and the list goes on. All claim to be doing "science", all believe in the legitimacy of their endeavour, and all advocate and uphold its value. Yet, if one were to look at individual researchers within the different camps, one would find that each is involved in essentially different activities, and each takes a radically different philosophical stance on the meaning behind what it is they do. Some tell "stories" from the "actor's" perspective, while others develop theories, laws and rules of reality. Some use laboratories and clinics while others use cultural spaces. What seems common among these camps and among both experienced and budding researchers is the understanding that a legitimate representation of any phenomenon requires some form of "scientific" investigation. Central to this is the collection, analysis, and presentation of "data"

in a specific systematic way, in keeping with a scientific tradition. Some conduct qualitative research while others conduct quantitative research. Both take for granted the legitimacy of their activities as scientists; and both see their activities as a means to improve quality of life and to help humanity in its pursuit of happiness (see Schutz 1962, pg. 245). Nonetheless, there is an ongoing debate as to which is the best way, which is truer to this cause, which is *more* legitimate and *more* appropriate. My reflections on this debate are informed by Denzin's most recent work on ethnographic practices for the 21st century (Denzin 1997).

Many authors have compared and contrasted between qualitative and quantitative research methods (Bryman 1983; Creswell 1994; Denzin 1994; Firestone 1987; Guba 1990; Howe & Eisenhart 1990; Morse 1991; Neuman 1991; Patton 1991; Salomon 1991; Smith 1983). The debate over the legitimacy of qualitative versus quantitative research is ongoing and seemingly endless. Schwartz and Jacobs (1979) argue that the basic difference between qualitative and quantitative approaches is in the notation systems used to explain the world. Essentially, qualitative researchers use language to report their data, while quantitative researchers use numbers. This is, of course, a simplistic definition of qualitative/quantitative commonly heard, which is sometimes followed by a remark like: "a commitment to one notation system over the other relates to one's epistemological, ontological, and methodological framework for doing research" (Schwartz & Jacobs 1979). When challenged for further detail, the conversation usually focuses on method, accompanied by rather shallow debates on the nature of science as qualitative vs. quantitative research. The distinction is not

just about counting things against not counting them. Qualitative researchers can and do count things. Rather, the distinction lies in the deep philosophical foundations underlying the methods or techniques in the "doing" of research (Collin 1997).

Researchers embrace a diverse, multidisciplinary range of approaches, methods, and techniques (Brewer & Hunter 1989; Denzin 1994; Giorgi 1986; Tesch 1990). Many researchers will argue that they are not unbiased, value-free entities far removed from the focus of the exploration. They argue that the researcher is socially situated and is one who

> ... speaks from a particular class, racial, cultural, and ethnic community perspective. The gendered, multiculturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways (Denzin & Lincoln 1994).

Qualitative research, argues Tesch (1990), is not a monolithic concept like 'statistics'. It draws upon a rich variety of strategies and theoretical frameworks from different disciplines and traditions (Jacob 1987). Denzin and Lincoln (1994), citing Nelson (1992) state:

> Qualitative researchers use semiotics, narrative, content, discourse, archival, and phonemic analysis, even statistics. They also draw upon and utilize the approaches, methods, and techniques of ethnomethodology, phenomenology, hermeneutics, feminism, rhizomatics, deconstructionism, ethnographies, interviews, psychoanalysis, cultural studies, survey research, and participant observation, among others (pg. 3).

How does one choose from this overwhelming multitude of approaches? Creswell (1998) indicates, and I agree, that the researcher needs to understand that the different types of research methods originate from different theoretical frameworks within the social sciences and humanities. Researchers conducting

qualitative studies do not always know the disciplinary traditions and philosophical foundations from which a particular method originates, a knowledge which can help them make more informed choices in selecting a method and in designing more careful and sophisticated studies (Creswell 1998).

Thus, I have selected specific aspects within the works of Alfred Schutz, Peter Berger and Thomas Luckman, and Hans-Georg Gadamer to provide the epistemological and ontological underpinnings for my method of inquiry. I also rely heavily on Norman Denzin's work (1997), *Interpretive Ethnography: Ethnographic Practices for the 21st Century,* to guide my methodology. Denzin writes a thorough, accessible, and deeply reflective thesis on the ethnographic research endeavour, through which I attempt to answer many of the questions I have raised throughout this chapter. I find that Denzin's position parallels particular aspects of Gadamer and Schutz. Moreover, his thesis responds to the present era in which resistance to a hegemonic scientific order is actively displaced, giving way to a research paradigm that argues for a non-traditional ethic of inquiry, wherein moral, political and social criticism flourishes. What I discovered in Denzin's text is that debates about truth, science, and knowledge in the 21st century resonate in tandem with debates that flourished during the Eighteenth and Nineteenth centuries. A critical difference is the moral imperative that guides present day debates. The ideas of epistemic privilege, objectivism, and value-freedom remain at the heart of present debates against evocative, feminist, post-modern and critical standpoints. But, whose truth is true, asks Denzin (1997, pg. 265). Which community of believers is to be favoured?

I seek a method founded on negotiation, a fusion of horizons (Gadamer 1975), intersubjectivity (Schutz 1970), and a deep sense of ethics (Denzin 1997). My method attempts to encompass aspects of the narrative, open-endedness, conflict, history, language, and text. Thus, I will focus on Denzin's *Sixth Moment* in which he outlines a mode of interpretive ethnography labelled civic journalism (Denzin 1997). Denzin proposes what he refers to as a publicly responsible ethnography. This is simply an extension of critical ethnography, favouring moral criticism (Denzin 1997). To understand better why I have selected Denzin's work one needs to understand my research aim, which is, to study the idea of an equitable and accessible oral health care system. Implicit in this aim is my experience and understanding that the system is not equitable. In effect, it privileges certain groups over others. It excludes those who, for example, are poor, disabled, or elderly among others (Motley 1986; Capilouto 1995; Evans & Williamson 1978; Field 1995; Locker & Leake 1993; MacEntee 1997; Petersen 1990; Weiss, Morrision, et al. 1993; Wilson 1992).

Research Method

Within the biomedical science disciplines, the notion of science itself is never really challenged. From the perspective of research traditions, the biomedical and the social sciences have had a weak relationship resulting in a limited understanding of social factors that influence health care (Fredericks, Lobene, et al. 1980; MacEntee 1997; Susser & Watson 1971). Although a qualitative research approach is an integral part of the social sciences, this

tradition of inquiry is relatively new in dental research (Atchison 1996; Grembowski 1997) where quantitative epidemiological methods have been dominant for studying public health problems (Baum 1995; MacEntee 1997). Quantitative epidemiological methods do not cope with the complexities of social, political and economic factors that affect health. We know very little about the complex and multifaceted social variables that affect various issues in health care in general and oral health care in particular (Gift 1996). This may be one reason why dental research has had a negligible impact on social, economic and political barriers to accessing care. Dental public health research has placed a significant emphasis on the causal model when studying the determinants of health. This becomes problematic when studying societal factors of health care. Several authors have discussed the limitations of epidemiology in understanding health issues that need to be understood as complex social constructs (Alderslade & Hunter 1994; MacEntee 1997; Williams & Popay 1994).

Considering my research question, I realize that in choosing a method I am influenced by my concern with social inequities and my interest in working toward "positive" social change toward reducing existing inequities in the oral health care system. The most suitable method for my thesis is ethnography, through which I employ the techniques of discourse analysis. I understand ethnography not in its traditional sense, but in its "new" sense as read through Denzin (1997). This new sense is continually shaped by multidimensional factors of a quickly changing world where national boundaries are blurred, where information is readily exchanged through technological advancements available to virtually everyone,

and where media images have sustained, in one form or another, the privilege of bringing the most accessible version of a reality to people (Denzin 1997). In such a milieu the ethnographer must be careful not to be entrapped by a particular version of truth. The truth is that the social world is governed by multiple truths (Schutz 1962). Thus, ethnography becomes a moral imperative to explain not how the world is, but how it can be seen to be.

The new ethnography is committed to human justice. A new ethic guides research. The ethnographer should not be distant from those written about (Clough 1992). The ethnographer can no longer believe to be presenting an objective, non-contested account of others' experiences (Denzin 1997, pg. xiii). Neither can the ethnographer take for granted the ownership of the research product. Such contested issues are challenged not only on an ethical basis, but on a legal one as well (Lee & Ackerman 1994). In and through method, most researchers take a position of superiority over laypersons regarding a world-view. The researcher's world-view is seen generally as more accurate, closer to the 'truth', thus more privileged. The layperson, most researchers will argue, is not a systematic and careful observer. The layperson, researchers will say, takes many concepts for granted, lacking the necessary reflexivity and method demanded in research. Researchers are scholars. They are seen to be more thorough, more sensitive, and more careful, thus considered privileged in rendering a more accurate picture of phenomena under study. I never really question the privilege I take as researcher. I accept that what I do as researcher is natural and true to my experience and to the experience of other researchers. By taking various aspects

of the research endeavour for granted I accept tacitly that the scientific method is the most legitimate form of academic pursuit. It is these assumptions that I wish to explore further. How is truth sought through method? What do existing methods tell us about our scientific practices?

I understand ethnography, through Denzin (1997), as that form of inquiry and writing that produces descriptions and accounts about the ways of life of the writer *and* those written about (pg. xi). The ways of life in this postmodern[11] world can be said to be fluid, eclectic, multiperspectival and ever-changing. I am guided by an interpretative approach that takes a critical stance as argued for by Denzin (1997). He views ethnography through the work of Derrida (1981), arguing that a theory of the social is also a theory of writing, and a theory of writing is also a theory of interpretive (ethnographic) work (1997, pg. xii).

Ethnography in the 21st century: A new ethic of inquiry

Tesch (1990) indicates that Bronislaw Malinowski first introduced the term ethnography in 1922. It is a term that has its disciplinary roots in the descriptive science of social anthropology central to which is the study of culture and cultural

[11] The term "postmodernism" initially came from architecture to refer to a particular design style that stood in opposition to "modernism". Such a style rejects convention and is interdisciplinary in nature. Creswell (1998) explains that postmodern as a theory emerged in the humanities in the 1960s and became incorporated into the social sciences in the 1980s. Key individuals like Derrida, Foucault, and Lyotard were most influential in advancing postmodern thought (Derrida 1976; Foucault 1972; Lyotard 1984; Rosenau 1992). To paraphrase Schwandt (1997), postmodernism opposes four central doctrines that form the core of the Enlightenment tradition: (1) the notion of a rational, autonomous subject; (2) the notion of foundationalist epistemology (and foundational philosophy in general); (3) the notion of reason as a universal, a priori capacity of individuals; (4) the belief in social and moral progress through scientism. Postmodernism launches a continuous revolt against absolute standards, universal categories, and grand theories; it celebrates ambiguity, uncertainty and conflict; and it turns science against itself, asserting that knowledge is always tentative, incomplete, and perspectival as proved by Einstein's theory of relativity and Heisenberg's uncertainty principle (Seidman 1998).

behaviour (Patton 1990; Schwandt 1997). Culture provides "standards for deciding what is, standards for deciding what can be, standards for deciding how one feels, standards for what to do about it, and standards for deciding how to go about doing it" (Goodenough 1971). The traditional ethnographer endeavours to "describe and analyze all or part of a culture or community by describing the beliefs and practices of a group studied and showing how the various parts contribute to the culture as a unified, consistent whole" (Jacob 1987). An ethnography, as understood by Malinowski and Jacob, is essentially an in-depth description and analysis, a portrait of the ways in which a culture-sharing group interpret their experience. Traditional ethnographies have studied culture-sharing groups such as faculty within an educational institution (Bruckerhoff 1991), college fraternity students (Rhoads 1995), a baseball team (Trujillo 1992), a cancer unit (Germain 1982), or elders in a nursing home (Kayser-Jones 1981). The ethnographer's aim, according to Malinowski, has been to "find out the typical ways of thinking and feeling, corresponding to the institutions and culture of a given community and formulate the results in the most convincing way" (Van Maanen 1995). This aim, of course, is no longer maintainable. To paraphrase Denzin (1997), the world we study is created, in part, through the text that we write and perform.

I realize that I can no longer aspire to present the actors' view-points. I agree with Gadamer that this is a misguided aspiration. I believe that meaning is not the sole function of the subjective intention of the author or actor. Neither is meaning the sole function of the interpreter's determination. Rather, it is a "fusing

of the two horizons" (Gadamer 1975). And, as Schutz emphasizes, understanding is intersubjective, which places social science in the common world of human practices. There is an ongoing correspondence between my meaning and what I read, and those with whom I speak (Berger & Luckman 1967). Like Gadamer, I do not believe that understanding is possible from the actor's view-point. One cannot enter the actor's mind because this denies the inevitability of contextual aspects of understanding. Furthermore, it calls for self-alienation, that is, the need to transcend the self to enter the world of the other. Gadamer denies the possibility of this egoless feat. What is possible, however, is the fusing of the two, whereby the interpreter and that which is interpreted come together to produce an understanding within the interpretive act. As a result, neither the actor nor the interpreter claims epistemological primacy.

Ethnographic practice is now a postmodern/post-structural endeavour, favouring intense reflection through "messy texts" (Marcus 1994). These messy ethnographic texts do more than "celebrate cultural difference or bring another culture alive," instead they tell of "the agonies, pains, successes, and tragedies of human experience ... and the deeply felt emotions of love, dignity, pride, honour, and respect" (Denzin 1997). Thus, they assert a moral discourse of the contemporary world through which the ethnographer commits to more honest ways of writing, particularly within a communitarian ethic that respects human experience and human solidarity while facilitating civic transformations in the public sphere (pg. xiv).

Revived theoretical formations have emerged that are antifoundationalist at the core, poststructural[12] in standpoint, and influenced by a strong emancipatory commitment through critical, feminist perspectives (Denzin 1994). Through these perspectives, qualitative researchers face a number of challenges. First, the qualitative researcher is challenged to *capture* lived experience (see Denzin 1997, p. 3). Any such capture traps the subject in the author's text through writings that inscribe irrevocably what readers will then consider real, immutable, and privileged. To put it succinctly, "description becomes inscription" (see Whittaker 1994). Herein lies what Denzin calls the inescapable problem of representation. Thus, challenged is the notion of the ethnographic project as a narrative structured by a logic that separates the writer, text, and subject matter. Language and speech do not mirror experience, argues Denzin (1997, pgs. 4-5), *they create it*, in the process of which what is described is constantly transformed and deferred (Gadamer 1975).

Second, the qualitative researcher is challenged to consider issues of evaluation and interpretation, particularly within a post-structuralist stance that rejects post-positivist notions of validity or authority. Denzin (1997) identifies this as a problem of legitimation, having to do with notions of knowledge, its production, and representation. He explains that good qualitative research has traditionally been identified with the researcher's ability to adhere to a set of

[12] Poststructuralism is often used interchangeably with postmodernism. The latter, however, is generally regarded as a more encompassing notion (Schwandt 1997). Advanced by individuals such as Foucault, Derrida, Lacan and Lyotard, the idea of poststructuralism is essentially a textual criticism of metaphysical and empirical world-views. It is in a sense antiscience and antitheory as conceived through a notion of pure objectivity.

procedures and rules that enable the written product (text) to convince the reader of its credibility. The researcher claims credibility through normative standards in qualitative inquiry like respondent validation, member checks, triangulation, comprehensiveness, etc., which are accepted as the currency for authoritative representation of the experience and social world under study. This currency has been devalued.

Today, the researcher must aspire to gain credibility and legitimacy through a text that acknowledges the *re*presentation of multiple versions of truth, including the researcher's, showing how each version can impinge on and shape the phenomenon being studied (Denzin 1997; Schutz 1962). No single version is given authoritative privilege, for each has its own strengths and limitations (Lather 1993). The aim is to allow equal privilege to a plurality of interpretations. What is implicit in this position, however, is the stance that the notion of "giving" and "allowing" of equal privilege is in fact possible. I do not accept that it is. I find that the researcher as "allower" of such a task, regardless "of the egalitarian motive, holds a position of power, and does so through an inevitable prejudice that is part and parcel of being human" (Gadamer 1975). Respondent 'checks' may confirm the poignancy of the representation, but it is still and always will be a *re*presentation. The writer still holds the pen, the writing is not neutral, and as long as this is true, the only hope is to write in a way that invites deconstructive criticism of the text itself. I do not think that Denzin would disagree; for, in citing Richardson (1992), he states that authority and legitimacy of any representation

lies in the intersection of the researcher's and the subject's voices (Gadamer 1975).

Finally, what we know as contemporary qualitative inquiry, argues Lather (1993), still holds postpositivist assumptions within a subjectivist-objectivist polarization. The evidence for this is in the ontological and epistemological stance assumed by some qualitative researchers in the way they approach their "subjects" and the ensuing "data". Although there is an effort to present multiple interpretations, it is done so rather vicariously. The lived experience of a face-to-face encounter between the researcher and the respondent tends to be deferred to an inscription of that encounter in the form of transcription. In this stance, knowledge is a derivative of the captured, transcribed voice; and the known, originally of flesh and blood, is transformed into an amorphous mass only to be recreated and solidified in text. Both, the captured voice and the fixed subject can now be manipulated without fear of losing them to the continuity of life and time. The transcribed text is privileged over the initial experience and is "taken as the final court of appeal for such researchers," and it is given equal, if not more power than the original, and considered more real than the real (Denzin 1997, pg. 42).

Can it not be argued, however, that without a transcript one cannot be sure that what was said was really said? Yes, but therein lies a danger in assuming a stable external reality recorded by a stable, neutral, scientific observer (pg. 31). If the idea of "truth" is reliable only through a transcript, then every face-to-face encounter of lived experience is untrustworthy, if not void altogether. We should

all carry tape-recorders and transcribers to ascertain the true truth of inevitably contextual and shifting social encounters.

Although under the banner of "socially constructed meaning," transcription can have little if no regard for a reality of "shifting minds to a shifting, external world" (pg. 32). A transcribed text can be seen as containing a set of meanings that remain frozen for all time, thus more reliable. Yet, such texts are read and reread, interpreted and reinterpreted with every new reading through which the reader as researcher creates newer meanings and reifications. What goes unrealized is that each encounter with the text is a new experience. To believe that each reading is still an encounter with the original experience ignores the contextual, historical moments that produced it (Bakhtin 1986). The text is given a life of its own. It is no longer just a copy of the original because the original has since changed. "Every transcription," states Denzin, "is a retelling—a new telling of a previously heard, now newly heard voice" (1997, pg. 43). And each (re)reading of the transcript is yet another newly heard voice.

Ethnographic practices of the 21st century call for a momentary suspension of the field interview and the carefully transcribed voice of the other (pg. 47). The goal is to move ethnographic deconstructive writing in new directions, into what Denzin calls the sixth moment—Ethnography through civic writing.

Ethnography through civic writing

The social sciences are witnessing an explicit, more definitive move to eradicate the traditional boundaries between scientific and sacred understandings of the world (Lincoln & Denzin 1994). Patricia Clough (1992)

sees ethnography in the twenty-first century moving toward a sacred and critically informed project anchored by moral imperatives. Ethnography must also go beyond the moral imperative. It must move the participants to action in public and private spheres, where people care for, are responsible for, and are accountable to one another (Denzin 1997; Ryan 1995). This requires new or different ways of learning about the world.

One such way as proposed by Denzin is what he terms "a civic or publicly responsible local ethnography that speaks to the central issues of self, society, and democracy" (1997, pg. 252). This approach, to paraphrase Denzin, invokes critical ethnography (Carspecken 1996), embraces moral, political, and social criticism, and advocates a form of participatory democracy without necessarily forcing particular solutions to particular problems (Charity 1995). It sees science as one among other social institutions not immune to "values that often exclude or distort the perspectives of minorities, women, the poor, and the powerless" (Denzin 1997, pg. 257). Thus, the publicly responsible ethnographer writes for and not about the other (Denzin 1997, pg. 268). There is no denying that a privilege is still assumed. But, the researcher in pursuit of knowing, a fundamental human desire, now does so not pretending to be a "morally neutral observer," but one who acknowledges the inevitability of personal involvement and political commitment (Denzin 1997, pg. 274). The now researcher becomes one who strives for human dignity, care, justice, and interpersonal respect (Lincoln 1995).

This new way of writing is by no means immune to criticism by traditionalists. Denzin lays out six points that summarize these criticisms (1997, pg. 264):

1. The new writing is not scientific; therefore, it cannot be part of the ethnographic project
2. The new writers are moralists, and moral judgments are not part of science.
3. The new writers have a faulty epistemology; they do not believe in disinterested observers who study a reality that is independent of human (thought and) action.
4. The new writing uses fiction: This is not science. It is art.
5. The new writers do not study lived experience, which is the true province of ethnography. Hence, the new writers are not participant observers.
6. The new writers are postmodernists, and this is irrational because postmodernism is fatalistic, nativistic, radical, absurd, and nihilistic.

These criticisms are obviously influenced by a markedly different paradigm.

Through Schutz, Gadamer, and Denzin, I have attempted in this chapter to outline the paradigmatic differences based on "axiomatic" issues[13] as advanced by Creswell (1998) and Guba & Lincoln (1988). It is important to realize, however, that these criticisms are not based solely on a difference in world-view. Power and politics too play a significant role in influencing accepted conceptions of science and ways to knowledge (Carspecken & Apple 1992; Denzin 1997; Foucault 1980; Gordon 1980; Smith 1989; Spivak 1994; Whittaker 1994). As

[13] See note 1.

newer forms of ethnographic practices emerge and challenge traditional realist ones, a counter criticism is mobilized with a powerful hegemonic position (Huber 1995; Farberman 1991; Prus 1996; Sanders 1995). Postmodernists are regarded as transgressors by these critics; they are "policed, punished, mocked, even ridiculed," explains Denzin, and "(r)esistances to the hegemonic order (are) marginalized and the deviants (are) labelled ... " (1997, pg. 251). Denzin finds that some such critics, such as Huber (1995), if given the power, would ban transgressors from academia, while others, like Prus (1996), are inclined to tolerate the differences and simply exclude transgressors from certain theory groups that favour what is considered a more legitimate approach to inquiry.

At the risk of being ostracized by such critics, I too see the need for a research method that embraces postmodern values within a communitarian and ethical model. Thus, I do not assert that there are no standards of right and wrong. I simply acknowledge that notions of right and wrong are influenced by many negotiated factors. I accept that facts are not independent of values, histories, and social contexts. Prejudice, as Gadamer (1975) stresses, is a part of being human. Therefore, I acknowledge that it is through a particular prejudice that I conduct my research. I believe, through lived experience that it is wrong to privilege certain people over others when it comes to health care. I oppose what I see as inequality and injustice. But, my intention is not to take a moral high ground, for I realize that multiple truths are at play, and I need to hear other voices and see my point-of-view in relation to other points-of-view.

Still, I find nothing wrong with stating the belief that I have experienced what I consider unjust, and I wish to change the situation. Yet, although I engage my research through a form of cultural and social criticism, I endeavour to respect principles of democracy, responsibility, a communitarian sense of ethics, accuracy, nonmaleficence, honesty, agency, and critical reflection as I deconstruct discourses of social responsibility. Some will consider my endeavour illegitimate for "scientific" inquiry (Huber 1995; Farberman 1991; Prus 1996; Sanders 1995) while others will see it as a necessary aspect of a science (Carspecken & Apple 1992; Denzin 1997; Foucault 1980; Gordon 1980; Smith 1989; Spivak 1994; Whittaker 1994).

As I deconstruct the interview narratives, I try to take a civic approach as advocated by Denzin (1997, pgs. 280-84), meaning that I make an effort to write an ethnography that seeks to move people to action, promoting serious discussion about democratic and personal politics of social responsibility in oral health care. My study begins with an epiphanal event – a recent occurrence that effectually denied access to dental care for a significant segment of the population in British Columbia. My inquiry into this event aspires to, using Denzin's words, "a socially responsible ethnographic (writing) that advocates democracy by creating a space for and giving a civic (public) voice to the biographically meaningful, epiphanal experiences that occur within the confines of the local moral community" (1997, pg. 281).

Using the ideas of public writing as outlined primarily and effectively by Charity (1995), Christians and colleagues (1993), and Mills (1959), Denzin points

out new positions in ethnography. I have here adopted and adapted these positions for my own research endeavour (1997, pg. 281). Public ethnography, as I now understand it through these writers, should:

- help citizens make intelligent decisions about private troubles that have become public issues, including helping to get these decisions carried out;
- promote interpretive works that raise public and private consciousness, helping people to collectively work through the decision-making process, and helping to isolate choices and core values, utilizing expert and local systems of knowledge, and facilitating reflective, civil discourse;
- reject the classic, heroic model of investigative inquiry that seeks out to somehow reveal the scandal, the corruption, the inside story, taking the moral high ground on various positions;
- require the ethnographer to learn how to listen better to the talk of citizens, to hear better emerging consensus and to realize that this is achieved best by remaining a full-time citizen and not someone who, during the research endeavour, stays mainly in the ivory tower of academia venturing to come out when in need of "data";
- require the ethnographer to champion deliberative, participatory discourse, encouraging the public's awareness of its own voice;
- value writing that moves a public to meaningful judgment and meaningful action, with a goal toward civic transformation; and
- expose complacency, bigotry, and wishful thinking through self-understanding.

Through the above principles I took a different approach to interviewing, placing an emphasis on "a more aggressive, information-gathering mode of interaction and confronting persons with contradictions in their accounts" (Denzin 1997, pg. 282). I listened for a common awareness of problems and distinct differences in points-of-view, always striving to acknowledge the filter through which I saw and heard.

In choosing this research method I was influenced by my concern about social inequities, and by my interest in the Canadian health care system. Denzin presents a cogent discussion of the methodological[14] rationale behind a civic approach to interpretive ethnography that I used as a basis for discourse analysis.

Discourse Analysis

I analyze my findings on social responsibility using discourse analysis. Fowler (1981) explains that "'Discourse' is speech or writing seen from the point of view of the beliefs, values and categories which it embodies; these beliefs etc. constitute a way of looking at the world, an organization or representation of experience—'ideology' in the neutral non-pejorative sense. Different modes of discourse encode different representations of experience; and the source of these representations is the communicative context within which the discourse is embedded" (Cited in Mills 1997, pg. 6). In other words, discourses affect all social institutions and are adopted and adapted in ways to allow us to make sense of

[14] I use the term methodology here not to indicate research technique and procedure, but as the philosophical framework, the fundamental assumptions and characteristics of my qualitative research perspective (see Van Manen 1990, pgs. 27-30).

our behaviour and reasoning (Pratt & Nesbit 2000). Discourses "are never "neutral" or value free, they reflect prevailing ideologies, values, beliefs, and social practices that can serve a hegemonic function by promoting dominant ideas and practices as normal or natural, and the language used to describe them as a form of common sense" (Pratt 2000, pg. 3). Hegemony, explains Bocock (1986) is a form of domination without force in that the interests of one or two social groups eventually dominate political, economic and cultural life through a taken-for-granted[15] consent of most members of society. This taken-for-grantedness comes about through common practices that are soon regarded as natural in that they are reproduced through social interactions and socially constructed power relations that become institutionalized over time. The central point about the concept of discourse is that those who control the discourse have the power to define the position of others and actually influences what is seen as real by determining what can be said and thought. It provides the words and conceptual frameworks for understanding the self and related experiences. This understanding then shapes the creation of political decisions, social norms and practices.

[15] The term 'taken-for-granted' is used repeatedly throughout the thesis. I use it to mean something taken to be true or valid without any critical reflection and only because the idea inherent in what is taken for granted seems so familiar that one ceases to appreciate its deeper meaning.

CHAPTER FOUR

IMPLEMENTATION OF THE STUDY

"Since we can only enter into another person's world through communication, we depend upon ethnographic dialogue to create a world of shared intersubjectivity and to reach an understanding of the differences between two worlds."

Barbara Tedlock

Selecting Research Sites and Interview Participants

Although issues of access to dental care permeate throughout Canada the bulk of the interviews were conducted with individuals selected from within British Columbia in order to contain this study within manageable boundaries. Moreover, since the impetus for this research comes from a recent series of events that has effectively denied access to dental care for a significant segment of the population in British Columbia, it was appropriate also to delimit the study within B.C. I conducted open-ended interviews (Kvale 1996) with 34 individuals drawn from an accessible group of dentists, dental educators, administrators, and those in the governance of dentistry. I employed three strategies for selecting participants: 1) *Maximum variation*, 2) *Purposeful*, and 3) *Network* (see Patton 1990).

The people I interviewed were purposefully selected to represent a range of vested interests and privileged positions in relation to the provision of dental care or the training of those who provide dental care. However, the focus of my study is not on individual, idiosyncratic interpretations of social responsibility. I accept

the position that no individual speaks entirely free of their social and cultural context and affiliations. As a consequence, any discursive account of social responsibility is, in part, not simply that of the speaker; it is also part of a larger discourse. Thus, I examined how people I interviewed communicated their ideas of social responsibility and positioned themselves in relations to this concept. I tried to listen for indicators of power, privilege and status within the context of economic, social, political, professional and cultural dimensions of their explanations. I listened for the different ways in which people addressed social responsibility and how their expressions shaped the boundaries that define what is acceptable and unacceptable within the community of professional dental practice. I also listened for who is included and who is left out from the system. I sought to gather the most varied and insightful information possible and the participants were selected to reflect the possible diversity of opinion on the subject of social responsibility in dentistry.

Selecting a heterogeneous group of participants helped to maximize the opportunity to obtain a range of views based on people's varied experiences within different social, professional and political contexts. Patton (1990) describes this as *maximum variety* selection strategy, whereby participants are selected from a variety of backgrounds in which the phenomenon of interest is of importance. Using this technique can provide unique variations in information, particularly when studying an abstract concept (Patton 1990). Moreover, explains Patton, in an attempt to increase the variation of participants, researchers not

only receive greater assurance in common patterns that emerge, but are also able to describe and understand the variation that has emerged.

The maximum variety *selection* strategy was employed within what Patton (1990) refers to as a *purposeful sampling*[16] method, whereby the researcher, based on personal knowledge and professional relations, seeks those participants believed to be able to provide the most insightful information according to their knowledge base and receptivity, and they are most likely to be interested, able, and willing to participate in the study (Morse 1986; Germain 1993). The Faculty of Dentistry at the University of British Columbia served as the initial site for purposeful selection of participants. I sent "contact letters" (see appendix A) to selected faculty members (based on the two *sampling*, or more appropriately, *selection* strategies mentioned above), followed by either a telephone call or an electronic-mail message. Additional contacts were made by means of *nominated or network sampling*, that is, I asked participants for support and assistance in identifying others who may be able and willing to contribute to the study (Patton 1990). Similarly, I contacted individuals from the British Columbia Federation of Dental Societies (BCFDS). I was fortunate also to interview dental educators and researchers from other universities in Canada, the United States, Britain and South Africa, whom I accessed through an international dental conference held in Vancouver, held for the first time in Canada.

[16] The term 'sample' suggests a 'population' and a means by which this sample represents that population. The term(s) more in line with my research methodology is 'selection'.

Ultimately, the number of people I interviewed depended on specific logistical and philosophical factors. I stopped interviewing additional participants when I began to notice that the last three to five interviews were not contributing anything different from previous interviews. I conducted, therefore, a total of thirty-four interviews.

The Interview

Qualitative researchers, explains Kvale (1996, pgs. 29-36), generally use interviews to discuss and understand how the social world is conceptualized (see also Schutz, 1970). However, Krefting (1991) cautions that some respondents will respond in a manner that will reflect what they think is a preferred social response (pg. 218), or with responses that are socially constructed from the interview itself (Fleming 1986). I realized that it would be difficult to avoid entirely one or both of these possibilities. However, by conducting the interviews as conversations I hoped that the evolving interaction might allow both the interviewer and participant to feel comfortable, unconstrained and free to share views honestly and openly. Thus, each interview was in effect a conversation and a reciprocation of views. Yet, I still saw my self as a researcher and during the interview I took a critical stance in the discussion to constructively and respectfully challenge the participants to explain fully their understanding and knowledge about social responsibility (Carspecken 1996; Clough 1992). This process is enhanced when the researcher allows the participant to control discussions as much as possible (Marton 1986). However, I did not take a morally neutral stance during the interviews. I shared my views when

appropriate, and I hoped to hear in response to this the various political, social, historical, professional and pragmatic factors that potentially influence ways of thinking about social responsibility in relation to dentistry. In a sense, every person interviewed is speaking as a member of a larger social group. The participants have been acculturated into broader conversations or discourses about social responsibility. In some part the broader discourse they have appropriated has become a part of the person and, as a consequence, is invisible to the speaker. It has become a natural and self-evident way of thinking.

The concept of social responsibility is a highly abstract one and is deeply embedded in people's understanding. To bring this concept to the fore I thought it useful to try to establish a practical connection between the concept and the participant's thinking and professional practice. At times, the interview evolved as a dialogical process, an exchange and building of ideas through agreements and disagreements and respectful challenges of emerging views (see Carspecken 1996, pgs. 154-155; see also Gadamer 1994, pgs. 383-405).

Each interview began with a consent form (see Appendix B) fully disclosing the nature of the research that each participant read and signed, which I decided to use as a point of departure for the ensuing conversation:

> *Upon reading the first paragraph in the consent form how did it strike a cord with you? What went through your mind as you read that?*

I assumed that my topic of inquiry was going to be very sensitive, politically and professionally. I decided that it would be best to get right to it rather than try to begin in a general and perhaps 'neutral' manner, which I thought might come

across as contrived. The participants generally regarded social responsibility as a highly abstract concept, not evident *readily* in thought or locatable in some form of actual practice, although seemingly perceptible in that instant:

> **Dr. C:** Whenever you delve into a topic that no one's dealt with before, you say gee why haven't they? Well, you have to ask yourself, maybe cause it's too damn hard! Or maybe people have started looking at it and said whoa, this is a real quagmire!! You can get bogged down in small issues ... that's what your supervisor has to guard against. Maybe pick one or two issues and concentrate on something that you can grab a hold of ... it's a huge area ... huge!!

Having anticipated this challenge, I introduced the word immediately, right at the outset of each interview so that I could focus the conversation on where and how each participant began. Thus, I asked for initial thoughts about a doctoral thesis on "social responsibility" to see where the participants located the idea before taking the opportunity to reflect on it through intense discussion that I anticipated and hoped would follow. Evidently, some began speaking to it immediately and expressed strong opinions about it, while others began by stating how broad and complex the idea of social responsibility was:

> **Dr. F:** What intrigued me when you spoke to me first about this was that I don't see much serious consideration of a very serious topic here.
>
> **Dr. D:** Social responsibility is a huge term, it's so vast! Everyone has their own idea of social responsibility.

With most participants, it was toward the end of the interview that I asked specifically, "how would *you* define social responsibility?" Although we had an hour or more of critical reflection, some participants still found it challenging to define the term.

Interview Questions

I used an interview guide to help begin and when necessary take the interview conversations in specific directions as relevant to the research theme. Kvale states that a "good interview question should contribute thematically to knowledge production and dynamically to promoting a good interview interaction" (1996, pg. 129). I used the following interview questions to stimulate a conversation on the research topic and to guide the dialogue when appropriate:

- Upon reading the first paragraph how did it strike a cord with you? What went through your mind as you read that?
- How important is dental health within the scheme of an individual's general health?
- What do you see as barriers to accessing dental health care in Canada?
- I read an article in the Journal of Dental Education encouraging the dental profession to adopt an ethic of social responsibility in order to affect change in dental education and in the existing philosophy of dental practice toward providing better access to dental care to those who are underserved. Can you help me understand what this concept of social responsibility means to you?
- Does the Canadian dental health care system need to reflect a particular notion of social responsibility?
- My interest in this study comes from two situations: First, about two years ago the British Columbia Federation of Dental Society (BCFDS) and the Ministry of Human Resources (MHR) within the Government arrived at an impasse on a dispute concerning dental fees for treatment of patients on social

assistance. I understand that the BCFDS recommended that dentists in British Columbia stop accepting new dental patients on social assistance until the Ministry agreed to a reimbursement plan according to the Dental Federation's Fee Guide. Can you tell me what happened and what implications this has for patients on social assistance?

- In your experience, in what ways does the idea of social responsibility manifest in dental education, practice, and policy?
- What code of ethics do dental professionals adhere to in relation to the concept of social responsibility?
- How can dental educators teach "social responsibility"?
- Why has dental care evolved separately from the general health care system in Canada?

These questions were not asked in a predetermined order, nor were all of them asked during every interview. It depended upon the depth of each participant's response and the ensuing conversation. Nor did I assume that these would be the only questions to prompt the interviews. I expected fully that other issues would emerge based on the ongoing analysis. I also used follow-up and probing questions to invite participants to clarify their views and to provide in-depth, reflective insights (Kvale 1996).

My intent was not to make global truth statements about social responsibility, but to describe how participants speak of this concept within particular social contexts and social realities. My aim was to explore the discourses that influenced how people made sense of social responsibility among

those who teach, study, practice, and develop policy in the fields of dental health care. The discursive constructions of social responsibility are presented through the contexts within which the participants work and live, both of which are influenced by related underlying and prevailing ideologies, values, beliefs, and social practices. I acknowledge, therefore, that no individual speaks entirely free of their social and cultural context and affiliations. As a consequence, any discursive construction of the concept of social responsibility is, in part, that of the participant, and also part of a larger discourse. Throughout the interviews I too went through a reflective process as I responded and reacted to the discussion. I tried to take a critical role in that reflective process and during the interviews. Inevitably, as 'researcher', I did not stand outside of the relationship with what is 'researched'. Through this research, as is the tradition in critical ethnographic studies (Carspecken 1996; Denzin 1997), I contributed to the discussion on approaches to dental education, policy, and service delivery by challenging, when appropriate, the respondents on their views.

Ethical Considerations

The Ethics Review Committee of the University of British Columbia approved this project. The ethical standards of this investigation were ensured by obtaining informed consent from participants, and by striving to maintain confidentiality and anonymity of the views expressed. Each participant was made aware of the study, its purpose, and the level of involvement required. All participants were assured that their interview data would be kept confidential and that the only use of the information would be for the stated study.

Participants reserved the right to refuse participation, the right to refuse answers to any questions, and the right to withdraw from the study at any time. Anonymity was achieved by assigning randomly the interviewees to alphabetical letters (A to Z and then AA to AH). Any names recorded on tape and/or transcripts were blanked. No information is identifiable as ascribed to any particular informant in this dissertation.

The issue of confidentiality and anonymity were certainly a concern and some were clearly guarded in their responses right from the beginning and intermittently glanced at my tape-recorder, while others felt very comfortable expressing their views, whether negative or positive, and were not bothered by the tape-recorder. Some wanted to make sure that their anonymity was protected because they felt that what they were about to say would not be looked upon favourably by fellow colleagues.

The Transcript and its Analysis

With each participant's permission, the conversations were tape-recorded and transcribed verbatim. Each one-hour interview took approximately five to six hours to transcribe. Each interview lasted at least one hour, but this varied considerably depending on each participant's time constraint.

In reading and rereading the transcripts I tried to identify how participants made sense of the ways they spoke about social responsibility in dentistry. I wanted to know, therefore, how they conceptually constructed and situated themselves and others in relation to what they considered to be social responsibility within dentistry, and how different expressions and understandings

relate to the issues of access to dental care. I also wanted to know how they justified and rationalized their positions. I studied the transcripts to identify, interpret and elaborate on how the participants account for social responsibility in relation to the issue of access to care. Each emerging narrative and related account guided my approach to subsequent interviews. I studied emerging accounts both within and between individual transcripts to aid in reinterpreting the issues that seemed to affect each view. My purpose was not to objectify and reify the transcripts, but to explore the range of accounts within, by reading and rereading, interpreting and reinterpreting with every new reading (Denzin 1997). My findings do not represent all dentists, dental educators, or people involved in the governance of dentistry, only those whom I interviewed.

Ensuring Accountability

Research of all kinds ought to have regard for the scholars, practitioners, and community that will read and participate in it (Pratt 1996). In this study, concepts of adequacy, trustworthiness and believability form the foundation for standards of accountability. These concepts call for "well grounded, cogent, justifiable, relevant, and meaningful" philosophical and practical processes for the study (Hall & Stevens 1991). Hence, I studied ideas of reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty, relationality, and mutuality to inform and develop my sense of accountability (pgs. 21-26). My framework for ensuring accountability is based on these ideas, which I interpret through Gadamer's work on hermeneutics, acknowledging that prejudice is presumed in all understanding and that it is an integral part of being human; and

Denzin's work, acknowledging that all interpretations remain open and incomplete (1997, pp. 249-289). Those who read my study should judge its credibility based on their interpretations of it. Consequently, I explain in detail the steps I took in conceptualizing and implementing the study. I endeavour to share my known bias through reflexivity.

Accountability ought to be judged on my ability to convince the reader of my honesty and transparency through my writing. The reader should be able to assess how the writing constructs and negotiates meanings, providing multiple versions of truth, and how it invites criticism. I seek to gain credibility and legitimacy by showing how each version of truth can impinge on and shape the phenomenon being studied (Denzin 1997; Schutz 1962). I endeavour to recognize equal privilege to a plurality of interpretations (Denzin 1997), while at the same time acknowledging the interpretations that I favour (Gadamer 1994) in seeking change in a dental health care system that does not fully appreciate the need for social responsibility toward individuals who are impoverished, or otherwise disadvantaged and cannot access care. Therefore, others can learn from this study and analytically—by comparing findings with their experience—take what they learn to different settings where they may want to apply the findings (Krefting 1991). Thus, in this qualitative research it is the readers who can recognize and confirm general applicability of the research (Cobb & Hagemaster 1987); the premise being that understanding others can help one understand one's own thinking.

I shared my transcripts, thoughts and analyses with my thesis supervisory committee who assisted in interpreting information and in assuring *dependability* (Lincoln 1995). Through dependability I strive for carefulness and thoughtfulness in the research process. The committee acted like auditors. They reviewed my records, provided feedback, participated in discussions on the analysis, literature reviews, transcripts and any other information related to this study (Lincoln 1995). Qualitative inquiry is a complex, dynamic process enriched by the experience and integrity of the researcher, the research team, and the participants within the inquiry. It is influenced by and dependent upon the social and political settings in which the study takes place. It can provide significant insight into the social world as lived and experienced by those who participate in it.

Advantages of Using a Qualitative Method for this Study

While a quantitative approach is framed by deductive designs used to test hypotheses that lead to predictions and statistical generalizations, qualitative inquiry is inductive and focuses on the socially constructed aspects of various phenomena to understand better the context-bound nature and meaning of social experiences. We do not necessarily experience social or natural phenomena in the same way, and the social world and people's social experiences are not easily measured. Consequently, qualitative research does not focus solely on the quantity, intensity, magnitude, or frequency of experiences (Denzin & Lincoln 1994). Rather, it seeks to understand social phenomena through detailed exploration of social life and how people construct social meaning.

Qualitative methods allow for inductive, interpretive, and descriptive approaches to studying human or social phenomena—where "reality" is socially constructed and socially established (Berger & Luckmann 1967; Schutz 1962). A qualitative approach is well suited for investigating the discursive constructions of social responsibility in dental health care. It can help to reveal some of the underlying biases associated with this concept about which remarkably little is known within the context of health care.

Researchers using a qualitative method, in general, seek to understand the nature, meaning and content of social experience; they explore constructions of reality through the interpretations, discourses, understandings, and experiences of persons, including their own, within particular social contexts (Denzin 1994). In short, unlike the natural sciences, where the preferred method of inquiry is controlled experiment and quantitative measurement, the human or social sciences choose approaches to inquiry that help understand the interpreted meanings of socially constructed realities.

Assumptions

Qualitative researchers work within an interpretive framework that reflects the researcher's ontology, epistemology, and methodology. Here I will briefly outline various assumptions that frame this study.

Researchers make certain assumptions about the world—how it now works or looks, and how it should work or look (Pratt 1997). In reflecting on the former premise of seeing the world, I am informed by a phenomenological perspective. Consequently, I take the position that the world is seen to be subjectively and

continuously re-created by its inhabitants through a social construction of shared meanings (Wagner 1970; Van Manen 1990). Accordingly, a person holds various conceptions of the world which are both a matter of personal interpretation in addition to a world view developed from "...the many customs and norms regulating human conduct, plus the many recipes for practical behaviour in social as well as technical matters" (Wagner 1970). Berger and Luckman (1967) articulate this understanding effectively:

> The reality of everyday life further presents to me as an intersubjective world, a world that I share with others. This intersubjectivity sharply differentiates everyday life from other realities of which I am conscious. I am alone in the world of my dreams, but I know that the world of everyday life is as real to others as it is to myself. Indeed, I cannot exist in everyday life without continually interacting and communicating with others. I know that my natural attitude to this world corresponds with the natural attitude of others, that they also comprehend the objectifications by which this world is ordered, that they also organize this world around the "here and now" of *their* being in it and have projects for working in it. I also know, of course, that the others have a perspective on this common world that is not identical with mine. My "here" is their "there." My "now" does not fully overlap with theirs. My projects differ from and may even conflict with theirs. All the same, I know that I live with them in a common world. Most importantly, I know that there is an ongoing correspondence between *my* meanings and *their* meanings in this world, that we share a common sense about its reality (pg. 23).

Using the above articulation as a point of departure, and keeping within its position, I see that various aspects of "reality" can present as problematic. For example, I believe that economics, politics, power and privilege can play an important role in determining resource and service allocation, leading to various forms of injustice and inequity. Certain ways of seeing things and understanding the world and how it works are taken for granted, consciously or unconsciously, and propagate and sustain the ways of the problematic world in ways that may

be unproblematic to others. This position leads me to assumptions of how the world should work and look.

In reflecting on how the world should work, I would like to take the position of an advocate for the disadvantaged who do not have access to dental care. I seek to understand and to attempt to redress some of the existing inequities and injustices. Through this research, therefore, my intention is to explore particular aspects of social, economic, professional, and political frameworks that facilitate injustice and inequity as these present themselves to me and to others. I raise questions of ethics and a right to access to reasonable levels of dental health care.

I maintain that ways of understanding and experiencing various phenomena differ among people depending on their experiences and the situation at hand. That is to say, people experience phenomena in the world around them in qualitatively different ways (Marton 1981). Consequently, the particular ways in which people understand a concept, or phenomenon, can enhance or establish limits on how they think and act on the concept (Marton 1988). It should be fruitful, therefore, to understand policy-makers, educators and health care providers as they reflect on the concept of social responsibility within the healing professions; and to explore what established institutional practices and power relations influence their understanding. This means that I must endeavour to take nothing for granted so I can understand the points-of-view of those who will participate in the study. In this regard, Schutz suggests approaching scientific observation with a "disinterested attitude" (Wagner 1970). I understand this to

mean that I need to be cognizant of my own understanding of the phenomenon under study, and I must be careful not to force my views and opinions during the interview conversation so the participants do not feel constrained to communicate their ideas as fully and freely as possible.

Personal reflections on social responsibility

The concept of social responsibility is not articulated explicitly anywhere in the literature on effecting change in dental education and dental practice. Throughout my research interviews, I was challenged to reflect and articulate my own notions and assumptions of social responsibility in order to bracket my assumptions (Patton 1991) so that I could listen with a "disinterested attitude" (Schutz 1970). I soon realized that as I listened to and analyzed the first few interviews I was unconsciously drawn to statements that touched on the three assumptions I made above—statements that inform my taken-for-granted views of the world. I certainly was *not* "disinterested" nor could I pretend to be, but I needed to be aware and mindful of this. So, early during the research, I consciously reflected on the following questions: *What does it mean to me to be a socially responsible dental health care practitioner, or educator? In that case, when is someone being irresponsible? As a dental professional, if I were attempting to act in a socially responsible manner to meet the needs of underserved populations, what would or should I be doing? Reduce my fees? Provide dental services at no cost? Lobby the government for funding for public dental health projects? How should I begin to think about social responsibility?*

These questions occupied my thoughts constantly. I hoped that my thoughts would become increasingly sophisticated and critical as I reviewed the literature. I thought that my understanding of social responsibility (the meaning I ascribed to it) would became increasingly evident the more I read and reflected. I felt it was important, however, to write about social responsibility early on so that I would better understand my personal assumptions and taken-for-granted views regardless of how unrefined my thoughts were. My aim was to explore the concept of social responsibility, and not to produce a single, dictionary definition. I began by examining the term *responsibility* and exploring its use in common discourse. I then analyzed the concept within the context of dental health care and the question of access of care. The concept of social responsibility is most meaningful when applied to a context like professional practice and it is within this context that I situated the idea.

In communicating with others, we express our ideas through words that attempt to convey some meaning. I realize that I often take for granted that others truly understand what I mean by the words I use. It is not just a matter of minimizing vagueness or defining terms. The problem is much deeper; it stems from an unquestioning belief that others see the world just as I do. This tacitly held belief hinders communication leading to misinterpretation of conveyed ideas, actions, and intentions. This is particularly true when using terms that convey more than simply a dictionary definition. Take the word *God*, for example. The word is used in many different ways in day-to-day conversations. From a religious perspective, *God* is understood in a particular way. However, I have

heard the saying, "he likes to play God," or use the expression, "for God's sake!" or, "oh my God." When using certain words, therefore, the concern is more than merely a stipulative or technical definition to express meaning. Instead, what is involved is a concept. It is unlikely, then, that one could go to a dictionary to find the various meanings a concept conveys because questions of concept are not concerned with *the* meaning of a word.

Thus, when dealing with a concept, there are many different meanings, not in existence of their own right, but existent only in the ways that the concept is used. Yet, one cannot always be certain that words are being used in ways that express a certain underlying idea. In addition, different words hold different meanings depending on the context. A further challenge is the taken-for-granted nature of the communicative process that others hold similar meanings to the words used.

The term *responsibility* tends to emerge within a framework of certain actions, or inaction (as in failing to do something), intentions, or behaviours of an individual or a group of individuals, and may or may not be associated with various levels of consequences that may follow. Responsibility involves personal agency, and it is something that is learned. Responsibility is also linked to a moral notion, and for these reasons, it seems inappropriate, for example, to attribute responsibility to objects or animals (and I do not mean this in a hierarchical sense), although the term has been used in such cases. For example, although a fallen tree could have caused damage to a house, I hesitate to assign it responsibility for the damage caused. Responsibility is something that

is given, and assumed or accepted by someone, such that one can be held accountable for that responsibility, either to oneself or to someone else. Here, the element of volition is a critical factor, and it seems unreasonable to be responsible for things outside of one's control. The example I used, of the tree falling on a house for instance, although the cause of damage, cannot be held accountable because it cannot take responsibility for its happenings. The tree did not act purposely to fall on the house; moreover, the tree could not be said to be irresponsible for falling on the house, for that would be anthropomorphic.

To say that someone is a responsible person is to make a statement that the person exhibits consistency in behaviour, among other considerations. It seems inappropriate to say, "she is a responsible person today, but yesterday she was not, and tomorrow only tomorrow will tell." I would hesitate to refer to someone as a responsible person if I witnessed that this person, on various occasions, did things that neglected responsibility. A responsible person is one who fulfills accepted commitments and takes care in doing so. If, for example, I made a commitment to return at a certain time something I borrowed (call it B), I would take care to ensure that I accomplish what I committed to do. Unless something happened beyond my control and I could not return B, I would have to have a reasonable explanation and I would hope that the owner of B would understand. My intention would be to uphold my position as a person who takes care to fulfill commitments, and would fail to do so only under unavoidable circumstances. However, if on a consistent basis I did not live up to my commitments and I always seemed to have an excuse, which did not always

seem legitimate, I may be held suspect of not truly taking care to fulfill my commitments. If I could not organize my commitments, nor take care to fulfill what I accept because I tend to over-commit myself, then I would be acting irresponsibly. In this case, I may lose my position as a responsible person. Thereafter, I would have to convince people to trust me to make commitments and take care in fulfilling them. It would be unreasonable, however, to be regarded as an irresponsible person if my actions on some occasion, given their nature and past frequency, are inconsistent with my usual disposition.

A responsible person is also one who does not take unnecessary risks in fulfilling commitments; risks that would compromise anyone's or anything's safety or integrity. A responsible person would take care to not compromise safety, or the rights of others. In other words, a responsible person is a careful person who lives up to commitments and takes care to do so. For instance, it would be difficult to assign a task to someone who, in the course of fulfilling that task, was unnecessarily reckless and dangerous. For example, say a given courier company prides itself in being the fastest company to deliver goods. However, their efficiency is achieved at great risk. Their drivers are reckless and at times come very close to causing accidents or do in fact cause them. They risk the safety of others and also the safety of the goods they transport, all in the name of their commitment to deliver goods in an extraordinary amount of time. They cannot be trusted or relied upon to consider the safety of others above the commitment to their task. This is problematic, for to fulfill a responsibility a responsible person ought not to compromise the safety of anyone or anything,

and would take care not to do so. A responsible person is one who can be left in charge and can be relied upon to make appropriate decisions. There is an element of trust and reliability to attend to all matters as committed to and to take care in fulfilling the commitments without undue risks to any persons or property.

To say that someone is a responsible person requires a moral premise. Morality here refers to the rules of conduct examined and established within a society to understand and do what is right, while respecting the rights of others (Frankena 1962).

> Morality is a normative system in which evaluative judgements of some sort are made, more or less consciously, from a certain point of view, namely from the point of view of a consideration of the effects of actions, motives, traits, etc./ on the lives of persons or sentient beings as such, including the lives of others besides the person acting, being judged, or judging (as the case may be) (pg. 26).

Frankena places the concept of morality within human relations, that is, before one decides to act, one must think how it may or may not affect others. In so doing, one cannot help but consider one's moral obligation to others. So, can someone be a responsible but not a moral or ethical person?

It is problematic to accept an immoral person as responsible if an immoral person cannot choose right from wrong. If being responsible is a matter of moral principle, then fulfilling commitments due only to accountability, or in anticipation of positive or negative consequences is superficial. A responsible person is one who is responsible not out of self-interest, but because it is the right thing to do. It is a matter of moral principle. An immoral person could make a commitment and take care in fulfilling it. That is, for example, an immoral person can commit to do

something that harms others, and take care to accomplish it, and be considered reliable in so doing. Does this make this person a responsible person?

Responsibility, I believe, is a moral concept and the notion of responsibility in one context (among a group of criminals for example) ought not to hold different standards in another context. Responsibility is responsibility. However, it is conceivable that a group of immoral people would hold a different notion of what it means to be responsible. I do not believe that it is appropriate to consider a criminal a responsible person just because other criminals consider this person to be responsible (in fulfilling criminal commitments, etc.). Imagine a thief, C. Now imagine this thief is applying for a teaching position and had the qualifications to do so. C provides as reference two teachers who attest C to be a responsible person. These teachers have dealt with C on previous occasions in thievery. In C's criminal dealings with them, C made commitments and took care in fulfilling them, just as any responsible person would. I find it difficult to reconcile this idea. The notion of responsibility becomes more than making commitments and taking care to fulfill them. A responsible person is someone whose character withstands an element of time, integrity, and the test of ethics. In matters of responsibility, it seems that we are concerned with the agent, his or her actions, intentions and behaviours. We evaluate these elements against specific moral standards. The idea of responsibility is central to moral concerns. What, then, is *social* responsibility?

I believe that the social world plays a critical role in moral relations of responsibility. Moral responsibility is formed through the influences of social

practices. Thus, responsibility forms a fundamental part of the individual toward a sense of collective integrity. My idea of responsibility is rooted in moral foundations whose core is the integrity of individual identity within society. I view responsibility as situated within society to help individuals decide what kind of people they ought to be. Notions of responsibility are influenced by the context of a person's social role, social position, and occupation.

The concept of a socially responsible person is closely related to ideas of responsibility. However, the idea of being socially responsible entails something more than taking care in doing something and being honest, reliable and moral. It is more than not doing the wrong thing and not infringing on the rights of others.

The socially responsible person can be one who decides to leave the car at home and opt to take the bicycle to work with the intention of making a small difference toward reducing automobile air pollutants in the environment. Although this person's actions are not required by law, it is something that is done for the common good. In a legal sense, for example, one is responsible for one's actions within the law, and one could be held liable or accountable to a legal body for failing to take responsibility. For example, in obtaining a driver's license I have accepted the responsibility to obey all traffic laws, and I must bear full responsibility for breaking any such law, the breaking of which can result in a fine, imprisonment, and/or revocation of my driver's license. In other words, I am answerable and can be held accountable for my driving in that I cannot disclaim responsibility for breaking a traffic law, knowingly or unknowingly, for which I must accept the full range of potential legal consequences. The concept of social

responsibility, however, is not *always* tied to the law, but it may be tied to a certain ethic of what it means to live within and as part of a community.

It seems to me that social responsibility has to do with actions and intentions that are directed toward improving the general well-being of society toward a common good. A socially responsible person is one who considers his or her actions, or inaction, in relation to its effects on society as a whole. It may not be the case that matters of social responsibility are constituted within legal frameworks, like non-smoking by-laws, for example. A socially responsible person acts not only in self-interest but also in the interest of the welfare of others. I do not mean, however, that a person acting in self-interest can do so without considering the welfare of others. Yet, there is a certain ethic that pervades the idea of social responsibility. For example, not engaging in charity or not engaging in community service is not necessarily the wrong thing to do and it does not presuppose the notion of a responsible person as identified above. One is free to choose to be charitable, or volunteer in the community; and as a free agent, to decide not to do so does not infringe upon the rights of others. To say that charitable acts are the right thing to do cannot presuppose that not doing so is wrong. The notions of right and wrong in that sense cannot form the foundation of social responsibility in a democratic society.

As social beings, we live, work and have our being within the social life of our communities. As social beings, we encounter social problems, for which we incur certain social costs. These complex problems emerge within various contexts of social, economic, and political settings and cannot directly be

attributed to any one individual or individuals. As social beings, we have various private and public interests. We hold conceptions of "the good life" and we institute measures of justice and fairness to protect personal and social interests. Yet, social systems can and do disenfranchise some people who become distanced from public decision-making, and often because they are excluded from the political system. I believe that the idea of social responsibility springs forth from here. It is tied to a social conscience and it is a notion that is shared among individuals because it connotes an ethic of care and trust beyond individualism and private interests. Decisions should not compromise the welfare of those who are affected by them.

As a result, for example, the idea of corporate social responsibility has been made popular in the last decade and the message is that profit ought not to dictate all the decisions we make. The depth and complexity of the idea of social responsibility is made evident in current experiences of privatization and corporatization, particularly in social institutions such as health care. Health care generally is considered a social good that is needed by all. The social value of health is a common societal concern. It is a premise through which society recognizes and accepts the position of a health professional. It is also a premise that delimits the ideas of social responsibility. It seems to me that health professionals are not only responsible for providing competent and ethical services, but they ought also to accept the social responsibility of public service. This seems an inherent part of the social contract between the health professional and society within a sophisticated and democratic social and political

system. Social responsibility is not the exclusive domain of health professionals, however, what distinguishes a health professional from others is that the former has a fiduciary role in society. Nevertheless, the political and social environment often has a profound influence on the role of the health professional. In the practise of health care, therefore, the idea of social responsibility should be dependent on moral concerns that affect the welfare of all people regardless of economic and social status.

A responsible professional, I believe, is one who is ethical, dependable and reliable in the delivery of service, while keeping up-to-date in the art and science of the profession. Although a responsible professional can be called to account for his or her actions, and is culpable, the notion of responsibility stands by itself and should not be dependent upon, or held to, because of fear of punishment, or the expectation of reward. The notion of social responsibility has the same roots. There exists a certain relationship between the idea of a profession and the idea of social responsibility. Professions exist within a social tradition that accepts the purpose of the profession in service to society. In this sense, a member of any profession acts not only in self-interest but also in the interest of the profession and the interest of society. In the field of health care, the notion of social responsibility ought to penetrate perspectives governed by economic or legal factors. Dental health professionals, having been ascribed the status of "profession" by society, have a social responsibility to direct their education, research and service toward the health of all, and not just those who can afford to pay for dental services. This is not merely a personal viewpoint but one that has

been developed over centuries within societies that advanced the notion of "profession".

Suppose, for example, K were an ordinary dental health care professional that owned a private dental practice in a free market economy. K would not be considered an irresponsible person for not giving charity or not providing a service to someone who could not pay. It would not be unlawful not to do these things. However, would it be socially responsible for a health care professional to provide services only for personal gain and deny services to others that could not pay—especially if K provided the service? This position is self-serving and is dominant in a free market system where access to goods and services are determined by ability to pay. This example becomes critical in the field of health care, where a patient in a vulnerable situation is highly dependent on the health care provider. In the dental health care model of service delivery, largely based on fee-for-service, this is problematic. Social and economic standing can become critical factors in making treatment decisions. Within the fee-for-service model of dentistry (as it exists in North America) dental practitioners are not legally responsible for providing service to those who cannot pay for it. Just as a car dealer is not obliged to sell you a car if you cannot pay for it, a dentist is not liable, or responsible for providing care to whose who cannot pay. This is not within the legal responsibilities of the dentist. Although health care professionals are socially responsible for providing competent and ethical service, the law limits professional responsibility. Social responsibility is not achieved within the present model.

Social responsibility exists within a larger professional and societal framework. Various professions are given recognition and freedom to operate as professions within society, and its members reap the related rewards (status, income, prestige, etc.). However, their services ought not to be exclusive. I feel that this should not be the case in matters of health care. I am unsettled by the idea of a society in which financial gain dictates social worth. A society that lacks the ethic of care and a sense of social responsibility towards the poor, the weak and the disabled is a society that is not as sophisticated as it perhaps could be. Moreover, there is a moral attachment associated with social responsibility, and moral issues affect the welfare of all humans. So, there is something unsettling about a society, which restricts care only to those who can pay. However, social responsibility is also a matter of being able to choose to do what is good rather than being forced to do what others consider to be good. I am uncomfortable with the idea that moral principles, no matter how righteous they seem, should be imposed. Social responsibility becomes meaningless when "what is right and good" ceases to be an ethical standard to be upheld but rather a matter of legal injunction to be enforced. In the field of dental health, practitioners must assume the responsibility inherent in their choice of profession. Social responsibility cannot and should not be imposed—it must be embraced.

The interpretive ethnographic research method encourages the researcher to take account of personal assumptions thus allowing one to explore, in a specific way, the relationships between private constructions of *social responsibility* and the public manifestations of those constructions. I believe that

the outcomes of this research will enable people to reflect on the issues raised and perhaps change how things work. The ideas on social responsibility I describe here were written down during the initial stages of my interviews and were influenced by my previous believes as well as by exposure to my research as a whole.

CHAPTER FIVE

DISCURSIVE CONSTRUCTIONS OF SOCIAL RESPONSIBILITY

"Society not only continues to exist by transmission, by communication, but may be fairly said to exist in transmission, in communication."

John Dewey

From my analysis of interviews with individuals drawn from an accessible group of dentists, dental educators, administrators (of dental schools, within government, dental associations, and public dental health clinics), I present here the different ways in which participants deal with the concept of social responsibility to those who cannot access dental health care primarily because they cannot afford it. I present my findings in four separate sections, each focusing on the different discursive constructions of social responsibility as 1) an economical discourse; 2) a professional discourse; 3) an individual choice discourse; and 4) as a political and organizational discourse. Within each of these, I present the accounts that the participants offered that point to the fundamental tensions between the different constructs of social responsibility. It is important to note that the participants speaking from a particular discursive space are not defined or located in it per se; it is their accounts that are located there. Most of the participants moved within and between discursive spaces as they talked about their own inability to resolve the issue of social responsibility.

In each of the four sections I discuss the participants' sense of the professional role and responsibilities of dentists relative to social responsibility

and what they see as acceptable and unacceptable within the community of professional dental practice. I present, therefore, how at times some of them challenged the appropriateness of the current dental health care system as based predominantly in a private, fee-for-service delivery structure, in effect, the ***status quo***. The status quo, then, is the way the dental health care system is seen by the participants to presently operate—essentially as a private system available predominantly to those who have the means to pay for services. Those who challenged this status quo supported a view that dentists ought to be more socially responsible, such that access to dental care should not be restricted to those who can afford care. Those who accepted the status quo tried to legitimize and defend why dentists operate in a way that may be thought to preclude a sense of social responsibility. The participants provided various *accounts* to explain, rationalize and justify their views in accordance with how the system is seen to operate or should operate. I use the term *account* to refer not only to the moral and practical explanations the participants construct to justify their views, position and role—their reasoned justifications—but also how, in their narratives, they try to legitimize why it makes sense to see and do things in one way and not another.

'SOCIAL RESPONSIBILITY' AS AN ECONOMICAL DISCOURSE

Reference to dentistry as a commercial enterprise focuses on the business side of dentistry. There were some participants who were critical of it, while others presented it as an inevitable and necessary part of the dental health care system. Those who were critical of it described it more clearly, while those who supported it did so defensively and much more subtly, trying to legitimize why things were and had to be this way. The critics pointed to its hegemonic function in dentistry and resisted what they considered an unacceptable construction of their professional identity and what it meant to be a dentist and a provider of health care. As a result, they invoked a counter discourse rooted in issues of professionalism and rights to health care to support their position and criticisms. They were critical of the image of dentists as commercial entrepreneur, seen first as business-persons with a primary desire to economic success. They expressed concern over the profession that they felt was absorbed by a corporate mentality, driven by profit. They held firm to a professional identification more closely related to their views of what health care ought to be—accessible, universal and impartial.

In this Chapter I highlight the discursive construction of social responsibility in relation to the economics of dentistry. I present my findings through a series of accounts that give an insight into the various dimensions that frame the participants' sense of social responsibility and the tensions surrounding the issues they raise.

The 'monetarization' of dentistry

There was no doubt for some participants that the business side of dentistry influenced strongly the decisions on who received care and who did not. They indicated that dental health care was seen as important to the extent services were "billable." The amount of money to be generated played an important part in the decision making process. Some indicated that this was the inevitable and detrimental influence of the "monetarization of medicine" where the delivery of care is increasingly dictated by economic priorities. Dr. F presents these issues forcefully and forthrightly:

> **Dr. F:** What I'm saying is that the financial, business side of the American Dental Association crest is so important and generates so much funds that one would have a certain suspicion that the whole process is money driven. What is the dental organization really all about? It's about the dental trade! You want to talk about social consciousness right; well sorry, we're a dental trade organization! You'll have students tell you that what you're trying to teach me is a waste of time. If it's not billable, it's not going to be done. Is social consciousness billable!? (...) There's no doubt whatsoever that that has become an example of the negative impact of the monetarization of medicine. I think the kind of dental care and health care that's delivered is becoming extraordinarily dictated by what is profitable, maybe to a frightening degree and it's something that we don't even have a handle on.

In his narrative, Dr. F expresses a clear discontent and unease about a profit motivated dental health care system. He relates dentistry to a trade organization; similar to any other industry engaged primarily in buying and selling goods and services. He likens dentists to members of trade unions concerned first in protecting their own interests. He also alludes to how student and professional attitudes are influenced by a trade mentality—the value of dental health services is gauged by profitability—treatments, even if therapeutic, are

essentially useless if they do not generate profit. This, he says, is occurring "to a frightening degree" with an added concern that the profession does not "have a handle on" it and he sees it spiralling out of control. Dr. F is among a few participants who expressed concern about the way the system is structured to protect and reinforce the dentists' economic interests. Not all who held parallel views constructed it in the same way; they raised their concerns within different contexts invoking different reasons to support and extend their position:

> **Dr. L:** (...) there is a vast area there, which is really in the North American scene in which the public is ripped off and that's both unethical and its societally unacceptable and unsupportable!! The number of people that you must have run up against that come up with a story, my God! I had a sore tooth and I went and saw my GP, and he took a radiograph and examined me and that was fee one; then he referred me to an endodontist and *he* took another radiograph, another examination and that was fee two, and then he had to do a root canal, and then he referred me to some bloody crown specialist, another examination and another fee! End result: one tooth that cost $1500! And they are seething because they can get a heart transplant for $1000 or close to it—I'm exaggerating, but you see the point! But to me that's educational policy and it requires educational direction and all the other kinds of things, and the profession is responsible here too!! There are 9 specialties recognized in Canada! Nine!! Maybe 10 for all I know now! Is there a need for that? I don't think so! (...) (T)he thing that is driven it in this direction is money! (...) Dentistry is still a private entity in this country and it's milked to a tremendous amount!

Dr. L points here to what he believes is a dental health care system that is structured in a way that inevitably increases the cost of dental care with a motive to generate profit. Throughout the interview, Dr. L rejected arguments that attempted to support a commercial approach to dentistry that discriminated against patients who cannot afford care. Similarly, when challenged, the participants who held such views invoked a range of accounts to support their

beliefs. Dr. J, for example, calls on the ideal of professionalism, and the privilege and exclusivity accorded to the professions, to support his views:

> **Dr. J:** Well yeah, there is a real difference in the nature of legislation that gives exclusivity to these kinds of people. And you cannot be a dentist... you cannot have competing people come moving into dentistry. Only dentists can be dentists so there's a...you can be a lawyer, an engineer, or you can be any number of things, but only dentists can do dentistry and in the social contract it is most explicit around those kinds of professions where a society says we will set you apart, we will grant you these unique privileges we will let you be self-governing, and in return you will meet our needs.

In this example the dentist is seen as set apart from other business people in the market where producers are rivals in competition for consumer outlays. Dentists, were seen to have no external competition—in effect, they have a monopoly—a privilege granted to their profession by society in return for meeting societal needs. The 'dental culture', from the point of view of these few participants who were clearly critical of prevailing norms and the status quo, was seen as one in which working relationships, traditions, customs, and social and professional interactions and structures are primarily economically driven, where the credo is, "it is okay to do it if you make money."

Earning an appropriate level of income

On the other hand, the need to have adequate income levels to survive and to support a family, to sustain particular living standards, and to recover expected rates of return on educational investments, were the reasoned justifications used by some participants as a way to mitigate pressures of social responsibility, and to some extent legitimize the status quo.

Dr. A, for instance, uses an economic perspective to construct more generally an account of the burden the individual dentist faces that constrain aspirations to social responsibility:

> **Dr. A:** If I had to make my living in the world that's out there presently as a private practitioner on a fee-for-service, I'd probably disagree with most things, or have an argument or a rationale like, you know, I know you're right, but what do I do, I've got, you know, mortgages, family to feed and everything, and within my practice I'm the most ethical dentist, I do the world's best dentistry and people...I'm booked up for eight months ahead, what am I doing wrong? Nothing, you're not doing anything wrong! This is when, then you look at policy makers (...) the policy makers are really not interested in providing dental care for people and its not a big enough issue for them in the total health care media.

Dr. A refers to policy makers, indicating that that the matter of access resides within the responsibility of those who decide how resources should be allocated to ensure the provision of health care. It is important to note here that throughout the interviews most participants pointed frequently to where they thought the problem was. They provided an important insight into their sense of the locus of social responsibility—in effect, raising the question, "who is responsible for social responsibility?"

Another mitigating factor was education, which required a significant investment, and it placed a considerable financial burden on dentists. As a result, it was perfectly reasonable to expect a certain level of remuneration to cover the opportunity cost of forgoing years of earnings while at school. This became an important issue in the debate on social responsibility:

> **Dr. N:** (The) notion of proper reimbursement, or the perceptions of proper reimbursement to providers...it's a large part that's left out of the equation! When someone goes to dental school, and you went to hygiene school so it's very similar, you make a decision (to) make a commitment to go to dental school for 4 years, and you forgo 4 years worth of earnings!

> Perhaps if you just assume that someone who is a college graduate can earn 20-25 thousand dollars a year, they're forgoing anywhere between 80-100 thousand dollars worth of earnings. It's an opportunity cost of going to school. The cost of dental education is somewhat substantial, I am not sure what it is at UBC but the average debt for the dental graduate in the U.S. is on an average 90 thousand dollars! So you put the opportunity cost and add that to the actual cost of education, and aside from the actual cost of living at that time puts you at somewhere about 200 thousand dollars. Somehow or other, this person who makes this decision to go to dental school has to, in some way, receive compensation to make up for that 200 thousand dollars in lost wages!

Dr. N indicates that the premise behind the idea of social responsibility is biased, constructed "only from the perspective of people who need services who might not be able to acquire services because of financial constraints." He argues that people in the public health community often suggest that the providers should just give dental care away, thus focusing the argument on the economics of becoming a dentist and providing free care. Dr. N uses economic principles to construct carefully the plight of the individual dentist—first as a student (paying high tuition fees while at the same time is deprived of an income), and then as a practising dentist (able to recover lost opportunity costs, actual costs and cost of living). Student debt coupled with high overhead costs to start a practice was seen as a justifiable reason for constraining aspirations to social responsibility. The dentist, as "businessman," was seen also as having an important fiscal responsibility:

> **Dr. AA:** The thing is that a dentist to some degree is a businessman and he's got a big overhead and he's got to look after this business and he has to make a living. And many dentists have debts that they have incurred when they were students.

Many expressed the importance for dentists to be concerned about their financial position long before they can begin to consider social responsibility. There was

frequent reference to "remaining economically viable." Yet, some of the same participants also felt that they had an equal obligation to social responsibility and as they tried to balance between the two they encountered some difficulty. For example, as the narrative continues, Dr. AA explains that he ran his practice differently:

> **Dr. AA:** (...) I agree to some degree, but I ran my practice very differently than from a financial point of view. (...)

Dr. AA positions himself in a nobler fashion, and steps onto higher moral ground. He explains that he practised dentistry without much concern for business schemes and the bottom-line; he did not charge patients for treatment they could not afford; and he never peddled dentistry. As a consequence, he felt that he was not in the same league as some dentists—he made less money compared to some of his colleagues:

> (...) I never, you know, there are a lot of people around who tell the dentist how to run their practice and how much they should make in a week and how much they should make in a year and look at the bottom line and get the staff to hustle and promote and you know, all kinds of business schemes. I made less than most dentists. I had a great practice, but I made less. Some people I didn't charge, those who couldn't afford it. I never promoted things that I wouldn't suggest for myself, you know, I used the golden rule: would I want to have this? And I never made the money that some of my colleagues were making, and I was comfortable with that, and there are people like me! I mean it's not that I was starving or anything, but I wasn't in the league of...because if you look at the incomes of dentists, you know, there is a range. But on the average it looks good.

Notice the words Dr. AA uses. He states that he used the "golden rule", he never promoted treatment that he would not have for himself, and he takes pride in that. As the interview proceeds, however, there is a clear discursive shift. The more dominant business discourse seems to overwhelm his moral position. Dr. AA

goes on to concede that economic viability and profit play an important role in determining access to care, and that it did not seem fair to ascribe his moral position to the entire profession, and particularly on less established dentists:

> **Dr. AA:** Yeah, well I guess the main barrier is economic, I suspect. If we ask the profession to donate services to one-third of the population, you are asking a great deal. No profession is asked to do this. And you would not hit the profession evenly because the well established ones have got their clientele, so you would be looking at the new graduate who will have spent hundreds of thousands of dollars to set up a practice and you would ask them and they would end up with those who are new members of the public who need the services, but among them you will find a lot of those who don't have the means. I mean, that's my experience. When I set up a new practice, I took on all comers and what I was getting and it was at a time when things were very different, when dentists were still very much in need, and what I ended up with was many that were rejects from, not rejects, but from dentists who were very busy and they couldn't take on, and among those were a fair number who were very needy and financially handicapped and that's something you have to do, but where is that burden gonna fall. Let's assume that it would be distributed evenly. Thirty percent of clientele is about the profit in a dental practice and if you are asking the dentist to forego that entirely, well that certainly wouldn't work. And don't forget that not everyone in the profession is willing to service the needy at a reduced fee or at no fee at all. You know, a lot of our colleagues are willing to do something, but what are you going to do, you're going to impose it on them, you're going to force them, I mean how do you handle that!? And without governments taking a role in this I can't see how it can develop.

Dr. AA reveals the problem others too experienced in trying to reconcile between issues of economic viability and social responsibility. Notice also that Dr. AA characterizes economically disadvantaged patients as "rejects." Some participants either directly or indirectly implied that many dentists try to avoid to the extent possible those patients who make it difficult for them to earn an appropriate (meaning high) income level. Labelling patients who cannot afford care as either 'rejects' or 'these types of people' was not uncommon. As he says, the ultimate aim is to strive to accumulate a preferred 'clientele', who are thought

to comprise about thirty percent of the practice. Dentists who have an optimal patient carrying capacity are not going to replace preferred clients with "rejects" as this would effect negatively on profit. This attitude is reinforced further through professional education seminars. Dr. Paddi Lund, said to be[17] "one of the world's most successful and unusual Dentists of Australia" conducts continuing education courses worldwide for dentist, teaching how to achieve a preferred clientele, and to work less and make more money:

> "Here's a dentist who was miserable and so, "fired" half his patients, locked his front door, took down all his signs, and only accepted new patients "By Referral". And now Paddi works 3 days a week, makes 3 times more money than the average dentist and has made happiness the focus of his practice! (...) Paddi has a negative accounts receivable and no bad debts – customers like to pay their bills! (...) This is what we all want in our practice. Paddi has an amazing story to tell and his philosophy of work will revolutionize the way you envision and operate your dental business."

The message to all dentists, new and established alike is that they should all be striving to be like Dr. Lund—if you are not earning an "appropriate" level of income and you are miserable as a result, then fire your patients and get new "customers". Dr. Lund's approach is said to have "received high recognition from leaders both in and outside of dentistry..." Dr. Lund's approach reinforces the dominant business discourse that seems to permeate societal networks where economic growth has become an insatiable phenomenon. Some participants were quick to point this out. It was seen to undoubtedly influence how some dentists think about their practice and their profession:

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[17] The Continuing Dental Education (CDE) Department at McGill University hosted a session by Dr. Lund in November of 1999. I found the registration form and advertisement for the course on a bulletin board for faculty and students within the department.

Dr. J: So, how do you handle it when the norm is shifting to this entrepreneurial grab-all-the-money-we-can way?

This phenomenon was not considered exclusive to dentists—it was seen by some as a prevailing and dominant reality—dentists, many argued, could not be expected to be immune to it. A dentist too, argues Dr. W, is influenced by societal norms and trends:

Dr. W: (...) you can't take a trend, a general trend in society and isolate it and say it doesn't impact on a professional person.

As a result, dentists were also branded as among those in society driven predominantly by money, and greed had become a prevailing phenomenon in today's consumer society:

Participant R: I'm not a dentist and I'm not driven by money...I think it's human being, it's instinct, and most of us learn to be greedy because it is a consumer society...

Like participant R, some saw the influence of the corporate mentality in dentistry in North America now spreading also to other parts of the world. Dr. D, for instance, explains that the aim among many dentists in the United Kingdom is to make an "obscene amount of money, to sit back and watch it role in, to come into work late and leave early," and so on. As Dr. AA established previously, these dentists are in a "different league"; and Dr. D categories them as the "seven series BMW guys":

Dr. D: (...) some make an obscene amount of money because they own several practices and they've been very good business people, as well as good dentists. They have several practices and they employ associate dentists working for the NHS and off they go...they just sit back and watch it role in! Now the dentist I worked for had two associates and he made probably 60-70 thousand pounds a year. Which is a very nice income level and he didn't bust his butt. He left at half four and he got in at ten. Now, private dentists make 120-200 thousand pounds a year. They are the

seven series BMW guys and they make huge amounts. They look toward North America and they see what we have here and they say, "Well, we want a bit of this!" So you see, it's a move from very good income levels to obscene income levels.

This discourse was not uncommon, and those participants who used it partly did so to point out the prevailing norms within dentistry and within society in general. The implication is that there is such an overwhelming societal focus on financial gain that dentistry had in effect become *victim* to it. Yet, many also held the position that there was nothing wrong with doing very well. Dentistry was a profession associated with a high income. It was acknowledged that many choose the profession particularly because it meets this criterion first, and rightly or wrongly, specifies Dr. AD, that is how many dentists are:

Dr. AD: I mean all the high earning professions are interested in earning high incomes. Now you can say that's right or wrong, but that's what many people are! Many people choose the profession because of the living standard it provides. Whether it be law or dentistry, I think that a lot of people go into that because one of the things they want to achieve is the income level that those professions offer. I think some of them do it exclusively for that, and there are many that are probably also very interested in caring for patients, but they tie it into the requirement to also earn a high income. And then there are those that fundamentally go into it because that's what they see as what they really want to do in life. And if they happen to make a good living then that's great and if they didn't make a good living it wouldn't be that big a deal either.

The thread that permeates through many of the interviews is that dentists, like other health care providers, accept that it is their *professional* responsibility to provide health care to those who need it, but at the same time, they also have a fiscal responsibility to manage the dental business and to profit. The underlying tensions, many argued, centre on the challenge that dentists have to ensure that health care does not become a privilege only to those who can afford it. Some

took the position that health care is first and foremost a universal good not to be restricted on the basis of socio-economic or other factors; while others maintained that within any socio-economic system no one should be denied the opportunity to economic success; and, there were those who were between these extremes. Among those who took a middle ground, some were clearly conflicted by opposing moral demands and had difficulty reconciling two incompatible viewpoints; while a few felt that a healthy balance was possible.

The market as a fair arbiter of social responsibility

One important dimension of social responsibility constructed in relation to economic factors trusts the market to be a fair arbiter—social responsibility governed by economic structures was believed to present an equal opportunity to all. Even if the business side of dentistry was believed to limit access to care, and the market acted to disadvantage some individuals, it was difficult for some participants to discount the role of the market as a vehicle for delivering dental health care efficiently. This was evidenced clearly by those participants who hesitated to accept that service to society ought to be *more* important than free enterprise. Although the espoused belief that health care ought to be a universal good was common, equally if not more importantly to some was the notion of free enterprise and earning a good income. Dr. Z, for example, adopted throughout the interview a position that supports strongly the need for social responsibility in dentistry. At one point, however, he acknowledges briefly the affect of the market economy:

> **Dr. Z:** What I'm saying is that some people would look at health and say that it's more the market economy that determines who gets health care.

> We don't want anything entirely driven by the market. (...) I don't think you can rule out any market force. Standard dental services like periodontal care, or fillings have been put into a market setting, and it works! I mean private practitioner are rewarded for their labour, they work hard and produce a lot, but the problem is that there is a segment of the population that doesn't get service and that is a big problem!

The market was regarded a natural phenomenon, and for some it was seen to be without disposition to particular vested interests, thus considered to be a relatively fair arbiter of distributing care. Although not perfect, indicates Dr. Z, the market works! An underlying contention among some was also that the problem of access to care was almost always ascribed to the dental profession, and that was seen as unfair. Dr. N, for example, points out that first of all, the conventional understanding, constructed over time by public health advocates, is a biased one. It consistently takes the patient's side and ignores the plight of the provider:

> **Dr. N:** My first thought is that social responsibility really is a much larger topic and concept than most people would think of it. Usually, when people think in terms of social responsibility they're thinking of terms only from the perspective of people who need services who might not be able to acquire services because of financial constraints, and I think that is an important part of social responsibility. But when you talk about social responsibility you are talking about the public good, you are talking about who is *really* responsible for this, and what I found is that people in the public health community for instance will often suggest that the providers should just be responsible to give this care away! And that's how they will define social responsibility.

Like Dr. N, some participants felt that the dentist should not have to assume the sole financial burden for caring for those who cannot afford it, particularly within a socio-economic system that can potentially cater for such issues through government structured welfare initiatives. Dr. N argues that, within the existing and accepted economic (*Free Market*) structure in North America, dentists should not be held accountable for subsidizing access to dental care:

Dr. N: (...) Now, the market usually works, so for the people who can afford to pay for the services it's usually not a problem, because somehow or other it will balance. The dentist can charge fees commensurate with what the market will allow and usually that will compensate, plus some return that is greater than the amount they've invested, and that rate of return will ultimately dictate how many people apply to dental school, how many people don't apply to dental school, and dentistry will be perceived as a good profession or not a good profession, and people will make decisions about whether to enter the field. And so, it all works! But when you have a situation where the reimbursement rates are going to be artificially constrained because government decides that you will provide these services and you will accept this level of reimbursement, then you have some problems in the market, and one of the things dentists can do is to decide not to provide care. And they can do this a number of different ways: they can just say we're not going to do it, or they can go on strike or they can just sort of less aggressively or passively not do it! So, more of a passive dissidence is by just not aggressively trying to provide that care, not trying to be as helpful when people are looking for that kind of care. So I think people kid themselves when they think they can sort of force dentists into doing this. They are ignoring market forces and so I think it all needs to be thought out together. I think it is unfair for the government to, whether it be the US government or Canadian government, to basically absolve themselves of the responsibility and shift the burden to the providers, and say to the providers that you will assume the social responsibility of providing care for people who need care. I don't think any one would question the need to deal with this. I think it's important that people who need care be provided care; it's a question of how this should happen. Should the dentist essentially subsidize the rest of the government and the entire population by providing this service at a lower, reduced fee? Or, should this be subsidized by the larger population? Should the population at large, the entire population, be responsible for this care or providing levels of reimbursement that are more reasonable, not necessarily what the market would pay, but something that would be fair?

Dr. N presents here a sophisticated legitimating account of the economics of dental health care based on the market premise. He argues essentially that the market provides an organized arena for individuals to compete for and to pursue economic initiatives. The determination of what is good and what is not is vested in the economic viability of market transactions. The market is seen as a place for the development of *individual* capacity, self-determination, and well-being. Dr. N's

focus, therefore, is first on the economics that govern market forces and the acceptance that dentists are a functional dynamic of the market in a natural and fair way. Disrupting this dynamic, he indicates, will ultimately lead naturally and inevitably to resistance. This is further evidenced in his discursive construction of the dentist, first as an individual agent, then, more importantly, one who can be encumbered by non-market (socialist) forces. Those participants who subscribed to this type of understanding held *social* responsibility marginal and in the background to *individual* priorities. For example, although Dr. N does not deny the need to deal with issues of access and he believes "people who need care should be provided care," he questions rhetorically the locus of responsibility for this: "Should the dentist subsidize the entire population?" This was a common point that some participants raised. As the interview continues, he concludes that the responsibility of ensuring access to dental care is certainly not the dentist's alone, if at all, unless they are adequately compensated.

On the other hand, some argued that the market indeed discriminates against a certain segment of the population who find it difficult to access care. The market was seen as a badly chosen vehicle for the delivery of health care. In effect, these few participants presented an oppositional stance. Some saw the market to be constrained by vested interests, and any attempts to suggest otherwise were seen as misleading:

> **Dr F:** Oh!!! The mythology of the *free* market!! That's a big myth! I'm not an economist, but the idea that the health services are a *free* market is ridiculous! They're not at all! Now, I don't say there's no market, I just think it's a very constrained kind of market. It's constrained by public knowledge, it's constrained by professional organizations—their self-interest is enormous!

Those who took this position argued that participants like Dr. N fail to acknowledge the problem of monopoly. Dr. K, for example, points out that dentistry enjoys and fights hard to protect its monopolistic privileges, but fails to uphold its professional obligation to society to ensure that care is available to all who need it:

> **Dr. K:** ...the hallmark of dentistry as a profession, you know, that this is a legally protected monopoly, it is a legally protected autonomy, so we grant it the right to control, if you like, the dental market, and to place itself, and there should be a professional payback for that privilege that we've been granted, and that payback may be in a form of ensuring that dental care is accessible to all who need it.

Dr. K highlights the point that a few others also expressed—dentists have reneged on their promise as professionals to ensure accessibility in return for the privilege accorded to the profession. Hence, the subtext within the enterprise or economic discourse of dentistry is that dentists are seen to be no different from other entrepreneurs. The only obligation they have is to abide by the laws, rules and regulations that govern commercial enterprises. As a result, it becomes difficult to expect to hold them accountable to social responsibility. The dentist is then considered no different from any other business-person, and the decisive factor in any agreement becomes the commodity and its price, and to secure the greatest advantage in any transaction. Moreover, like any other business transaction, what the dentist decides to sell is to be based on what will provide the greatest return at the lowest cost, and what the patient is willing to pay. Yet, the dentist is also regarded as a health professional, and as such has to reconcile the expectation of service-above-self with the impetus to self-interest. A

commercial standpoint plays a powerful and influential role in creating a corporate ethos within the dental profession, which some argued neglects to either acknowledge or recognize the conflict between economic and professional self-interest and issues of equitable access to care.

Trying to accommodate incompatible views

Dr. C is a good example among those who tried to hold and stay true to two substantially conflicting discourses, one rooted in enterprise and the other in professionalism, periodically shifting from one to the other as the interview progresses and introducing accounts that were often in tension with each other. Like other participants who were concerned by this, Dr. C is upset by incompatible moral demands that compel him to try and accommodate two incompatible positions. He notices and acknowledges the hegemonic function of the dominant economic discourse. He concedes that dentists have always been concerned first about money. He expresses a strong discomfort with health care as a commodity, practitioners as providers and patients as clients, similar to any other business enterprise. While maintaining this critique, he also invokes a right to health care argument, positioning health care as an inalienable right, where money, or anything else for that matter, should not play a deciding factor in who receives care. He argues forcefully, and his position comes across powerfully. However, as he continues to narrate his perspective, confounding points begin to emerge to reveal subtle shifts in his position. I began to notice disparate viewpoints as he attempted to accommodate conflicting accounts. The following quotations illustrate this point:

Dr. C: I mean dentists have always been concerned about what they do: How much money they make, the fee structure, who runs the show, who tells me what to do. No they're not new issues at all. No! So I can see a profession who is just making sure that everything is going just great, right! (Said with a tone of sarcasm).

At the outset, Dr. C declares that the general predisposition of dentists is to financial success and professional independence; and he also implicates the dental profession in being complicit in this orientation. Dr. C then goes on to take a strong stance against treatment decisions based on one's ability to pay. He invokes a moral argument to condemn the affects of economic-based decisions on the provision of care:

Dr. C: Well, what right do you as a dentist have to say to this patient, sorry I'm not going to help you!? What right do you have to say that!? This patient has come to you for help. You're the trained professional; your job is to help this individual. And I think that by refusing to help this person because you have some sort of higher ethical standard is wrong! Personally, it's wrong! Now, should we inculcate that to students? I don't know! I think we should! And if I was involved in that area, I would, although I suspect I would be criticized. No, no, no, no, you must do the root canal and you must do the crown, but I know for a fact that the patient would simply leave and would put up with the pain and infection and it may go away, or may go to another dentists and finally find somebody who would take the tooth out. So I mean, in my view that's ethically wrong. Just as It is ethically wrong to say to somebody, OK, we're gonna take this tooth out for you, we're gonna have to take an x-ray and it's going to cost $50 bucks! I want the $50 bucks on the table before I do anything! I've been in practices like that! That was the policy! Cash only! Now, if the person doesn't have the $50 dollars and says I'll write you a cheque or send me a bill. The dentists says sorry, can't do that! So away they go. Now that's ethically wrong. That is, *that is* ethically wrong! It's morally wrong! It's socially wrong,! It's bad!! In my view! Now there are other people who would say no, that's fine, it's a business. You can't walk out the store with a television until you give them the money! You can't buy a case of beer until you give them the money! Cash on the barrel! What's wrong with the same thing for dental? Well, see, this is my view, where health care is different! In my view, that is wrong, and I'll say to the patient OK, you haven't got the $50 bucks, I'll take your tooth out, we'll take your x-ray, and write me a cheque and we'll send you a bill. Now I may never see the money. I know that. On the other hand, by not doing it I'm shirking

my responsibility; I'm being unethical, quite frankly. In my view, as I say, other dentists would say no, no, you're perfectly within your rights. If (the Government) isn't going to pay us any more money then we won't see these patients.

Dr. C then goes on to invoke a rights-based discourse as an extension and in support of his view. Notice, however, how he also acknowledges the counter and more dominant discourse, in contrast to the one that he says he favours, in which dentistry, as is presently the case, is accepted as a private for-profit business within which the dentist is seen as "perfectly within his rights" to operate as an entrepreneur. As the interview proceeds, Dr. C begins to raise some pivotal points to reveal the conflicting views he is wrestling with between two opposing ideas:

Dr. C: Well, personally I think health care is a right not a privilege and that goes right across the board. Now once you say that then you run headlong into another perception that dentistry is good health care for those who can afford it. So you have an immediate conflict between the fact that dentistry is a private or for-profit business. The business is providing a care for a part of the body. It's always somewhat of a conflict for me to decide that this patient can have this but this patient can't have this and the only difference is money! To me that's wrong! Now there are others who would argue well that's fine. If you can only afford A that's fine. But if you had more money you could have B. My view is if B is better, then forget A, give him B. The money shouldn't enter, but of course it does! So, in my view money should be no object. It should be globally funded public system. Much like Medicare in Canada.

Dr. C then points to conflicting moral demands that prevent him from enacting what he espouses. Thus far he has presented a firm position on what is right and what is wrong, arguing that money should not be a discriminating factor on who receives care. As much as he believes this, he goes on to state that it would be "inappropriate" to impart these views to others:

Dr. C: As far as views on global health care and dentistry, should you provide the same dentistry for everybody irrespective of cost...I mean I might believe that, but I um I don't think I could, you know, sort of inculcate that to students. I mean I think that would be inappropriate.

Interviewer: Tell me why?

Dr. C: Well, because that's not the way the profession is set up to do that. That's pretty much a personal decision. A dentist as a private individual, his or her practice is their responsibility and if they choose to provide all dentistry for all their patients regardless of money that's their issue, that's fine. They would probably go broke if they did under the current circumstances.

Here we notice an important discursive shift. Dr. C has moved from a discourse that is critical of the business of dentistry while at the same time adoptive of the moral rights to dental health care, to one that is now sympathetic to the status quo and its normative structures and economic practicalities. This is evidenced in his statement, "that's not the way the profession is set up..." and "they would probably go broke if they did..." He acknowledges that "under the current circumstances," in which dentistry is a private business endeavour, it is virtually impossible for him to commit himself, despite the fact that his previous statements were very categorical and where he went as far as to say that it was "ethically, morally, and socially wrong" to have money dictate the provision of care. Yet, the issue of economics emerges to become an underlying and important concern eventually superseding what is considered wrong. Dr. C is a good example of those participants who experienced similar tensions.

Another important dimension of this shift is one that is rooted in an individualist understanding justified by an economic premise. Notice his words, "a dentist is a private individual," free to choose who receives care and who does

not. As the interview continues, there emerge other dimensions (i.e., allegiance to the profession and the inevitability of existing structures) that compete with his espoused moral stance:

> **Dr. C:** You know, recognizing that if you make dentistry universal the current structure would collapse. Particularly, if it was imposed, but even if it wasn't imposed what would happen would be pretty disastrous! You would take what is a very strong and proud profession and destroy it! So I mean, I recognized that. And I recognize that I hold all these personal views, which likely will never come to pass in my lifetime. That doesn't mean that I should apologize for holding those views. But it does mean that I have to be responsible in espousing them and talking about them. If you'd like, that's professional responsibility! There's no point in mouthing off, particularly to students who are very impressionable young men and women who are looking to me for advice and whether they hang on my every word I don't know. But it's possible. So one has to, you know, be a bit temperate when you speak. That's why I say, when I'm talking to students on a one to one basis or in a seminar when it gets off the topic a little bit I can sometimes mention a few things that I sort of feel personally, but you have to be careful when you do that. I know I'm in no position to change anything. It does work well, people get excellent health care, dental health care! I just object to the fact some people who can't afford it don't, and they don't get the help or oral health care they need simply because they don't have money. That's why I start to come undone a little bit. But again, I can't do very much to change that.

Dr. C illustrates well the dissonance and at times despondence that other participants too experienced as they tried to reconcile their views on social responsibility within established socio-economic and institutional structures and influences. At times they espoused strong views on the existing inequities within the dental health care system, however, as they tried to resolve the issues at stake, some realized that they felt helpless to change things, and they felt obliged to defend their responsibilities to the profession, and the existing economic structures and expectations, which were seen at times to be all powerful and pervading. In other words, the dental profession is influenced strongly by a set of

presupposed norms that consciously and unconsciously shape rights and opportunities toward economic and professional self-interest.

The issue of economic viability played an important part in determining one's sense of social responsibility. For example, it was considered acceptable by some to engage in socially responsible practices provided it was periodic, but to institutionalize the effort was considered unreasonable. A common account presented by many participants related to the excessive costs associated with running a dental practice:

> **Dr. AA:** (There are dentists) who have a social conscience, and who contribute, yeah! But, if we are talking about looking after a third of the population let's say, to ask the dental profession to provide it for free or at least for a much reduced fee, we are talking about something else here because don't forget that in the dental profession, in order to practise you need to create your own small hospital and there are huge costs involved in setting up, to get yourself ready to look after the public. And if you don't know, to run a dental practice is a business and an expensive proposition. So, you know, it is all very fine to treat some people from time to time, but, you know, in medicine the government pays...
>
> **Interviewer:** We pay, right?
>
> **Dr. AA:** We pay, ultimately, that's right, but in the dental field it's different, it's not funded by government, or only a very small segment is funded. And the dentist looks at an overhead of 60-70% depending on the location and set up that the dentist has. And when the government is offering, I forget how much of the fee guide, that is designed on the average cost of running a dental practice and we know that the segment that is left for the dentist is a small one, and if you ask him to work for nothing, basically, there are problems and you are asking an awful lot!

If social responsibility was seen to be an "expensive proposition" it was difficult to reconcile issues of access to care. Accordingly, it was difficult to ultimately justify a change in the way the dental health care system is structured. Dr. AD, for instance, asserts a firm position on ensuring access to health care, and

expresses distaste for what he calls a "two-tier system" that discriminates between those who can afford health care and those who cannot:

> **Dr. AD:** I mean that's what I believe...I'm a passionate supporter of our medical system. I was born in Britain and I've seen the decimation of the National Health System. I've seen the establishment of the two-tier system, and I have contacts with people in the United States that have access to private care and I see the extraordinary high quality of care they can access. And I see more and more people having to wait longer and longer...I mean this idea that private health care is going to solve the waiting list problem is garbage, absolute garbage. What it means is that some people get in very much more quickly and everyone else has less resources and are worse off and that's a two-tiered system. And that's the trouble of the two-tiered system and that's why I'm prepared to put up with a one-tiered system and universal system. So I'm a passionate believer in that and I've turned heads discussing this at tables in restaurants in the United States. I make it quite clear that I can't understand a system like in the United States where 40 million American don't have access to medical care. Now that's where I stand in the social contract argument.

Dr. AD draws on notions of efficiency and effectiveness to legitimize his position. A few others also invoked similar accounts, arguing that the system works very well for those who can afford it. Consequently, there was no need to change it for those whom it served well. When challenged Dr. AD attempts to construct a rationale to defend a two-tier system in dentistry, and begins to criticize the very universal system he was strongly advocating moments earlier:

> **Interviewer:** So that's from a Medicare point of view. Now, earlier you suggested that one way we might address the problem of the 15-20% in BC for example who don't have access to dental care is to have government sponsored insurance or salaried dentists. Doesn't that in fact lean toward a two-tier?
>
> **Dr. AD:** (Pause) Well, I guess, I don't know that it would fall into the two-tier in the way you would equate it in the medical model because the...in my opinion, in the medical model we have...it is close to a universal system. I mean, I don't know...and there are people that are making inroads into the universal system, but with medical care, or shall we say non-dental care, because after all dentistry is part of the overall health but we have tended to put dentistry as something different from medicine and

that worries me to some extent as well, but let's accept that because it is so widespread. I think the difference is that you take the universal system, and it has problems with it and people don't like those, and what you are going to do is you'll take a privileged...what you want to do is to create something for what will become a privileged group, in my opinion. Dentistry has a very widespread private system, which, some like (Names a dentist) will argue very persuasively that it is a very efficient system, and therefore we don't need particularly to change that. But we do believe that for what the system offers, the general concept of oral health care is a good one. And, therefore, you look for ways for allowing other people to access it. Now, those people who can't, maybe it is such that the economics of that particular system are such that you want to keep that system because it is efficient for those that can be part of it, but, for those who cannot, you create something that is different. Now I don't really think that as a two-tiered...it is two tiers if you like...you...what it's doing is allowing more people to access the system whereas the other way around you are going to create, by doing that you are bringing in people (who) don't currently get access to it.

As the response continues it becomes clear that in fact Dr. AD prefers essentially for dentistry to remain private. Notice how he turns the premise of his original argument back onto itself, and begins to accept the earlier contested principle of private health care:

...The other thing is, in my opinion, what is going to be done here is that some people are going to get very much better access, a much smaller group, and everyone else is going to be left behind and it will become even worse for them. And that's why I have a problem with private medical care. I don't have a problem with private medical care, but if you want private medical care it better be private. There is no basis for any government funding at all. You build your own hospital, you run your own hospital, and you charge whatever fees you like. If people want to do that well that's fine, the problem I have with private care is that they still want the government to pay a big chunk of money. I think if you are a physician or a health care provider you are in or you are out. If you build a facility then I think your patients come and pay you separately and I you shouldn't expect the government to pay you and those that want private should have private and don't go around and say oh I pay my taxes and so I'm entitled to the government paying these private people. You want to be part of the public system then there is a public system, pay your taxes and we'll use it for the public system. But don't siphon it off for other people. I really don't have a problem with people who truly run it like a dental office, which is private and that's why it's expensive of course because all the costs are up

> front and have to be paid for by the dentist and dentist has to find the premises and has to put in a quarter of a million dollars worth of equipment of his own money and no one is paying for that. The dentist has to pay his own staff and that's why someone goes in and has a filling and says, "what do you mean you're charging me a hundred bucks, it only took ten minutes!!" I mean, it costs a lot more than that to go get care in a hospital but no one ever sees that because it's all paid for. You see!

Dr. AD, at the outset, uses compelling words in support of a universal medical health care system yet, when addressing the challenges of the dental health care system, rather than looking at it critically takes an argumentative stance trying to substantiate existing structures. The above example reveals how at times some participants evaded an attempt to provide a solution to the problem of access and focused instead on the economics of health care, using the account of cost as the ultimate concern in determining the interpretation of social responsibility and issues of access to care.

Some argued that as long as dentistry is seen as a business first and foremost it will be seen also as having its prime objective in generating profit. The fee-for-service model was seen by some to perpetuate the corporate mentality. It was a framework that was such an integral part of the entire system that it was considered difficult to change, and economic viability was an important aspect underlying this difficulty.

Leaving the business-side

A few participants presented a narrative that sought to distance them philosophically from the status quo; and, some of them went even further—they left private clinical practice, in effect *leaving the business side* of dentistry and going into public administration and public health careers.

The business-side of dentistry impacted differently on those who were critical of it. Some simply left clinical practice and went into public administration, some went to work in public health clinics, and others continued to wrestle with the issues but remained in private practice. Those who left private or clinical practice sited what they considered compelling reasons for doing so. Dr. Q, for example, does not accept that health care is only for those who can pay for it:

> **Dr. Q:** My attitude has always been that nobody should be denied quality treatment for any health conditions, be it oral or anything else purely because they do not have the resources to pay for it! This is a very deep feeling and this is why in my own lifetime I decided to go into public health rather than private practice because I made a sort of promise to myself that I would never accept money for the delivery of health.

Dr. Q considers it his moral obligation to ensure that health care is available to all regardless of ability to pay for it. He grounds his argument in the ideal of equal access, positioning health care in general as an undeniable good, like food and shelter. Similarly, other participants who also felt that the predominant culture within dentistry discriminated in favour of patients who were able to pay for services questioned if they were in the right profession, or doing the right thing. Dr. G, for example, finds it "intolerable" to determine the provision of dental care based on one's ability to "purchase" it:

> **Dr. G:** The goal in an urban practice in the late sixties was to weed out those who weren't going to be 'good patients' and that meant you weeded out those who weren't going to pay you well and that was intolerable to me; and in the late sixties there were no dental plans. (From) the five or six hundred patients I had, I remember only one or two who had dental coverage and so there was a tendency to restrict your practice to those who were quite well-off and I found that that was not my life mission.

A "good" patient, explained Dr. G, is generally seen by the proponents of dentistry as business as one who is able to pay you well. What disturbed him was

that the affluent patient was always favoured to receive care while those who may have difficulty paying for services were shunned. For this reason Dr. G eventually left private practice and went into public administration. Not all who expressed criticism of what they saw as the dental profession's strong bias toward paying "clients" had always held negative views about it. Participant MM for instance, who eventually left private practice to work in a public dental health clinic, at one point defended the very position she now criticizes. In her narrative, she scrutinizes the modes of conduct that place a greater priority on the interest of the dentist over the patient:

> **Dr. AF:** ...I came from a very high profile dental office and my job was to sell dentistry. I was given an imaging machine and I booked time with patients and I sold them crowns, veneers and high-end dentistry. I did this for 18 years. I took a lot of courses like the Quest program, which is a big US marketing program where you were taught how to sell dentistry. I went to Florida, Tennessee, Texas and I learned how to sell dentistry and I was very good at it. But it bothered me when I went home at night, was I really selling things that people needed or was I making them want something for the benefit of the practice? I got paid a lot of money, I got to travel, I got bonuses, but it just didn't fit after a long time. I was hired here to set up the dental practice and I've been here 8 years and it has been a real eye-opener for me. I work very hard and I have used some of my marketing knowledge and a lot of my business sense in setting this (community-based clinic) up; and I work very hard and I have great support from all the people who work here and I go home and sleep well at night! It is a great feeling to give back and I think that is what was missing. So I have seen both sides of this and there are dentists out there who make a lot of money and certainly do good dentistry, maybe some of it isn't necessary, so I think the people who work here do have that need to give back.

Notice that the object of concern is not the business-side of dentistry per se, but the moral imperative of the business. Note the words she uses to identify the differences in business approaches and related consequences. In her previous job, she "sold" dentistry, but realized that patients did not always need the

recommended treatment. It was seen as purely a business endeavour with an emphasis to maximize profit, to earn a good living, with opportunity to travel, etc. While giving this example she expresses uneasiness, questioning her allegiance: what comes first, an obligation to profit for the practice, or to the integrity of meeting the patient's health needs? What follows is a discursive shift in the way she constructs her new role and her relation to the patient. After changing jobs and "seeing the other side", she is able to affirm a different perspective. Her words, "I went home and slept well at night," suggest a feeling of redemption. Yet, she does not deny the value and even importance of good business sense and marketing knowledge, but now uses it for purposes of advancing first the patient's needs. Moreover, she points out that she felt the need to "give back," as this "is what was missing" in her previous experience. Giving back was a common phrase used by many of the participants to identify social responsibility. For Dr. AF, like Dr. G, and others who held similar views, an exclusively entrepreneurial approach to health care created for them an inherently conflicting situation and a sense of discomfort, or even guilt. They saw health care as undeniable, and the health professions as guardians of that care and the public good. As a result, when care was geared to serve the provider's interest over the patient's, it was seen to compromise what they saw as a fiduciary relationship between the provider and patient, and this created for them a moral conflict.

The way in which the dental health care system is organized and structured emerged as a key factor framing how and why dentists carry out their work in particular ways in relation to social responsibility. The affects of the fee-for-

service structure within the dental health care system played a critical part in reinforcing practices that institutionalize, sustain and reproduce the dominant discourse.

Fee-for-service

The participants referred to the reimbursement mechanism for dental care (what dentists charge for providing care) as fee-for-service—a direct fee charged to either the patient or to a third party (insurance companies) for services rendered. Those who referred to this mechanism also linked it to the dominant economic discourse, and saw its role as shaping and structuring dentists' orientation to dental practice:

> **Interviewer:** Well, I'm hearing something a little different, (on the one hand) it may not be social responsibility and that people don't want to do the right thing, but it is economic viability (that) impinges...
>
> **Dr. B:** Well, it's structure and process. It's the way we get paid and what we get paid for. There's quite a bit of money in the system, but it's not equally distributed. Services are not dealt out equitably! There are tremendous amounts of resources being expended. (**Interviewer:** And this is within the government?) No, this is within the system!! Financing dental care. Privately and publicly...it's huge!

The fee-for-service system was seen by some to reinforce inequities because it restricted access to dental care based on one's ability to pay for treatment. On the other hand, those who accepted dentistry as a business had little or no reservations about it. Dr. C, for example, points to the issue of "cash on the barrel," suggesting that payment structures play an important role in determining the mode of health care delivery:

> **Dr. C:** Now there are other people who would say no, that's fine, it's a business. You can't walk out the store with a television until you give them

> the money! You can't buy a case of beer until you give them the money! Cash on the barrel! What's wrong with the same thing for dental?

The "same thing" was seen as inappropriate for dental or any other health care service. It was argued that payment schemes structured in this way were inappropriate for health care systems because they inevitably restrict access to care to those who can afford it. Dr. Q argues that although no one should be denied health care, the prevailing fee-for-service structure precludes access. He feels that highly industrialized societies are inevitably moving away from socialized to capitalist systems. As much as he feels strongly about it and is working to resolve the issues, he realizes that the coalescence of his theory with practice seems impracticable given the reality on the ground:

> **Dr. Q:** Well North America has been particularly fee-for-service oriented. Now the moment you have a rugged fee-for-service system clearly you make for inequities because the more money I have the more services I am going to be able to *easily* access. And the less money I have the less services I am going to be able to access, easily or not at all. (...) Now trying to get away from my opinion and to the real world. Again if we concentrate on this part of the world and perhaps the highly industrialized world in general I think there is stronger and stronger movement away from social services to fee-for-services. So we have to live with that because I don't think we're going to change it easily. (...) I believe in trying to apply my philosophy of people not being deprived of health services because they don't have money. You need to find some way in which when you reach a certain level of society where you see deprivation occurring you have a policy which tunes into the system and starts to provide the services even without the fee-for-service. Now that's all fine in theory but of course the practice is different...

Like Dr. Q, there were a few participants who were very vocal in expressing a discontent with taken-for-granted views and defended an ideal of social responsibility that recognized what they considered shortcomings within the dental health care system; and they also expressed a deep sense of

despondency, feeling that their views were in the minority and against the accepted norm.

Those who spoke about fee-for-service and its affects on issues of access to care accounted for it in specific ways, invoking different arguments to substantiate their truth claims. Some of the accounts are repeated from the previous section and will again repeat in subsequent ones. In this section, these accounts manifest within the context of organizational and structural influences within dentistry that predispose dentists to situate themselves in predictable ways. The fee-for-service mechanism was buttressed further by other structural elements that supported it—namely, the location of dentistry within the structural lattice of the general health care system. Those participants who attended to this architecture talked about the consequence of placing dentistry outside the public health system.

Dentistry outside the public health system

All of the participants acknowledged that dental health care in Canada has evolved independently from the general health care system, and although it is essentially a direct fee-for-service enterprise as is most of the health service, it is not part of the Canadian social service, giving rise, therefore, to the problem of access to care. Although most everyone recognized this and identified it as a problem, they accounted for it differently. Dr. AD sees himself as a "passionate supporter" of the universal health care system and its principles on accessibility. During the interview, he argued quite vehemently, asserting that he has difficulty accepting "a system like in the United States where 40 million people don't have

access to medical care." He acknowledges also that a similar problem exists for dentistry in Canada primarily because it is not an integral part of the publicly financed health care system:

> **Dr. AD:** Dentistry is outside of, or mostly is outside of, general medical care. I think that one of the great strengths of this country is its general medical care system and dentistry has been outside of that, which means that dentistry which of its nature is a very expensive form of health care for a number of different reasons, is not paid for through the general purse and is left up to others to pay for it. So you either got to have the personal wherewithal to pay for it or you have to have the benefits of dental insurance and those that don't have either of those have a tough time accessing care.

Having made clear his position, Dr. AD proceeds to provide accounts to justify why dentistry is and should remain private. He constructs the problem as one that resides in the hands of policy makers and taxpayers. If society is interested in ensuring universal access to dental care then it will have to pay for it. The problem, he states, is that decisions to make dental care available to all are overwhelmed by cost—society is not prepared to spend on ensuring care to all:

> ...So, presumably if we are interested in those that don't get access to dental care then, are there ways to get them access to dental care. What you have to recognize is that for a while this province actually had a dental care plan, the British Columbia Dental Plan, and although it still exists in a very small form, it was wider ranging, and it lasted about two years, and it practically bankrupted the health care system and was promptly scrapped, and it offered a wide range of treatment options. The issues are why don't people access dental care? Well it's the cost, I think.

Dr. AD then goes on to question dentists' obligations to provide care if society is unwilling to ensure it. In response he constructs a portrait of the patient, as an important dimension to attend to before dentists decide what their responsibilities are to this effect. He indicates that there are those patients who *genuinely* cannot afford the cost of dental care and those who should be able to afford it if only they

prioritized their lives accordingly. There are also those who are simply not interested in their dental health:

> ...I mean there are some that aren't interested, but if you put them aside there are others who would like to but feel for whatever reasons that they cannot afford it. Some of them may be able to afford it if they put their priorities differently and others genuinely cannot afford the cost of dental care; so then does the dental profession have a responsibility towards them? I think in some respects it does, ...

Immediately following his affirmation of the professions responsibility to those who genuinely cannot afford care, he asserts an important account to mitigate this responsibility:

> ... but as I'm not just sitting in an ivory tower, I do practise dentistry on a regular basis...there are some very significant costs to running an office. Setting aside the fact that dentists in society are at the upper levels of income earning, but that's not the only factor, I mean because dentists, many dentists I presume, expect to earn the sort of incomes they do! I think that there are quite a few dentists that probably do offer care to people that aren't able afford it and probably do it because they feel that's just something they want to do. But the costs of running a dental office are huge. What has to be taken in before the dentist actually starts making any money on any day are really remarkable and if you go below that as income you are actually losing money providing dentistry and I don't think that's reasonable to ask of anyone. So if we are going to continue with a fee-for-service basis as the main form of providing dental care to the population in a private setting then there have to be other approaches for caring for those that don't fall under that.

We see an important discursive shift in how Dr. AD problematizes the issues at stake. He states that dentists expect to earn a high income and that treating patients who cannot afford care would compromise this fundamental expectations. Many of the participants revealed similar shifts in similar ways:

> **Dr. T:** The problem is that a lot of the people that you're treating for at that low end of the socio-economic sphere aren't well organized and don't necessarily always show up for their appointments, so the cost of actually providing the care for them ends up being greater than it would be for an average patient. And (because) there's some down time to fill in, what the

dental profession has really been doing for years is doing it for cost, which is fine. I don't think that, the majority of the profession aren't concerned about getting the full fee, we always argued with government that we wanted the full fee and deserved it and so on but knowing full well that we weren't going to ever get it but, but as long as its only something like ten or twenty percent, the profession can live with that but once its goes beyond that, then not only are you subsidizing directly, you're also paying, you know, your tax dollars are going to the project and so on and so, you see its of very little significance for someone like myself in Vancouver because the number of people that live within my practice area are relatively few people but, you know, in some of these communities around B.C. where thirty-five to fifty percent of the population are covered by human resources, you know, so, so suddenly that, if that dentist is to serve those people and he's getting no return at all from that, he simply can't do that.

Dr. T's narrative provides an insight not only on how patients at the low end of the socio-economic sphere were characterized, but also the level of importance they occupied. Indigent patients were seen as less organized, and also indifferent to the *value* (as principle and as cost) of keeping appointments. The implication is that indigent patients are predominantly irresponsible; and it was difficult to be socially responsible to irresponsible people. Dr. T also provides an insight into the appointment booking patterns for indigent patients. He indicates that it is economically feasible to treat patients having difficulty affording care but only during down time. Priority, therefore, is first to paying customers. He points out that dentists in some communities simply cannot afford to provide low-income care when the majority of the population are in this category. Others who raised this issue also used economic survival and appointment breaking as accounts to legitimize the situation:

Dr. M: For example in Virginia and a lot of other states the reimbursement for dental care for kids is at 25%-26%. Paediatric dentists can't treat these kids because every time they do they lose money! And they treat as many as they can and they do, but only to certain level. They've gotta eat too, so a lot of them don't take Medicare patients! CHIPS will provide a

> reimbursement level higher than that but then these kids break appointments. So a lot of dentists don't want to deal with this socio-economic class individual who don't show up, etc. Now I'm not being critical of them, but I'm being critical of us. (...) I think we are a bit parochial in the way we look at it and don't look at it as a whole. Each of us is looking at our own particular piece of the pie and not trying to come to a solution to a major social problem. It really boils down to money.

The underlying point is that the relationship between dentists and patients is patterned on privilege and economic status. The dentist holds the privilege of deciding who will be treated and under what circumstances; and paying clients are given first priority. Earning expectations, high costs of running the business, and other such accounts as embedded in the dominant discourse played a definite role in framing the problem of social responsibility. For some, in effect, it was seen as ridiculous to try to accommodate for the stark realities of the dental business:

> **Dr. AB:** ...people laughed at me, they said "oh, you know, you're going to set up a dental clinic for twenty-five thousand dollars, you're crazy, you know, you could never, you know its impossible and I got quotes, I called Toronto, I called everywhere there was any clinic and, you know, all the quotes came back—it was supposed to cost close to two hundred and seventy-nine thousand dollars.

The balance sheet and the bottom-line were seen understandably to be inevitable forces within existing structures that excluded those who could not afford to pay for care. Regardless of how sympathetic some were, the expectations were thought to be too high:

> **Dr. AF:** I think the government has produced a backlash among dentists who have a bad name now because they won't accept social services; but coming from a private practice I can understand the impact because of high overheads and high costs for equipment and supplies.

No one denied, however, the need for alternative approaches to caring for those who cannot afford private dental care. It was felt by most that it was just too expensive to the individual dentist to provide this type of care in a private setting.

Patient as profit

The fee-for-service system was also seen to promote attitudes that associated the patient with profit. Wealthier patients and those with dental insurance became preferential clients. The problem of the disadvantaged was seen by some as long-standing, with a significant backlog of unmet needs and requiring considerable investment to address outstanding issues. Dr. U articulates the problem clearly:

> **Dr. U:** I think that we certainly have a multi tiered system in dentistry. Fee-for-service, private insurance, etcetera, is really what drives the private practice. I believe that the disadvantaged in the community are very much underserved and how we would ever deal with that is a tough one. Its been neglected for so long that it will take a major initiative and a whole lot of money to go any distance correcting and addressing it. I don't think a fee-for-service type of model will work (...) it's only just a small dent in dealing with a big mess.

However, later on, through the use of subtle language, Dr. U provides an insightful construction of the prevailing circumstances:

> **Dr. U:** (...) (T)he entire system seems to encourage individuals to be more concerned about themselves and their own personal accumulation of perhaps not wealth, but comfort at least. That equates then with or ties in with a fee-for-service situation where most dentists charge a pretty good fee, expect to collect it, and when they don't collect it, they move away from those situations that are not remunerative and the practice tends to become one of individuals who are able to pay either individually or personally or with the help of some third party carrier and all of the others, all of those other potential patients or clients fall away.

Notice first how Dr. U uses the words "patient" and "client" interchangeably, thus signifying the underlying relationship between two parties: the

dentist/businessperson and the patient/client. Notice also how he frames dentists' attitudes of resistance toward clients who are not profitable ("they *move away* from situations that are not remunerative"). The implication here is that the dentist does not actively marginalize patients, but merely "moves away" from the situation. The final corollary is revealed through the selection of choice words to describe how unprofitable patients are impacted—they simply "fall away." The language used comes across naturally and it is deliberately passive. Nevertheless, the discourse is unambiguous and the expectations are clear.

The privatization of dental health care and the mode of payment for services undoubtedly oriented some dentists to place a greater emphasis on profit. Some participants pointed out that social responsibility also means that the poor too had to carry their share of the burden—"you can't just ride the system":

> **Dr. M:** I think that the social responsibility is there, but I am an ultraconservative political man and I don't believe in giving away care to someone unless they are physically, mentally disadvantaged and they can't pay for it. Now for those who are just poor, I'd be more than willing to provide them care in return for something, whether it is working on my car and it may sound demeaning but I don't mean it that way. They have to assume some responsibility; there is no such thing as a free lunch. If you can afford to provide some sort of service in return for what I'm giving you I think that would be great! And the only exception I would make is for the socially, mentally, physically disabled. We're not here to take care of the poor without some return from them. You can't just ride the system!

A few of the participants stood firm to the idea that "there is no such thing as a free lunch." There had to be return for services provided. The fee-for-service system was seen as a central pillar within the existing structure, and it sustained the notion of patient as profit. As a result, some participants acknowledge that

the system and the fee structure do affect dentists' orientation toward social responsibility:

> **Dr. B:** Financing dental care, the fee structure, how dentists get reimbursed, what they're reimbursed for...so the provision of health care doesn't really orient oneself towards anything beyond the fee. Now that's cynical, clearly there are people who have a tremendous amount of social responsibility. They do that despite the system, despite the structure, and that structure and process exist and aren't going to go away and it has a profound affect on health care providers orientation toward social responsibility.

Furthermore, like Dr. B, many believed that the structure was unalterable, and to work against it required a very sensitive orientation to social responsibility.

Some participants also identified the fee structure as predisposing dentists to see procedures as service commodities. Each treatment modality is regarded as something to be sold for a specified fee. The more sophisticated the procedure, the higher the fee. Dr. J gives the example of technological advances that have effectively enabled dentists to reduce operative time so that no longer does it take as long to complete surgical procedures. Since billing is time dependant for select procedures, the professional association in one of the provinces proposed a revision of the fee guide, and "the profession went ballistic":

> **Dr. J:** Clearly in (the fee-for-service) system more money is generated. You generate more money by giving more services, or more expensive services, or at least more high cost services. So if you can get a hygienist or a dental assistant to do prophys and fluorides in great numbers or a minimum amount, and charge them full fee, then you're laughing. It doesn't matter who does the service, it's charged as if the dentist were doing it. So it's like charging for every letter as if the Chairman of Canada Post that was actually physically sorting and carrying it to your door. So you know there's a whole bunch of problems, and the toughest one to

> crack is the fee-for-service. In (names Province) there's been arguments for a couple of years over the fees. The profession itself recognized that, you know, the time units no longer reflected the technology. The technology reduced those time units considerably. So they proposed a revision of the fee guide or time billed and the profession went absolutely ballistic.

It was argued by some that the profession closely guards the fee structure, so that nothing can justify a change within the system that may result in diminishing profits. The approach to patient as profit under the prevailing payment system was seen also to influence the clinical reasoning ability of the dentist.

Profit motivated treatment-plans

Some participants indicated that a profit motivated system made it difficult for dentists to be impartial to the financial outcome of the treatment to be provided. Dr. AF believes that quality of care becomes compromised because treatment decisions are influenced by the amount of money to be made, regardless of therapeutic value:

> **Dr. AF:** Now I can get into a huge thing about fee-for-service billings too. I think it really puts limitations on how well you are looked after.

Some participants felt that practice norms tend to favour treatment plans that focus on income generation over health care needs. There was a feeling that what the patient is willing to pay, or the insurance companies are willing to cover can influence treatment planning. Some also raised an issue over the normalized six monthly visits to the dentist, pointing to ways in which patients are not only conditioned to assume this behaviour, but business approaches are subsequently designed to institute this practice within operational plans. The

resulting economic impact is significant, thereby reinforcing the viability of this type of approach:

> **Dr. D:** (...) There's a tendency for care to be delivered as defined by (insurance) plans and for patients to sometimes be encouraged to have care because its covered rather than have care because you need it anyway. A simple example is the frequency of recalling patients, your plan will cover you to be recalled every six months, therefore, we have our computer set to recall you at that frequency, and that became the norm and it became unquestioned and I've attended sessions put on by software people who show dentists how manipulating the software, manipulating the rate of recall could have a very, you know, a very strong impact on their bottom line. You (should) talk about the health issues first and you talk about the dollars second, and you find a way and you work with the patient to find an acceptable way for the patient to pay for their care. This is coming at it from the opposite way, its looking at patients as being an opportunity to make money and designing your practice and making treatment decisions based on the opportunity to be paid. You know, we've known since the mid-seventies that this so-called dental prophylaxis is not an effective preventative measure, but even now, most dental practices continue to provide prophys and still use that language and quite genuinely believe that the dental prophylaxis is a prophylaxis.

Some participants indicated that the influence of a fee-for-service system coupled with a third-party payer entices practitioners and patients alike to seek care that may not really be immediately necessary if at all. A patient with an insurance plan is seen at times as a bottomless pit of resources. The resultant behaviour, explains Dr. A, has caused insurance carriers to be more guarded in judging claims:

> **Dr. A:** And why are insurance companies starting to back down and starting to look to alternatives for financing dental care? Because dentists have pushed that limit so far! Maybe, I think, that it's just the whole issue of the fee-for-service system. If you have a fee-for-service, you (the patient) are a shopping list, and you (the dentist) go through that shopping list and I'm afraid that we tend to slip into, hey, you know, I'm going to do it, you know, because his insurance covers it...let's do it!

A few participants interpreted the situation very differently. Unlike the views presented above, Dr. V reconciles the issue of social responsibility by differentiating between the terms "medical" and "dental" within the context of "health needs". Medical services, he says, involve one's health and well-being, seen to be a human necessity. Dental services, on the other hand, are seen as unrelated to health, considered predominantly elective services, and exist to serve the dental business, something to be sold to a consumer. Since dentistry was seen generally as "medically unnecessary", the dentist had no moral, legal or social obligation to make dental service available to those who cannot pay for it. The dentist only had to have a sense of "market responsibility" and to create among consumers a sense of need in order to earn a profit:

> **Dr. V:** So social responsibility deals with needs. Dentistry has an uphill battle. As far as true health needs, we do have a social responsibility to that. The nature of dental care in this part of Canada is not driven by medical needs. It's driven by a generation of a whole series of dental services that are debatable about whether they are needed or not. Therefore, one doesn't have a sense of social responsibility; one has a sense of market responsibility. In other words, the provider feels responsible to himself to generate the need for some of these services so that he can sustain his livelihood. That's different from social responsibility. That becomes provider self-interest. And there's no law against that, I mean there's nothing wrong with generating a need to make a living.

According to Dr. V the business model does not really affect dentists' clinical reasoning ability because decisions are already based on a profit motive. For others, however, it was clearly seen to be a contentious issue. Some, like Dr. R questioned the need for a fee scale to begin with:

> **Participant R:** (...) I mean there aren't many organizations who have a fee scale so what is *that* whole thing about!? Why is there one!? If we got to the root of why dentists feel they need a fee scale...maybe it starts at

dental school and they teach you that this is the way you run your business and the most important thing is to make money.

Whether one supported it or criticized it, nearly all of the participants raised the concern that there are strong pressures to think first from an economic perspective. Dental marketing experts, for example, use the profit motive to have dentists rethink their professional worth. They capitalize on and perpetuate the pervading business culture and profit orientation, and its growing acceptance within dentistry. Within this discourse dentists are urged to consider raising their fees if they are to be seen as worthy professionals. Under a section headed "*The Exceptional Practice: Suggestions on how to make your practice work better for you and your clients*" Dickerson (1999) compares dentistry to multimillion dollar professional basketball players:[18]

> "Many of you struggle with your fees. Many of you don't feel you are worth what you are charging. Many of you find it hard to justify raising your fees when it is suggested by me and others. The role that dentists play in our society is very important. Do you want some justification on raising your fees? Here is some information I got from my clinical director of the Master Dentist Program, Mike Miyasaki. I think it would be hard to find anyone who thinks basketball is more important to society than dentistry. So let's compare your fee to the best in basketball. Michael Jordan will make $10,000 a minute playing basketball, assuming he plays for 30 minutes each game. Also assuming he will make $40 million in endorsements (that's a conservative figure), he'll be making $178,100 a day, regardless of whether he's working or not. Taking his income and dividing it by 24 hours, he makes $7,420.83 an hour; every hour of the day. Again, whether he is working or not. While watching a movie, he makes $18,550. While playing golf, he makes $33,390, not including anything he wins betting. If he wants to buy a $90,000 luxury automobile, it will take him 12 hours of savings. In fact, he could go to bed at 9:00 p.m. after spending every dime he had and still be able to afford it when the dealership opens at 9:00 a.m. the next morning. How long would it take you to save up for such a car? ... He will make more than twice as much as all of our past presidents for all of their terms... combined. The average dentist makes less than two

[18] The journal Oral Health in which this and similar articles appear is available at no charge to UBC dental students.

> tenths of one cent for every dollar he makes. I hope now you are thinking that maybe you don't get paid enough considering the difference in importance between a basketball player and a dentist. Do you want a little more help in realizing the insignificance of your income? Well think about this: Michael Jordan would have to save 100 per cent of his income for the next 270 years to have a net worth equivalent to that of Bill Gates."

Dickerson's article puts forth the view that social and professional importance is determined by how much money one makes. Such attitudes create social pressures that can have pointed affects, creating a tension between, as Wiebe (2000) in his reference to an undercover story by CBC's *Marketplace* on dental fraud puts it, the patient-first ethos of the healer and the survival-of-the-fittest demands of private enterprise where profit is the main end. Although Wiebe does well to argue that dentistry desperately needs a foundation in business ethics and that dentistry should "learn from its business confreres...and present a genuine corporate face of ethical unity in response to a demanding market," he still presents dentistry first as a *business*. The tacit assurance that dentistry *is* a business says that the prime imperative is to increase profit.

Too much social responsibility

Those who tried to reconcile competing viewpoints expressed a felt tension between wanting to see health care as a universal social good to be available to all and the private system within which dentistry is currently situated. Although some of the participants disparaged the business side of dentistry, they also presented a set of accounts that countered their principled statements. The tension for some centred on concerns between trying to realize one's private, individual goals and aspirations while simultaneously acting in the interest of others and upholding a fiduciary duty:

> **Dr. T:** Now the one thing that always stuck in my mind was...I can think of a particular individual who happened to be a public health dentist who came in to give a course in the dental school and the one thing that he talked about was this concept that as a dentist you're going to run your own business so there's going to be this major conflict between your own self-interests in earning a living and supporting your family and so forth and the other concept that you have a responsibility to the public to provide care and so on and so he said that he felt that the golden rule was to look at it like this: if you found yourself in a situation where you were not able to afford care and needed care, you'd be very happy if somebody provided that care, so put yourself in that context as much as you reasonably can, bearing in mind that you've got to pay your freight and so forth so, you know, and I always thought that that was a very, you know, a nice short way to sum up the kind of responsibility that I think people should be providing.

Dr. T speaks also about using the "golden rule" as a moral guide to help in the realization of one's social responsibility. It requires one to evaluate the situation from the perspective of those less fortunate, and to let that reflective experience guide the decision of whether to provide care. The principle is noble; nevertheless, the caveat that follows ("bearing in mind that you've got to pay your freight...") provides an important insight, which emerges in other interviews as well. Some participants clearly felt that too much social responsibility compromises personal welfare:

> **Dr. I:** (...) we're not looking for the person that only wants to just go out and milk the system, but I also don't want to think that there's just a person out there that's doing everything and then going broke or destitute because of their good will and this sort of thing. It seems to me there's an opportunity to be a really good dentist and just apply society's faith in giving us this privilege.

The anxiety of "going broke" was a common worry among some of the participants, affording them tolerable reasons against doing too much good. Remaining economically viable, dealing with high overhead expenses, among

other reasons, were accounts decisive enough to outweigh a felt moral obligation to society:

> **Dr. K:** I don't think that social responsibility is at the forefront of the thinking of organized dentistry. (...) Dentistry works under a market system, it is a fee for service system and it's private. So a dentist is in a position of being a business-person, as well as a health care provider. So, I mean, there is a tension between those two things. The thing is that I've got to generate enough income for my health care practice to pay for my office, to pay for my staff, to provide me and my family with an income.

The general feeling was that too much social responsibility was not desirable:

> **Dr. K:** But, it isn't like a religious order where life is one of total self-denial in working for the greater good. Well, we don't quite want to go that far left do we. So there has to be a middle position. And one thing you would like dentists to do, or what I want them to do at a minimum is to always put the interest of the patient first. We are too much to the right!

The noteworthy aspect here is the uneasiness and implication that endeavouring to social responsibility can entrap dentists into a mode of self-sacrifice at all costs:

> **Dr. D:** And then we'll get into a situation like here in Canada where people cannot get access to dental care! And I think it's atrocious. I really do, I mean coming from a system where you can get pretty much what they want to a system where unless you have money, you have very limited access to dental care, basically emergency care only. Unless you can pay for it you can't get it—that would be a sad state of affairs to happen in the UK. (...) I don't think everyone should be like this 'Mr. Goody-Goody' dentist that doesn't make any money and that prostitute themselves in an attempt to kind of help everyone.

Although Dr. D finds it atrocious that some cannot access dental care, he uses choice words to express the limits to which a dentist should go in ensuring access (they should not "prostitute" themselves nor forgo their financial responsibilities to be a goody-goody dentist). Dr. B constructs his narrative in basically the same way. He takes a strong moral position, insisting that the right

thing to do is to ensure equitable access to care. He also accounts for why dentists are not doing it:

> **Dr. B:** I don't think it's ethical...I mean it's very clear! What the right thing to do here is to create a mechanism where we provide a better service to society. The dental profession is not doing it! It's that simple! It's not a dilemma at all!! It's a problem, but it's not a dilemma because it's very clear what's the right thing to do, what's the moral thing to do...there's no lack of clarity there. It's a problem because we're not doing it and there are good reasons why we're not doing it. Dentistry's hugely expensive and you know, the professional has to, the profession has to remain economically viable.

Although Dr. B is clear on what is "the right thing to do", the problem is that doing the right thing is too costly. Here, again, we see conflicting viewpoints at play within which too much social responsibility is seen to draw fiscal problems:

> (...) Well, for example, if there's a provider out there and he or she is willing to treat patients from the Ministry of Social Services, if that's all they had, all their patients were from the Ministry of Social Services they'd better have a damn low overhead practice or their gonna go belly up!! Because that fee structure cannot support it and it's a very expensive operation...it's a money-losing situation! And I think that professional education and any education is an investment and it's reasonable to think that you can generate reasonable income from (it). And too much social responsibility is overwhelmed by the financial constraints. Small businesses, take for example in this province, pay such incredible taxes with such an incredible overhead that I mean that's what's happening here...the kids are...I mean I know of young practitioners who are great people and they're trying to do really good things, but are working their butts off to make the payments.

The idea of social responsibility being overwhelmed by financial constraints emerged clearly. Whether it was for reasons of recovering costs for the investment in education, or for accounting for overhead costs of operating a dental office, there was an expectation of earning a "reasonable" income. Yet, one recurring issue questioned the locus of responsibility for treating patients

who could not afford dental care. This question reveals a significant finding: Under the existing dental health care system, with its business-like organizational and institutional structure, dentists have not been required to integrate social responsibility into who they are. This is why the notion of "too much social responsibility" becomes an issue, and it is linked to economics, individualistic norms, and political and professional factors. This is evidenced thus far in the types of accounts participants appropriated to rationalize their position, and the ways in which they situated themselves in relation to their practise and their patients.

'SOCIAL RESPONSIBILITY' AS A PROFESSIONAL DISCOURSE

This section presents the ways participants related their notion of professionalism within the context of social responsibility. Although the concept of professionalism has evolved to include the principled acceptance of certain obligations—including a commitment to society to achieve a specified level of education, training and expertise, to agree to abide by stated principles and codes of conduct, and to place a high priority on society's welfare—dentistry, from the viewpoint of many of the participants, fails to either acknowledge or recognize the conflict between economic and professional duties and social justice. Despite this view, some participants who adopted a critical discourse of the dental profession and its lack of responsibility also saw the need to account for economic and professional viability. Inevitably, therefore, some could not reconcile what they saw as conflicting realities.

Some indicated that interpretations of social responsibility were shaped by an indispensable priority on professional autonomy and control over how the dental care system should operate. At the same time, the dental profession was seen to be influenced strongly by a set of presupposed norms that consciously and unconsciously shape rights and opportunities toward economic and professional self-interest, and this had become a regular and recurring part of daily interactions and viewpoints. The challenge to maintain a balance between desires for professional autonomy and control, social status, financial success and some measure of social responsibility manifested differently among the participants.

Professional autonomy and privilege

By virtue of their status as professionals, some participants expected dentists and the Dental Association to uphold the public interest before their own—a commitment that was seen to warrant the privileges accorded to the profession, such as self-governance, self-determination, and more generally, to determine how the dental health care system operates. Participants who began to reflect on the relationship between professionalism and social responsibility examined and questioned the privileges accorded to the profession and the related underlying obligations to society:

> **Dr. I:** (...) It's a responsibility for the privilege that you get in society and I think whenever we taken on responsibilities, we do it because we're granted privileges that nobody else can do. Nobody else can practise this profession and as a matter of fact we, we will penalize people who try to practise it that don't have the qualifications that you have, therefore what's your responsibility for having that privilege?

Some felt that dentistry fights hard to protect its privileges, but fails to uphold its obligation to society, mainly because it does not want to realize the meaning and implications of professionalism:

> **Dr. K:** (...) the hallmark of dentistry as a profession, you know that this is a legally protected monopoly, it is a legally protected autonomy. So we grant it the right to control, if you like, the dental market, and to place itself, and there should be a professional payback for that privilege that we've been granted, and that payback may be in a form of ensuring that dental care is accessible to all who need it. But, of course that's not happening. I mean that's why we have people who come in to the faculty to talk about the history of dentistry, and I am thinking well, I don't really think that's the issue, I mean the issue is, what is a profession? You know, what are the privileges that we accord to professions, particularly dentistry and medicine and what should society expect back for granting those privileges. Now maybe I'm cynical, but I think dentistry fights very hard to protect those privileges, but doesn't seem to want to recognize the obligations that go with it.

Not all participants who invoked issues of privilege were explicit in identifying the related commitments of the profession. Some stated that it was a matter that needed further thought, and others acknowledged that the profession did have some responsibility, but within parameters framed mostly by economic accounts. Dr. J was among the few who objected openly to the normalized premise that dentists have the right to discriminate between who does and does not receive care:

> **Dr. J:** Well yeah, there is a real difference in the nature of legislation that gives exclusivity to these kinds of people...and you cannot be a dentist; you cannot have competing people come moving into dentistry. Only dentists can be dentists, so there's a...you can be a lawyer, an engineer, or you can be any number of things but only dentists can do dentistry and in the social contract it is most explicit around those kinds of professions where a society says we will set you apart, we will grant you these unique privileges we will let you be self-governing, and in return you will meet our needs. (...) If you're gonna be a priest you gotta take all the parishioners; and if you're going to be a teacher you've gotta take the unwashed as well as the middle class kids, right; if you're going to be a physician you work in a hospital you're gonna get drunks and people who shoot each other and coming in to Emerg, and you're gonna have old folks. A physician in private practice will get the older, the elderly, the unemployed and the poor. And, well, not in dentistry! And any other professions, probably with the exception of chiropractic, where you can sort of say well I'll screen out or treat the kinds of, or types of people that I want. So!

The dental profession, therefore, was seen by some as either not wanting to acknowledge its obligations, or that it was simply not concerned:

> **Dr. B:** We have responsibility to the public. We have the privilege of autonomy because of that contract. Quite clearly we're not servicing that obligation to the full extent. There are huge segments of the population that don't have access to acceptable health services and I'm not sure the profession's too concerned about that.

Dr. B enters into the equation another dimension to account for the problem. He classifies dentistry as an elitist profession—exclusive and discriminatory, and geared primarily to the rich:

> **Dr. B:** Well, it's an elitist profession! People who go to dentists largely are doing it because they have the means to go and they have the orientation to go and it's a very high SEC kind of activity, so you kinda get caught up in that; that's what it's all about!

Dr. B reveals an important insight into how dentistry, in his view, has become a symbol of affluence and of the affluent. What is implied is that the elite—that dentists too have now become—shape, reproduce, reinforce and perpetuate a particular kind social inclusion around dentistry, defining what it means to be a dentist and to whom their services belong. In effect, it is seen as a profession to serve the rich.

The role of professional associations

Some participants indicated that dentists, as individual professionals and as a collective, through their Professional Association, had dual but prioritized responsibilities—first, they had a duty to their patients and to the community, and then an obligation to professional and self interest. These participants argued that serving professional and self-interests at the expense and welfare of the patient and community was unacceptable.

The concern was that the professional association is interested more in the welfare of its members than it is about serving the public. Some felt that as an influential leadership body, able to influence professional attitudes, the association does very little to address issues of access to care for disadvantaged

segments of the population. Some stated that the primary interest of the Dental Association is and has always been financial gain for its membership:

> **Dr. A:** ...I actually don't think (dental) organizations have done one single thing to help the poor or the disadvantaged really, their main intent and their whole purpose is to make sure that it's a decent income for the profession.

Some indicated that as long as the dental association does not take leadership in this area, the problems pertaining to social responsibility will continue to prevail:

> **Dr. L:** So I'm coming back to say to you that the Association is all important and if you can't carry the Association then the social problems are going to be enormous. (...) we just said the fees keep going up, who keeps the fees up? The Association! What's the Association? The profession! Who does it represent? The individual dentists, and so it goes on.

In contrast, some participants believed that the Association is obligated first to look after the interests of its members. This also meant that the responsibility for social responsibility was an option for the individual dentist to undertake, a point that emerges intermittently in a number of interviews. Dr. AA characterizes it as "the nature of the beast":

> **Dr. AA:** Well, I guess our member services association is in that business of looking after...I mean every profession has that body that is looking after the interest of its own people, and that's the nature of the beast. Can you marry that with the ideal and the professional responsibility to the public? It's difficult! It's difficult, and the way it has happened until now in our profession is that it's an individual thing! You know, dentist's that have been working in a free clinic and there are a number of these things, and there are dentists who are contributing in many ways, and not only in dentistry alone, but in other areas as well, like community service, in one form or another. What's needed, like in many things in life is a balance between the two and how do you strike that balance, how do you find that middle road? I think it's a very good subject to look at and for the Association to look at and to say what is your position?

Dr. AA posits that as individuals it is easier to hold a nobler and truer sense of social responsibility, if that is what individual dentists choose to do; however, professional associations have a vested interest to protect their members, so it becomes very difficult to balance the self-interest of the profession with social responsibility.

There was also the belief that the Association had an obligation to act paternalistically on behalf of the dentist. They had to protect dentists from making impractical economic decisions. Those who were just beginning their professional careers were seen as most vulnerable to this, and the Dental Association had to ensure that no one member would compromise personal living standards. One of the participants illustrated this point well. He uses the example of a recent initiative by the University of British Columbia Student Society who successfully negotiated with a group of dentists a fee discount for students to facilitate greater access to dental care; but the Dental Association had to block the proposal for it was seen to compromise the profession's earning expectations. Dental students had been called upon by the Association to boycott the initiative on campus. In his narrative, Dr. AA positions himself as protector and advocate for dentists, analyzing the situation from a business point-of-view:

> **Dr. AA:** Well, it has to do with the business of forcing, recruiting certain dentists...you are not talking about this as being available to all the dentists. They approach a number of dentists and they say, if you take these patients and you charge them less and you operate a fee guide that we will give you, then we will promote you and advertise you so that you will be the exclusive dentist for this project, for this scheme. And the profession has always rejected that approach because it restricts and isolates some dentists, and also puts pressures on these dentists because you commit to this kind of thing, and it could affect your bottom-line substantially. And a lot of them are young dentists that are willing to go

into this, but they forget that the scheme at UBC is 20% off and if you operate at only 30% and you develop a clientele among these people you are not going to survive. I mean we're trying to point that out to them.

Interviewer: So it's protecting the member and saying look you are going to be taken advantage off.

Dr. AA: You are, yeah!

Notice how Dr. AA portrays the willing dentist as an unwitting victim, to be protected from business ventures that were unprofitable. Another cautionary note he raises is that dentists ought to guard against building their practice by this type of "clientele" because it is not profitable. What is interesting, however, that Dr. AA had earlier positioned himself in a nobler fashion, standing on higher moral ground because he practised dentistry without much concern for business schemes and the bottom-line. There was a significant rift between what some participants espoused and what was put into practice, and the position one held within the dental system played an important role in shaping how some participants presented themselves. Like Dr. AA, some also felt that they had a duty to uphold the interests of the profession and its members.

Upholding professional interests

Some of the participants who held positions of leadership within the profession felt obliged to uphold the interests of the profession first, even if they believed that those interests were in conflict with their understanding of social responsibility:

Dr. AA: Well, you are putting me in a difficult situation here because I wear two hats, I wear a hat as a human being and as a citizen, and I wear a hat as a professional and the ---------- of the Association, so it depends.

The tension is obvious. Dr. AA is torn between feelings of allegiance to society on the one hand and as a dentist affected by the dominant discourse of economic viability. For some participants an allegiance to the profession was paramount, and it was evident that those who controlled the dominant discourse had significant power to define the position of others. Dr. A, for example, first expresses concern about who would have access to the interview transcripts, and when assured anonymity, he offers an important insight into his beliefs:

> **Dr. A:** No, no, that's fine, part of the problem is I have to be seen to be seen and to a fair extent support the profession of dentistry which happens to be the College of Dental Surgeons or the Association of Dental Surgeons, I actually don't think either of those organizations have done one single thing to help the poor or the disadvantaged really, their main intent and their whole purpose is to make sure that it's a decent income for the health profession.

Others were not as apologetic. Dr. AD, for example, makes it clear from the outset that he does not and could not represent the profession, and that his views were personal opinions, which at times conflicted with his official position:

> **Dr. AD:** As I said on the phone, this discussion is my personal opinion on these things and I'm not representing any other body or any other person. So that's important to understand. I work for an organization and it would be unreasonable for my personal views to be representative of the organization. But with that in mind, the issues of what you have down there, I agree that there are segments of society that don't get the same access to dental care as many others do and therefore have poor oral health. And the dental profession has not found a way, shall we say, to address those particular needs. (...) I have to be very careful of what I say in public because of the position that I occupy. I don't have the luxury any longer in joining in the public debates that occurs within dentistry as much as I'd like to because of the position that I occupy. The reason is that people will take what I say to be reflective of the organization for which I work. It is as simple as that.

Some participants were clearly torn between how they felt and what was being practised. Dr. J, for example, could not comprehend the extent to which at times the profession insisted on controlling the dental health system, to the point of wilfully excluding access to care. Dr. J cites an example of how the dental association in one of the Provinces "torpedoed" a recommendation to include dental care into the publicly funded system:

> **Dr. J:** Why did it not get into Medicare is one issue. Certainly, at the level of the inception of the health services there was a strong recommendation that dental health of Canadians...that dentistry was an important health service. The knowledge that visiting the dentist was important your health was still there. But the dental profession went ballistic! And this is the troubling aspect that I wrestle with all the time. Not only can we not do this, we as a profession cannot deliver care to children across Canada but nobody else can because this is our territory and we will sit here as a profession and let the children suffer and not let anybody else do the work! So they essentially torpedoed that recommendation of bringing dental care into Medicare...

He goes on to point out the general professional attitude—they take satisfaction even if their disposition marginalizes segments of the community from accessing care:

> ...So anyway, the Premier comes down to the Canadian Dental Association meeting and stands up and says that I'm here to announce that there will be no children's dental care program in this province and the audience stood up and applauded! We will applaud the fact that kids in the province will go neglected!

The profession was also seen as very rigid in its focus on protecting the economic interests of its members:

> **Dr. J:** (...) The point I agree with that makes sense is there are multiple forces impinging on these kind of things within the profession. I mean the ------ Dental Association's own leadership argues with the government and others (based) on the best interest of those practising dentistry. (If) it is a problem that we cannot get resolved within our own structures and organization, then how malleable, how changeable are we? And in that

> instance, presumably the socially responsible position would be to be honest, you know. Yeah, it doesn't take 15 minutes to do an exam; I do it in three and a half, so why am I billing patients on 15 minutes of time.

As Dr. J points out, social responsibility begins by being honest, and acknowledging that problems exist even if resolutions are not immediately forthcoming. Others introduced an interesting dimension to the problem, pointing out that the profession invokes artfully a range of moral arguments to defend their position, but their actual motive is vested in profit:

> **Dr. A:** The dentists have fought those under the guise of quality of care, safety of the public, all these things, the bottom line is safety of their pocket.

The subtext of this statement is powerful. On the one hand, dentists are challenged repeatedly to respond to both internal and external pressures to act first as professionals working in the public interest, and not succumbing to market pressures. The notion of professionalism is founded on principles that are supposed to ensure quality of care and public safety. In order, therefore, for dentists to maintain their professional position while at the same time acting in economic self-interest, they rely on the very accounts that underlie the privileges granted to professions. Knowing that professional standards and guardianship are rooted in fiduciary principles, to usurp the profession of its sovereignty and jurisdiction over dental practice would inevitably compromise these very principles. Others felt that this was the precise reason that the profession was at risk of losing its privilege to self-govern.

Losing privilege versus remaining economically viable

The issue of access was important enough according to some to warrant the usurpation of the privileges accorded to the dental profession:

> **Dr. B:** Without a doubt, the privilege of professional licensure and autonomy is, I think, in jeopardy. And I think it's only a matter of time before it is taken away. A large proportion of the public does not have good access to acceptable care, and the financial restriction of access.

Although Dr. B, like others who expressed a strong opinion on dentistry's indifference to social responsibility, he also believed that there was a legitimate reason—it was simply not economically viable, and the financial cost of doing the "right thing" was too high:

> **Dr. B:** I mean it's very clear! What the right thing to do here is to create a mechanism where we provide a better service to society. The dental profession is not doing it! It's that simple! It's not a dilemma at all!! It's a problem but it's not a dilemma because it's very clear what's the right thing to do, what's the moral thing to do...there's no lack of clarity there. It's a problem because we're not doing it and there are good reasons why we're not doing it. Dentistry's hugely expensive and you know, the professional has to, the profession has to remain economically viable!

As much as some argued that economics matters, others argued equally as intensely that economics is not the only determinant for providing health care:

> **Dr. Z:** (...) is there accountability to the people who help you be who you are!? It's not only an economic accountability!

Dr. D too makes strong comments about the risk the profession faces of losing its privilege if it does not change the perception that it is only concerned about making money. In citing Dr. D I have divided the quotation to illustrate the way he raises juxtaposing arguments and irreconcilable accounts:

> **Dr. D:** I agree to it to a large extent, that self-regulation is very important, but we need to act socially responsibly otherwise it can be taken away from us and so we need to. If it can be given it can be taken away! I think a

> lot of people think it is a God-Given right, and they don't realize it's this fragile! And the public at large perceive dentists as money grabbing shits, their sole purpose is simply to make money, then they'll say that maybe these guys shouldn't be self regulatory any more because they are not different...so they are just money making machines and why should we treat them differently....

Dr. D, like Dr. B and others, expresses sentiments that speak forcefully against what is seen as an inequitable system, yet at the same time weaving through the response emerge accounts that at times defend that system and its prevailing inequities:

> ...And so the idea that you can...I don't think you can enforce it with change...if someone was a bigoted racist, you can legislate it, like they do in universities, that you can't do that, but you and I know both know that it occurs and these people just either don't care about the consequences or don't believe they'll get caught. And so this is why this kind of things don't really work. (...) The other thing as well is that you do still need to make the profession attractive because whilst...well, certainly (dentistry in) Canada provides a very comfortable living and there is no problem getting into dental school and that can change if it suddenly becomes that there are easier ways of making more money. And if it is seen as losing some of its autonomy and its status then you would see a problem in recruiting the best students, which is certainly what you need. I just really come to hope that we can govern it ourselves and set our own regulations and understand that there is going to be individual variations on how socially responsible people feel.

What is noteworthy in the above quote is that some participants held accounts that were often in tension with each other. For instance, the moneymaking imperative was not only seen to be an inherent and at times an upsetting feature of dentistry, it was also considered somewhat justifiable and unchangeable for what were considered good reasons: "the profession must remain financially attractive if it is to attract the best students"; and that it is difficult to change deeply rooted attitudes.

Upholding professional standards

Although the dental profession, like most professions, is governed by a code of conduct and ethics, within which members can be called upon to account for their decisions and actions, insistence on access to care was not seen as part of the dental business, nor the legislative and ethical norms that guide the profession. Earlier, I discussed the view of ethics as being professionally coded, and that the profession's social responsibility is already embedded within these codes. A responsibility for those who cannot afford care was not seen as part of these codes. Within the context of professionalism, however, some participants expressed the concern that if the salient issue of access to care is left largely to each *individual* dentist to determine, there will be some who will decide that they do not have to care for those who cannot afford their services, and this conflicted with what some regarded inherent to the notion of professionalism:

> **Dr. Z:** Our professional codes, are really about professional ethics in the conduct of business, you know, you don't advertise and all that. I don't pay a lot of attention to that, only to know that you can make mistakes and cause trouble for yourself if you didn't follow the community norm for a part of your profession, but the bigger area is deciding what's your role as a professional! What do you do? For instance, do you feel as though you can make a decision not to take care of people who can't afford to pay for your services?

Dr. W, for example, typifies the concept of a health care professional as someone who is called to a higher standard in society:

> **Dr. W:** (...) you have a higher level of responsibility when you're trying to make decisions regarding people's health. I mean they...when you are in the title, "Doctor" people hold you to a higher standard and so they should; and so, you know, if somebody wants to rip me off at the corner grocery store by charging me an extra five cents for a pack of gum, I mean I don't condone that but in terms of...I would call it a higher level of responsibility. If you walk into a dentist's office and he puts an inlay in your tooth that you

don't need, or provides, you know, a level of servicing that is not called for or, you know, this type of thing...and I just think you're called to a higher standard.

The influence of commercialization was seen to impinge on standards implicit in the notion of professionalism. As these participants spoke about social responsibility they dealt not only with the issues of providing access to care, but also, and equally as importantly, with elements of professional integrity, trust and ethics in relation to those who were already accessing care. They expressed a strong condemnation of profit-motivated behaviour that compromised professional ethical standards. Dr. J uses the familiar television episode carried by CBC's *Marketplace* to illustrate his point:

Dr. J: (...) and when you get people practising you see all kinds of...well a significant (number of insurance) claims that go through would make you shake your head and say how can this person's conscience send this billing. The subtle stuff...a tooth extracted...if I call it a complicated extraction I get $45. If I call it a simple extraction... (**Interviewer:** Interpretation factors among different practitioners?). Yeah, but they have an x-ray to look at and the tooth is flapping in the breeze and they say, you know, it is a question of professional integrity. Now there is legitimate reason for variability in dentistry. There are several good reasons why things can vary. But I mean the hidden camera episode that I saw on TV was a standard patient (representing) the extremes that the profession is now dealing with—those under-treating and those over-treating and defrauding the insurance company. In the meantime there is all this business in the middle that's going on like just upgrading the call on the type of extraction that is done, which is getting to be in the practice norms. I think the social contract and social responsibility goes beyond that though, in the sense of quality of care, respect the individual, don't hoodwink them, don't sell them a bunch of things that they don't need. So there's that aspect which does not have to do with a patient that cannot come to you, but the patient who is in your chair to whom you have a social responsibility and your social contract. Are you a health care provider or are you some sort of smooth operator. It also has to do with the technical quality of your work and to do the right thing and do it well. So all of those things fall under the social contract. You'll stay current and you won't take them for a ride.

Dr. J acknowledges that there are extremes as depicted by the television episode. What he is more concerned about, however, is the subtle and less obvious professional decisions for the sole purpose of effectually increasing profits. Dr. W explains that a corporate ethos leads invariably to "bad" practises and a compromised sense of social and ethical responsibility. He introduces an important dimension to this discourse that some others also raised—once dentists start practising, they tend to look almost exclusively through and entrepreneurial lens where economic success and desires to profit play a central role:

> **Dr. W:** I think quite often (that) once a dentist gets out of the academic environment they are small business people and occasionally that results in practices that are driven by a business sense as opposed to, I guess, what you would term in a broader context the social responsibility, the ethical responsibility of the clinician. If you've looked at the history of any of the problems that have occurred with multiple billing, creative billing, etc., business and ethical issues that have come up within the profession, I think back in what I would term these are high inflation years, people came out of school with a very inflated idea of what success meant and what they had to do to be successful and I think those, the type of success that people were looking for was basically identified in their minds at least, was more economic and I think that that resulted in some very bad practises and bad attitudes and a number of people I think, you know, created problems because of it.

In the above narrative, notice how he explains dentists' behaviour. First, he points out, dentists also function as "business people" inevitably driven by a "business sense," so they become, as a result, predisposed in their approaches to overlook their social and ethical responsibility; second, he goes on to state that dentists are not an anomaly in society, they too are influenced by societal norms and trends:

Dr. W: (...) you can't take a trend, a general trend in society and isolate it and say it doesn't impact on a professional person.

This account emerges clearly from many of the interviews, and it is presented to accommodate prevailing norms. What is noteworthy here is that the dominant economic discourses influences the more subordinate ones, thereby effecting prevailing views and behavioural norms:

Dr. D: We have been in the last decade, we have measured the government, the operation of the government along business lines and that's certainly being reflected in all of our institutions and you're seeing an example within the university as well, and if we must operate strictly along business lines, we're going to have great difficulty addressing the social issues and we're going to see more disparity down the road.

Those participants opposed to the business discourse (either absolutely or in part) invoked the virtues of being a health professional to defend their position. In turn, they use a professionalism discourse to counter the market-driven model of dental health care. Many of the participants indicated that the concepts of social responsibility and professionalism are interdependent. To be regarded a profession dentistry had also to accept a strong sense of social responsibility, ensuring access to care:

Dr. Q: I do believe in social responsibility and I do believe that there are huge inequities. In the industrialized countries and even worse in the developing countries. But still you can find a little layer of society where they have good oral health care as you would find anywhere in the world. But that refers to about 0.2 percent of the population and all of the rest of the 14 million get almost no dental care or oral health care! So there you have the sort of range of inequity, but even in the richest part of the world you have inequities and I do believe that there is a very big social responsibility otherwise we shouldn't call ourselves a profession!

Dentists were seen as having certain standards or principles to uphold, regardless of the economic structures within which the dental health care system

is embedded. Intertwined with professional standards was also the issue of specialized knowledge. The health professions were also called to a higher moral standard because of the specialized training and education professionals received. Social responsibility was not an ideal to be left to the individual professional to decide on, the entire profession had to embrace it.

Specialized knowledge

Many participants constructed the image of dentist as a professional imbued with trust, and possessing expert knowledge not available to the laity. Some participants acknowledged that the idea of professionalism developed to include social responsibility as a fundamental ideal. Professionals are expected to use their knowledge and skill in the interests of the public good. In return for upholding their social responsibility, professions are in turn granted a number of privileges:

> **Dr. O:** Professionalism is larger than the ethic of medicine, it's the way we organize and structure and it's a newer phenomenon. It's actually a medieval kind of construct for the crafts, guilds and professions and that's how we emerged. But the professions, it's going to come right to how we have or have not understood social responsibility. The professions have had special privilege granted to them particularly for peer review, for the quality and standard of practice being an internal judgment. That's been a traditional understanding. Very powerful that *we* can, *we*, ourselves within the professions, can determine good dentistry (and) good doctoring; but the privilege of being a professional has always been understood to be granted because of the promise, professional promise, that practitioners make to use their knowledge and skill in the interests of those whom they serve.

Dr. O goes on to argue that this promise no longer holds true in modern society, however. Today health systems and organization have become much more complex. They have become saturated with layers of intermediary professionals

and auxiliary staff, leading to the creation and universal acceptance of a corporate-like system, thus altering the sense of social responsibility as originally conceived:

> (...) If you look then at what's the actual experience of doctors and dentists in modern society, what's happened to the nature of professionalism? How much has the business end of the practice and the complexity because remember you've got a fundamental commitment that doctors and dentists have is to this ethos of individual patients, but that developed in an era where my diagnosis of you was really me, I didn't need an X-ray technician and I didn't need lab people and my treatment of you was me! I mean I didn't need fifty thousand other people to assist me so the ethic is a definite one-on-one, but there are forces internal to the profession that, in fact, I think have created a different understanding of professionalism and I think have failed to understand some of the professional accountability and responsibility that flow from it. We've, functioned with the privilege of being professionals but in actual fact have become more and more either enmeshed in the complexity on our health systems and/or more like business entrepreneurs. So if you ask the question then what has happened to social responsibility, I think at the level of the profession, there's a reasonable critique that the professions have wound up, the professional organizations have wound up appearing, with the fair justification, appearing to pay more attention to advancing the members of the profession and the profession than the profession in its obligation to fulfill societal needs in order to be able to be granted that degree of autonomy and power and authority.

The problem, however, was that the expert knowledge that health professionals possess enables them to address complex biological problems, the understanding of which is mysterious and virtually inaccessible to the layperson. Knowledge was equated with power, and power meant responsibility:

> **Dr. C:** You're dealing with human biology as imperfect as that is. So, we like to think that we have an ability to alter or change or redirect that biology and that's because of our training, our background or whatever. I do it in a very limited way, a brain surgeon would do it in another way, a radiation oncologist would do it in another way. Does that make us (health professionals) different? Probably does! The reasons for that, however, are steeped in the midst of time. Our biology is a mystical thing to us—we sort of understand it but we don't understand it. We get cancer without any reason, miraculous things happen to our biology, which we don't quite

understand. And I think it's been that way since we crawled out of the trees. So, issues of health and body and living and dying and being born and what not, are very mystical for us. So any individual who dedicated themselves to managing those issues, I think, from time immemorial have been considered by society as something different, something special. The initial physicians going way, way back, were the priests, were the philosophers, were the well educated people, the leaders, and you'll still hear medical people today say, you know, life and death issues! So, I think the people in health care do think of themselves a bit differently. I think the public certainly does look upon people like us differently. I mean, if I'm at somebody's mouth and they have a white ulcerated patch on the lateral border of the tongue, and they're a heavy smoker, I mean, that person could be looking at me to say, "well, do I or do I not have cancer?" The big disease! So because of my training I can probably tell them yes or no. Now, that gives me a terrific amount of power and I think with that comes a terrific amount of responsibility. It certainly puts the relationship between the patient and me and the public and the health professional in a very different context. I buy a Porsche and it breaks down, hell I'll buy another carburetor, right, big deal! But when it comes to biology it's somewhat quite different. And I think part of it is the fact that we really don't understand it and we're only scratching the surface despite all the technology. So yeah, I think it's different actually.

As a result, professions were expected to apply their knowledge for the benefit of society and the common good; the knowledge they had could not to be seen as proprietary or taken to be exclusive:

Dr. F: The health professions (...) are service professions (...) to me it's fundamentally part of what we do. (...) The definition of a profession is a group of people who have a specialized body of knowledge applied in a public interest. There are two things: a profession must be knowledge based and it must be very concerned that the imparting of that knowledge is on a free basis; it's not protected information, it's shared information. It's discovered and it's shared, not just with the profession, but with the public; And then it has to be applied for the public good. Well, it would be very hard for me to imagine how that could be simply with individual members of the public. I mean that would be a very limited, partial scope. So that's what I mean.

He argues, however, "dental care and health care that's delivered is becoming extraordinarily dictated by what is profitable." He contends that limiting access

only to those who can afford dental care clashes with the privileges given to the profession in light of its specialized knowledge:

> **Dr. F**: (...) But with that license to a monopoly comes the responsibility and an understanding that this will be better for everybody, because you have this specialized knowledge you are going to apply it in the public interest and we will let you do that as a restricted group precisely because you will benefit the whole of the society. Well, I think that's largely ignored.

The theoretical support that informs the participants' views on the influences of professionalization and professionalism is well established in the literature. The priority on professional autonomy and professional control emerged from the interviews as a key feature of the struggle to reconcile the concept of social responsibility. Dentistry as an independent, self-regulated profession determines the content and conditions of its work and it also influences the work of others within the dental health system. Through professionalism some participants tried to achieve ascendancy over the more dominant economical discourse of dentistry.

'SOCIAL RESPONSIBILITY' AS AN INDIVIDUAL CHOICE DISCOURSE

While the underlying issue of professional privilege provided for some of the participants obvious and reasonable grounds for considering a social responsibility to meet the needs of those who cannot afford care, for some participants it all depended on where the subject of concern was situated—in the health of individual patients through individual dentists versus the health of communities through a community of practitioners. To this effect, contributing to the common good was seen to be an important factor of social responsibility.

A number of the participants also asserted that education plays a significant role in determining what constitutes acceptable professional practice and how dentists should interpret professional principles. What students were taught and how they were taught was seen to be inextricably linked to dentistry's orientation to social responsibility. If the delivery of dental care was to balance between the focus on the individual patient in the dental chair and a wider commitment to the oral health of society, then dental education had to reflect that, which most participants who spoke about this said it did not. Instead, students were seen to be influenced by an educational milieu that favoured academic, technical and clinical competencies over civic duty.

Contributing to the common good

The belief that an individualistic orientation in society was the root cause of a general lack of social responsibility was not uncommon. Social responsibility was seen as a construct of a well-organized society, but that it has been overwhelmed by an increasing individualism:

Interviewer: How would you define social responsibility, if you had to pin it down?

Dr. F: Well, we all give up a little freedom to gain the benefits of an organized society. If we don't agree to do that, we are taking a free ride, as it were. If we don't contribute to the common good that we're actually benefiting from, cause we don't live in a chaotic society, then how do we ensure the future of a well-organized society. I think the individual freedom argument that you hear in the U.S. all the time, *ad nauseum*, completely ignores the benefits that we all gain everyday. I think that's so over emphasized in the US. There really is a lack of understanding of that.

A well-organized society, explains Dr. F, is one where there is a healthy balance between individual pursuits and working to advance the common good. However, it was felt that an emergent and dominant individualism in society affected interpretations of social responsibility. Dr. I refers to it as the 'me society' pointing to Putnam's book on "Bowling Alone." Dentists were seen as having less commitment to the profession as a whole and more to themselves as benefactors of the profession to which they belong:

Dr. I: (...) I think as a society now we think differently about what we are responsible for socially. I think that there was a much better concept about this probably in the mid fifties sort of thing because culturally we've come out of an era where people had been in a depression and we've gone through a major war (WW II) and there was a lot of community sense of doing things collectively and I think over the, over the past thirty-five years our society has changed. Its much more like we call it the 'me' society but I think is the idea that people are much more individually organized and there's less of a, less of a societal organization. Its just, I listened to a guy the other day talk about a book that's been done by a guy from Harvard named Putnam called "Bowling Alone" and what it says is that there are more people in North America bowling now than there's ever been in the history of North America and there are less people in bowling leagues because its not organized, its all individuals doing things and I think its the same as professions. I see professions, you know, being less of a community kind of thing (...) so I think that our social policy is affected by this....

In referring to the affect of individualism on social policy, Dr. I raises an issue that others too observed: prior to the advent of institutionalized social services communities accepted this as their social responsibility. Now it is seen as the government's responsibility and people generally have absolved themselves from a social responsibility that was once part and parcel of one's attitude and practice:

> **Dr. T:** I mean we ran a program for quite a few years here with kids in high school where kids who, who had visible dental problems and were getting towards the end of high school years and they were having trouble getting jobs because of the appearance we, in the office that are, you know, seven or eight dentists and so we would take on some of these students and do the work for them at no fee and get them so that they were able to get out there and get jobs and that's just a small example of that kind of thing that's gone on quite often throughout the profession. Now the problem is that as governments got involved, once they were on programs what happens in my perception is once the government starts to pay for some of these services then people expect that that's what is going to happen and that sort of takes over as being the operating style...so, you know, I'll restrict my involvement.

Drawing from a recent experience, Dr. I realizes, however, that the social net is inadequate. As a result he believes that the dental profession ought to make a contribution to meet the shortfall. Dr. I's notion of social responsibility is vested in the concept of community, not individuals; and approaching the problem individually was unsustainable. He explains that as individuals dentists would not be able to afford treating the problem of access:

> **Dr. I:** (...) I think if as a profession, dentistry takes on a responsibility to deal with all people who have health problems and obviously if people can pay for it up front, its not a big deal to deal with socially, but as we get into this marginal area, how does the profession provide health care to those that can't provide it for themselves and is that, is that a responsibility for the profession, is that the reason we have those people licensed and all the rest of that? So the question is, is it the individual's responsibility as a practising dentist within the community? I'd say forty-five years ago in

school we would have said that if you go out and somebody comes in your office and they can't afford to pay for it, you're going to have a certain number of patients every year, every month or so that you're to have to deal with these things and you might do something and not charge people for it. I think that's less likely now because we've got all these safety nets, but just like you say these safety nets are really rounded up because many of them have to be supplemented and I'll just give you an example: I was just in the Downtown East-side talking to people who have about forty dollars each month discretionary spending, everything else is food and rent and this sort of thing and the people in Strathcona community say they need a dental program because these people if they went to see anybody in a dental office, it would absolutely take every bit of money that they have that's discretionary, so they just don't do anything and consequently the whole health condition of that community as compared to any other public school community within the, you know, is negligent, you know, and this sort of thing so I think its an obligation for us as a profession to deal with that. I think if I were a dentist practising in that area, I'm not sure I could deal with that, but I'd probably go bankrupt as an individual, but as a society...I think as a profession, I think we need to look at that and try to bring some resolution to it. Beyond the profession, as a government I think that we ought to be able to do that, that we should do that. I think that there has to be a relationship between a profession and between our government and between the social needs.

Those participants who located both the dentist and the patient in social communities stated that dentists are *collectively* responsible for the health of communities; and for them the subject of community is the element of concern, not simply the individual patient or dentist:

Dr F: Well, I think the health sciences, the health profession might be a better way to put it, are service professions. Their whole reason for being is to serve individual patients; and since I'm in public health I think I understand also to serve the community good, the good of the community. I don't know how well we impart that part of it but, to me it's fundamentally part of what we do and there are some things...there are some ways of acting and some ways of approaching this service to individuals in the community that will work better with the individual and there are some ways that will work far better with a group approach, and they are complementary and necessary, both essential. So what we have to do is to work out what can we best do for the group and what can we best do for the individual and do it!

Participants who looked at social responsibility from the viewpoint of communities were more optimistic toward finding solutions to the problem; and those who saw matters from an individualistic viewpoint guarded their responses and tried to rationalize the lack of social responsibility within the profession:

> **Dr. AA:** I think that dentistry being the kind of profession it is, you know, dentists operate individually in their own offices and have less contact with each other than physicians who are always in a hospital and mixed with their colleagues. Dentists are more individualistic and very refractory to having something imposed on them.

Dr. AA acknowledged the profession's lack of social responsibility, and accounted for it by pointing to what he felt was the inevitable professional disposition dentistry found itself. Yet, some participants were clearly frustrated and expressed a sense of despondency. The problem from their perspective had become too overwhelming:

> **Dr. K:** So where does social responsibility fit within a society that is increasingly individualist, materialist and consumer driven? I don't know the answer to this question. I mean there has been the decline of social responsibility in the sense that government is cutting budgets. Society doesn't really have the responsibility to do this kind of thing. So we *won't* provide day-care and we *won't* provide dental treatment!

Dr. K felt that social responsibility was more a societal problem. The ways complex and large societies are structured tend to create depersonalized tendencies among individuals and communities. Dr. T accounts for it by saying that many dentists in the city do not reside in the communities in which they practice and that contributes to the problem:

> **Dr. T:** (...) When it comes to things like helping the disadvantaged in our society, it's a pretty uneven kind of situation, and there are lots of practitioners out there who, you know, over the years have not just treated the patient covered by human resources, but the people that didn't have any coverage whatsoever could get emergency care without any problem

> in offices, and that's been fairly generally true. I think its better managed by the profession in rural B.C. than it is in the city, and I think that's largely because they're, they feel as though they're members of the community, you know, in a real way. I think dentists in the city often practise in a location where they don't live, and they don't, I don't think they have the same sense of community.

Although many participants acknowledged that dentistry has tended to focus narrowly in determining who is served, to move from an orientation toward the individual patient comprising primarily those who can afford care to the public at large was seen as a challenge:

> **Interviewer:** How would you define social responsibility?
>
> **Dr. E:** I think it has something to do with the public good, and defining the public good at a level greater than the individual, and greater than one's occupational creed. It has to do with your client group, in the case of dentists, patients and the public at large. Patients are only a subset of the public at large and so I would think it has something to do with the public at large good. Trying to get there from the patient in the chair is a great leap.

Many who supported the idea that social responsibility in dentistry meant that the profession had to look beyond the individual patient acknowledged also that to put this into practice would be very difficult if not impossible. Some considered it a collective professional obligation to ensure that dental care is accessible to all who need it, while others felt that it was a function of individual choice. Those who took the latter view described social responsibility as a way individuals could choose to "give-back."

Social responsibility was identified by some of the participants as "payback" or "giving-back." Dr. B, for example, was among a few who sees social responsibility as something one does not have to, but ought to do:

Interviewer: When you think about social responsibility, what do you think about?

Dr. B: Giving-back! (Pause) Some way where you are using the skills and experience that you've acquired through your education...giving-back, to help the public, and (to) help people in this world deal with their problems of...whatever! Giving-back, for rewards other than monetary, other than material!

A few of the participants who raised the idea of giving-back, placed it within the context of altruism, being a good citizen and helping those less fortunate. It was not obligatory however; it was seen as a human thing to do. Others maintained that the basic element of any profession is altruism—a necessary part of the definition of professionalism. In this case, altruism is seen as an ethical construct, and a fundamental component within the makeup of a health professional:

Dr. L: You are coming right back to social conscience, you are coming back to things really that the profession is intended to do! It is a giver, from the training and the education that individual health professionals get. It's a handout back to society of their professional expertise. I don't think that there is a hell of a lot of difference between ethics and what you're trying to get. Now don't tell me that you can leave that thing to the individual to make the decisions on, but the profession has got to have an ethical standard, and that's where the slippage has occurred in the last twenty years!

Interviewer: Why should a profession have this obligation?

Dr. L: That's the definition of a profession; a profession professes to look after people.

Interviewer: Some would say that that's too idealistic given the type of world we live in.

Dr. L: Yes, but altruism is still a phenomenon of individuals. It is a missing commodity, and in the bulk of modern life unfortunately, there are very few people who will do something for nothing, but altruism is one of the brick foundations of our profession!

Dr. O states that dental educators do not model well the traditional values of virtue and altruism and the approaches dentists took to care for the indigent before the advent of third party payers and social insurance systems:

> **Dr. O:** And the other thing we don't model well is part of what social responsibility has been before insurance systems and payment plans came into place. It had a lot to do with the demonstration of the virtue of altruism or it was self-effacement in the tradition actually. It was even, I mean self-effacement is a much more kind of deep rooted giving to, you know, acting for this best interest and altruism, altruism is a common, a common, very, very modified virtue but in a different time before insurance systems, part of the social responsibility that practitioners demonstrated was that they did pro bono work and that's, I mean when was the last time you saw somebody in the professions do something for nothing.

Dentists, many indicated, ought to be grateful for the professional privileges and status granted to it—for receiving subsidized education, and being able to enter a profession that paid well and provided good working conditions. For all of this it was expected that the dentist would "give back." However, the responsibility to give back, from this point-of-view was seen as more than just returning the favour. The professional had a "responsibility to society" to attend to the quality of care provided, and equally as importantly, to be more sensitive to disadvantaged members of society, and to be a crutch at a time of need.

> **Dr. T:** The fact that this truly is a privilege, you're being funded to go into a profession where you enjoy your work, you've got wonderful working conditions and you're going to earn a much higher income than the average member of society, so you're clearly privileged. So you then therefore have a responsibility to society, they've funded this for you, to give back. Now that means first-class professional care! But, it also means helping to meet the needs of those that are disadvantaged in our society and so on, and it means, you know, this whole concept of, you know, if a lot of people find themselves in this situation but for a very short brief periods of time, if they get a help, a leg up in that particular time, they, most of them will ultimately be infinitely appreciative and it will come back in spades to you whether in simple gratification for a job well done at the

time or long term patients and people referred to you, and that's exactly what happens.

Dr. T takes as given the obligation to "first-class professional care" and he believes that there can be no compromise in delivering quality care. He focuses instead on the point of helping the disadvantaged. In order to make more convincing his argument and to appeal to many dentists he suggests that giving-back can also pay dividends, first through the immense satisfaction one would feel for treating the disadvantaged, and second in future benefits through referrals resulting in a larger client base. Giving-back, therefore, had also to be accounted for in terms of future profit—it is a good thing to do, and it can produce a healthier financial return down the road.

For some, therefore, the notion of selflessness was not simply about providing free care, it was seen rather as a professional disposition that shaped how dentists ought to approach their work and how they interacted with others—being a bit more sensitive to those less fortunate. For others, however, it was about not rocking the boat. Dr. W, for example, constructs an insightful account, comparing the economic advantages dentistry enjoys in relation to other professions. He argues that dentists need to be more appreciative, primarily because they were so fortunate for enjoying the economic and self-determination privileges they did:

Dr. W: First of all I think what the average person in the dental profession has to understand is how well off they are! I mean you still have...you go to meetings and people are debating whether front end costs are too high, you know, a dollar or two here, a dollar or two there, I mean they're really getting excited over the impact this is having on their income, and let me tell you, if you want to talk to a frustrated bunch of professionals talk to people who have been a general practitioner in medicine for the last

> twenty-five years! Those are frustrated people because they...most of the colleagues that I know that have been general practicing physicians during the same time that I've been practising dentistry have had severe restrictions on their income, they haven't had the privilege of independent practise, they haven't had the privilege of setting their own fee guide every year that's managed to keep pace with inflation and even beat it by a bit. They haven't had the privilege of training different levels of auxiliary but still work within the profession that make it possible for the dentists to deliver better and more efficient service and also enhance their own income. I mean we have a lot of positives within this profession that other professions haven't experienced. I mean, you know, we're way better off than a lot of other professionals in terms of economic independence and economic well-being. I mean if you take averages I don't think that tells the whole story and so one of the things that, the sense I get quite often when I listen to dentists at meetings, particularly the ones that are complaining is you don't realize how well off you are! You don't realize, you know, that the level of income you're achieving is very healthy and at times almost obscene and you really don't have a whole lot to be complaining about! You know, you have a right to complain if your overhead is too high or your taxes are too high, anybody has that right, but I think one of the things that the profession needs to understand is just really how fortunate they've been and how well off they are. I mean trust me, the dental profession, since we're talking confidentially, would not want medium and average incomes when compared to the rest. We're doing way better than the medical profession, for example!

Dr. W acknowledges that the profession is very fortunate to have control over how much money is made and how it is made. Unlike the physicians, he argues, dentists have had no restrictions on setting income standards. Moreover, the dentist has also the advantage of exploiting "auxiliary" staff to assist in delivering services efficiently, which in turn has increased profit. His underlying statement is that dentists "don't realize how well off" they are, particularly in light of general expectations within the profession of "almost obscene" income levels. Dr. W goes on to argue, in effect, that instead of complaining dentists ought to stop rocking the boat and begin exhibiting some social responsibility, not only because it might

be the right thing to do, more importantly, because it will protect the economic opportunities dentists enjoy:

> (...) We do well and, you know, now in terms of what do you owe back, well, I mean I think if you accept the fact that, you know, you've gone to school for a few years, you get a chance when you come out in our profession to sort of achieve a relatively high income level fairly quickly and your colleagues in business and law may eventually surpass you, but they're going to take fifteen or twenty years to do it, so you're very fortunate; you get a faster start and a pretty good life style, fairly predictable as long as you're not a complete bozo! You're not asked to follow a lot of rigid rules and regulations, as some people would have you believe, because it's not the case. You know, and so what should you give back? Well, I guess everybody has to make that decision for themselves and I think, I think dentists at some point in their career should at least serve on a committee or help the profession in some way. I think dentists earning good incomes in the community should, at least, give-back in some way whether they throw a few hundred bucks here and there to help sponsor sports teams for kids in their community, whether they contribute to fund raising activities with some of the local high schools where a lot of their patients go, whether they coach baseball teams or hockey teams or whatever, they should get off their butt and get out and do something because they are successful members of our community and, you know, so I think that they should be giving something back.

Giving-back, for Dr. W, is a matter of individual choice; it also comes across at the end as a token gesture, a facade aimed at preserving privilege and status. This becomes evident in the words he uses, "throw a few hundred bucks here and there." Notice also that there is no mention of giving-back in relation to marginalized patients; the focus instead is on existing patients, and within the context of supporting leisure activities within the communities be (likely more affluent) in which dentists live.

What is important to note is that some of the participants felt strongly that social responsibility, whether in the form of giving-back, or ensuring access to care, was seen either to be at the discretion of each individual

person, or a collective responsibility either at the societal level or at the level of the dental profession at large.

Socializing forces

One view that emerged unmistakably was the recognition of the various socializing factors affecting one's orientation to social responsibility. There was the view that culture and family background as well as secondary socializing forces have a powerful impact on behaviour and world-view. An orientation to social responsibility was seen to be dependant on and determined by these forces. Some placed a greater emphasis on primary socialization, while others on secondary socialization. Most participants constructed their views to this effect from the perspective of the typical student who entered dental school. Accordingly, it was seen as difficult to change someone's orientation to social responsibility. Some believed that people are born and raised with a certain sense of social responsibility and although significant life events can have some influence the extent to which this happened was thought to be minimal:

> **Dr. B:** There are people who have a tremendous amount of social responsibility. They do that despite the system, despite the structure, and that structure and process exist and aren't going to go away and it has a profound affect on health care providers' orientation toward social responsibility. (Pause) So you're kinda born with it, raised with it or you don't have it! That's my view. Maybe some significant life event can reorient you slightly but... (long reflective pause).

Those who argued that social orientations and attitudes are formed from a young age indicated that it would be very difficult to change people:

> **Dr. F:** You see this goes back to the social orientations and attitudes that are formed by 13 years of age. I don't think dental school does anything to change that. It's already happened! Our mothers, our experiences in childhood, and the attitudes and our families! I think very much in families

because 13 is almost too young to have had any kind of major impact from peer pressure.

Some felt that it was a combination of factors, including acculturation through professional as well as educational institutions:

> **Dr. P:** Social responsibility is something each individual interprets according to his own background and sometimes on an institutional basis; we culture that institution so it's a combination of all those factors.

An orientation to social responsibility was seen as influenced by processes of primary and secondary socialization. The majority of types of students who were attracted to dentistry were seen as those who largely did not have this orientation. The prevailing discourse and related professional, economic and educational structures in dentistry were seen to also support and reinforce a sense of how things should work.

The education process

The education process was seen to be structured to meet the educational and training needs of students first (over the patient's) acculturating them to what is normal and acceptable to dentistry:

> **Dr. J:** I think some of that happens right in the education process—a patient coming to this facility has a missing permanent tooth...so the diagnosis shows that there is no chewing problems or aesthetic problems, there's no pathology around the adjacent teeth, there's no over-eruption, everything is fine. So what do we do? Well, what we don't do is tell them that you know you've got a missing tooth, but it's all right, good-bye, cause you'll live forever with one missing tooth. We say, oh gee, you know, we can do a partial denture or a nice bridge for that, so the issue of patients needs accurately assessed and appropriate care being delivered is compromised from the get-go because there are requirements for finding enough bridges for the students to learn on; and they pick up on that real fast you know, if it's okay for faculty to do it then when I graduate and get paid to do this then I guess it's certainly all right for me to do this!

In other words, the message that is being subtly conveyed through the educational process is that it is acceptable to use others for personal benefit; and this was seen as counter intuitive to social responsibility. As a result, the influence of the general dental education and health care system based in a society that favours an individualist orientation plays a significant part in shaping dentists' interpretation of social responsibility and reinforcing prevailing attitudes:

> **Dr. U:** I actually think that dentists do not display a high level of social responsibility over all, now that sounds like a damming statement, but in actual fact I think that we have not encouraged dentists during their training and actually during the early years of their practice to be socially responsible individuals. I think the basic desires are there. I think that is one reason that many individuals end up in dentistry, feeling of some sort of social responsibility, I don't believe personal gain is the main reason, but somewhere along the way it changes and instead of fostering a sense of social responsibility and giving something back, the entire system seems to encourage individuals to be more concerned about themselves and their own personal accumulation of, perhaps not wealth, but comfort at least.

Part of the problem is also attributed to health care systems that are structured to attend to the needs of individual patients and not to the general needs at the larger societal or community level:

> **Dr. E:** I suppose the first thing I thought about was responsibility for a larger societal group than just the individual patient. Usually one makes the assumption that in the health science context, whether it is in educational or delivery system, is on the one-to-one treatment responsibility or prevention responsibility, care responsibility. So my concept here is do health professionals either in training, or in actual practice, during the course of their professional life develop a sense of responsibility at a societal level, the community level, the local level, at the national level, or even beyond that, you know, a global sense of social responsibility? And I think that's the issue. The individual was always taught the technical care part of diagnosis, prevention, treatment, but we don't necessarily teach social responsibility. (...) I don't think that this system, or the process, or what you might do to the process, affects dentists' orientation towards social responsibility. I think that there are factors outside that; the context of the educational system that influences their behaviour and that perspective—it's all-powerful.

Many of the participants believed that there is a close connection between the ways in which students are educated and socialized that affects their sense of social responsibility. Moreover, it was felt that changing deep-seated attitudes would be difficult if not impossible. Efforts at change had to be systemic and at all levels of dentistry—in the ways in which students are educated and socialized, in the way the dental health care system is set-up, and in the way it is connected to the overall health care system.

Role models

The way dental students are taught and who teaches them was seen as an important predictor of how they would conduct themselves as dental practitioners. Some argued that educators generally seek for students to emulate them. There was a belief that students tend to try to be like those who portray traits that are mutually desirable. Dr. K indicates that educators are "in the business of cloning themselves" and that producing socially responsible students would first require the presence of a socially responsible educator:

> **Dr. K:** The concerns I've been expressing, how common are they? Would all my colleagues see it the same way? I think a minority hold these views. How many people might disagree with the IOM (Institute of Medicine) report; how many have read it? The message I try to give is that the patient comes first, and not the elite professional. I mean is there a will in faculties of dentistry to change the type of people we produce? Don't forget we're in the business of cloning ourselves! We are the role models; we want students to be just like us! Whereas our ethic of social responsibility isn't present in all the role models that students come up against. I'm sure some senior clinicians teach how to make a good living in dentistry and how to practice in a particular way. I'm sure much of that resonates with students because there is a desire for material well-being and success, and if students come in with that individualist philosophy then it has a great deal of resonance. It's a tough call! Where will the major force of change come from?

A few of the participants postulated that change will come from students who have experienced what it is like to be underprivileged, and can look at the dental health care system more critically. He acknowledges however that the socializing forces in dental and medical schools can be very powerful and students, regardless of their background, can be acculturated easily. As he continues to reflect on the forces of change, Dr. K believes that students who have experienced what it is like to be marginalized will behave differently and perhaps even against the status quo:

> ...Will it come from government? Well the government doesn't want to know about the lack of access to dental treatment because it is not interested in problems that it doesn't want to have to find solutions to! So, don't tell me about untreated dental caries because I'm not interested because I might have to do something about it! So where is the change going to come from? The dental profession? Students themselves? Why are some students different? Why are they different? I have my own theories about why minority of students coming through are in a position to do this. I think those students have experienced what it is like to be an outcast. They come in as an outcast. Maybe they come from a working class background. I have no evidence for that but looking at the people I know who are part of this opposition, have been at the margins, marginalized and look more critically at the system. I don't know, it's probably all bullshit... it's an interesting idea. But, I'm sure also that dental and medical schools are very powerful experiences and students from minority backgrounds can be acculturated, if you like. Going through dental school is very difficult. I'm not sure we can simply say that let's recruit minority people and that will solve our problems...

Again, Dr. K reverts to the powerful influence of the socializing forces in education. The purpose of higher education, the focus of knowledge advancement and value of science was also questioned. Some felt that prestige is a strong driving force of science. Dr. K presents an insightful narrative challenging the idea that science and research will in effect provide answers to

human problems. He concludes that biotechnological advancements have not and cannot help to solve prevailing social problems, but "that's where the money and prestige is:"

> ...I think the force of change can come from community dentistry, and those that sit outside organized dentistry and are marginalized, if you will. We have to move our thinking from the teeth and the mouth to the person and the broader society. We are going from tissues to cell biology to molecular biology. The highly valued basic sciences are moving toward smaller and smaller things—molecular biology—it's highly valued, that's where the money and prestige is. But, we need to broaden thinking. The objects of research are becoming smaller and smaller. The assumption being that if you understand those processes at that level, you can solve all human problems, which of course is bullshit. In fact, a very senior person from IADR came to talk to me and said well, we used to think microbiology would solve our problems and that proved to be a false prophet. And then we thought immunology was the answer to issues of dental disease and that proved to be a false prophet, and I'm convinced that molecular biology which we are currently embracing, our new church, will also equally prove to be a false prophet. Largely because all these issues are social issues rather than issues of the way molecules race around in our bodies, that's my view anyway. Even if they do ultimately understand all these process and they develop very effective treatment gene therapies—well, who is going to have access to them and who will pay for it. And are we going to have a new profession of gene therapists that only the rich and the wealthy will access and the poor and uninsured can't. So in a sense the solution to the social issue and the biological one have to go hand in hand cause one without the other is useless isn't it!? I mean let's say we found a cure for cancer but it costs $5 million or $10 million...we can cure your cancer but at this cost. Well, is that a useful treatment? I mean the scientist would go ape-shit wouldn't they? The $5 million tag would get lost in the euphoria. We can now cure cancer! I mean this is what I prejudicially call 'toys for boys' research. Why are we sending these little trucks to Mars that strut around and these scientists get really excited...look I've got my little truck and it's sitting on Mars and it told me that once upon a time millions of years ago there was water on Mars. Well so what!? How does that help me in my daily struggle to survive? Any way, that's just my prejudicial view.

The typical dental student

Social responsibility in dentistry was seen to be influenced also by the types of students who applied and were admitted into dental school. Those participants

who describe this feature insist that the typical student who enters dental school is more individualistic; someone concerned primarily about a career that enables them to earn a good income and achieving a certain status, rather than social responsibility. The implication was also that predisposing attitudes made it very difficult to change orientations.

> **Dr. K:** (...) I mean don't forget that students coming in now (are) in their early twenties (and) have grown up within these philosophies of individualism and the global market and that kind stuff. So, why do students want to come into dentistry? Well, our students write a little essay because we don't interview; and of course they talk about wanting to help others, you know, but a lot of them say well I want my own business, and I want to be my own boss. So there's this kind of individualistic ethic among those who come into dentistry, they see it as an opportunity where they as an individual can control their own work life. And then what does the school do!?

The typical student was portrayed as one who came from an upper or upper-middle class background, and lived a privileged life. Their socio-economic experiences were too far removed from the problems and issues facing disadvantaged segments of the population:

> **Dr. AC:** Well, I guess in a way our whole life we've been, you know, most of the people that get into medical and dental school, there's a few of them that you sort of hear, sometimes you hear stories about some student whose had some, you know, had some horrific sort of family life and there's always a real shock kind of thing, you know, and often, you know, I just had a student this morning saying that, you know, they had a family emergency and they have to go home for like the weekend and they won't be in and well, those things kind of come up, but I think that we're generally privileged. Most of the people that are in dentistry or medicine have had a fairly privileged life throughout their whole life, they've had, you know, housing and shelter and food and education and that distinguishes them from, you know, quite a few people in the world.

Most students were seen to have come from opportune backgrounds, sophisticated and refined by extramural educational opportunities. Most of them were seen to have had little experience, if any, of financial hardship:

> ... I always smile because no wonder there's so many talented people in medicine and in dentistry because they have parents who sunk their whole lives into them. They've sent them for music lessons and dancing lessons, and, you know, juggling lessons or whatever, and so they've always kind of been successful. So they haven't kind of been through that, that cycle that, you know, where people kind of, you know, keep running up against people saying no, or brick walls or, you know, the plant closes down (and) they're out of a job kind of thing....

Dr. AD felt that many who entered the profession were independent in spirit and unwilling to accept the dictates of a social service, which is a disposition that AD believed was characteristic of the profession at large:

> **Dr. AD:** The dental profession as a whole is...the people who come into it I mean, I'm not a sociologist, but as I look at it I think that they, a vast majority of people in it, are pretty iconoclastic: they are individualistic, they don't like to be told what to do, they like to run their own lives and they certainly resist having things imposed on them, anything imposed on them.

The problem of mutual attraction

Some participants felt that there is a connection between the types of students who are attracted to dentistry and the way the profession is structured; both were believed to be inextricably linked:

> **Dr. J:** (...) dental practice is still the same! The reality is that it is the last profession that you can dictate your own terms of how you'll practise. It's not hard to see that people with healthy smiles are more affluent. (...) If you're going to practise in an environment that serves the rich and affluent people then dentistry is for you!

Dr. J makes a strong concluding statement to characterize both the types of individuals who are attracted to dentistry and what it represents as a health

speciality. There was also a sense that students who do have an orientation to social responsibility will choose different professions, ones that are more enabling in nurturing this ethic. This also meant that dentistry would be left mostly with applicants who had limited viewpoints rendering, as a result, the problem as inevitable:

> ... So the people who think (social responsibility), or have that personality are the people who apply to social work or medical care or priesthood or teaching or whatever. Very few people see dentistry as the avenue by which they're going to change the world. So we have these kinds of folks that come applying and you only admit people who apply and you can't get the folks that don't apply.

There was a sense, then that dentistry was caught in a self-perpetuating cycle: the prevailing conduct of practice was driven by a corporate ethos which attracted individualistic and materialistic oriented students which in turn perpetuated the business enterprise approach. It was seen as a lose-lose situation. In essence, the notion of self-selection determined not only the type of students who were being admitted by also the type who selected dentistry as a career. Dr. F also contends that it is a function of the inherent structure of the professions that attracts certain personalities. In addition, however, he expresses cynicism about institutional intentions to try to change the situation:

> .... If that's true, I read about it so I don't know personally, but if that's so it's very difficult to change these things, you know, this idea of dentistry and the profession as self-selecting groups, that's true, but part of the selection is by the students, not just by faculty who choose future students. It's a dual thing, so when you say you want to change, if we were to say, I'm a bit cynical about this because in medicine in the US, when they were short of candidates they said how welcoming they were of students from the humanities and they'd make special provision and everything else. But, as soon as the curve turned upwards, they stopped talking like that and they weren't really looking for humanists any more.

Changing the selection process

There was a feeling, nevertheless, that *if* the profession *is* concerned about social responsibility the focus had to be on the next generation of dentists. The admissions criteria and recruitment strategies had to change to screen for students who demonstrated an evidenced commitment to social responsibility.

> **Dr. E:** Well, first of all, you have to assess where a person is when you recruit them into dental education. So, one really needs to look at selection criteria, and that's really the first place.

Dr. E explains that it is important during the admissions interview to focus on what students have done, and if the profession is serious about wanting individuals who are inclined towards a social agenda they have to look for and market to a different type of individual:

> ...When somebody says they want to help people, it doesn't say anything. That's sort of a trite expression, a socially expected response. But, there are lots of ways to find that out. Giving contexts, watching responses to situational contexts that you describe. Or giving experiences, what do they do with their free time, what are their activities. My former secretary's daughter would volunteer with the local rescue squad, because she always wanted to learn about medical care. She was a volunteer at the hospital, giving out milk and refreshments, because she wanted to experience what it was like in a hospital, or she volunteered in an old age home. Finding out what people do with their leisure can be much more sensitizing to what a human being is really like than the socially expected response. So there has to be a critical look at the selection criteria and interviewing process to get at that measure....

She goes on to suggest that the profession needed to attract students who had a well-rounded education and not just a background in the natural sciences:

> ...So to me that's the first step. I mean, who do we select into health profession's education, whether it's dentistry or medicine or pharmacy or any of the health science professions. But, even prior to that it's the recruitment and outreach! Who do you want to come into your applicant pool? So instead of necessarily looking for that person who does very well in the biology course, we also want to look for the person who does very

well in civics and social studies and related areas—a rounded educational experience, and this has been debated much in the literature. Whether physicians, for example, medical schools should be recruiting a different kind of person and not just target the biology majors.

Some participants argued, however, that it is difficult to select students who may genuinely care about the ethic of service and social responsibility. Dr. J narrates an example of the common discourse adopted by the typical dental school admissions interview, pointing to the use of socially expected responses to gain admission:

Dr. J: When you're interviewing students, and we went through this farce for several years around here. When a student says I want to be a dentist...why do you want to be a dentist? Cause I really like people. I worked in the summer time with retarded kids, and I really want to help those who are disadvantaged. That's good, what are your other interests? I like to read. What's the last book you read? Oh, I read the Bible! ... And, you know, it's this stream of guck that would come out of these folks to convince the interviewer that you're really interested in helping the poor and serving the community and really you could care less about these things. But these students know what a dentist lives like and that's their profession but they know that to get by in the interview you had to construct your answers this way...they all say the same thing...how are you going to discriminate?

Some saw the problem as rooted too deeply in a structure that precluded social responsibility. Dr. D renders an insightful narrative that highlights many of the issues that are seen as central to the problem of social responsibility in dentistry. He not only recognizes the dominant and hegemonic corporate discourse, he uses it to make his point:

Dr. D: Well social responsibility and the dental profession are not an easy marriage, you know, if we're talking about social responsibility in a broader context and asking the question how does it emerge, how does it come about, what triggers it, where does it occur and why? I mean (these are) questions that exist out there that have nothing to do with dentistry! To try and link dentistry with social responsibility is a real tough one because dentistry is the way it is and its not...it doesn't have time for social

> responsibility! It can't afford social responsibility! It isn't structured for social responsibility! You know, its expensive to set up a dental practice so don't talk to me about social responsibility when I have this reality! if dentistry, if that's going to change, the social responsibility or elements of experience in taking social responsibility would have to be a prerequisite, you know, its not something that one health profession owns, its much broader than that. And would that be allowed? I don't know, you know, would the University of British Columbia be allowed to purposely recruit future dentists who have demonstrated a high level of interest in social issues. I don't know, it might be difficult, but there was a time when the world was that way, more that way. I feel in a sense that I'm in between generations. Times have changed! I attended a university that recruited me because they were proud of what I was doing, it was almost like they were grabbing me, encouraging me and it was because of the work I'd done as an undergrad and because I'd gone off to West Africa for a couple of years and there were faculty who, who wanted this type of student so they, they fostered this and that's what it takes!

Dr. D inevitably takes for granted that the world no longer "allows" for social orientations. He accepts that times have changed and that no longer does it seem that dental schools value those students who come with experiences that orient them to be socially aware and responsible.

The privileged, individualistic and economically oriented student, some participants believed, will go on to become a privileged, individualistic and economically oriented dentist, thus shaping how dental health care will be delivered. Moreover, the profession itself is seen to be set up and structured in a way that inevitably attracts such students, and producing ultimately a professional that perpetuates these accepted norms and standards.

Currency to graduate

There was the view that dental students are educated to focus primarily on the technical and scientific aspects of dental health care geared toward addressing the needs of the individual patient. Students determine quickly which

courses are important and which are not based on how dental education is structured. Some participants felt that courses dealing with the science and art of dentistry are certainly considered more important by most students.

Although a few students may express an interest in learning about and experiences broader issues of health care, the currency to graduate in dental school is to perform well on courses that teach the art and science of dentistry, and to get all your credits, and that becomes the focus:

> **Interviewer:** When dental students, over the course of their education of four years, when they think of community from day one to year four last day, what do they think about?
>
> **Dr. J:** I'm not sure they do. Our program is, my perception is that our curriculum is so focused on them as individuals getting through the process and part of getting through that process is them as an individual doing well on tests, them as individuals getting all their credits on individual patients. Very few of them look up to see the bigger picture. Now there are some that do and some that say put me in touch with someone who might be doing something with the elderly or with international populations. So a small minority do come through this door and tries to express any interest in community. The currency to get out of here is not community service or community issues, the currency to get out of here is to do well on the chemistry test and get your credits. ... (It's a) credit-based curriculum, you gotta get enough of these to do that.

Many argued that the currency had to change and that dental education had to focus not only on training students to acquire technical skills, but also educating them to understand the complexity of health needs of individuals as well as communities, all within the context of larger society. The emphasis was primarily on the educational process as an instrument of change:

> **Dr. F:** We ought to be very careful that we don't continue down this line of over-structuring the curriculum so that it becomes an absurdity and an abstraction in the way we do it. And the way to do that is to go out and treat the health needs of real people where they are. It could be in a dental school, it's just the way you organize it. The currency in dental school is

> "requirements", [and] that's absolutely got to be thrown away. Because the currency has to be what people need. Dental students need to understand a whole lot better that the solution to problems, there are several many solutions for any one person, maybe they need to understand a whole lot more about how to engage people in decisions about that, the patients themselves, the community itself. That's a hard thing to learn and it seems very wasteful of time and it's an educational sort of process you need to engage in. I don't even think we're prepared to spend time on it.

It was argued generally that an orientation to social responsibility will require educational approaches that are transformative and meaningful. How students are educated will in turn influence how patients are treated and ultimately how dental care is delivered. Change would have to be gradual and purposeful:

> **Dr. AD:** Well I think it is interesting to look at how things change. I think that we can't ignore economics; even the idealists amongst us can't ignore economics! There are some powerful economic realities about practise in the format we know it. Now, one way to start, it will be a slow change, things that actually change start slowly, things that change rapidly usually don't. Revolutions come and go, but they often don't achieve everything they claim. The more permanent changes are evolutionary and not revolutionary. If one is looking to evolve, I think that we've already got a model in the approach to education. You know, the new combined medical and dental curriculum and the case based learning. One of the really strong guiding principles in there is the thought that there needs to be a different awareness of the relationship between the health care provider and the patient. The, I think superbly titled, Doctor, Patient and Society course. And, that type of approach will over a period of time turn out people with some different ideas. You may find that that is a more challenging thing to ultimately try to change things because there will be different concepts and the remarkable economically driven profession that dentistry is may find that there are less people that are inclined to follow that model so exclusively. But it can't happen instantly. I mean, what are you going to do get rid of everyone that is currently in private practice and comes in and teaches on a part-time basis to assist people to get their skills clinically? That isn't going to happen. Already I think the curriculum has produced some interesting changes.

Most all who addressed these issues indicated that the one constraint to change is that dentistry is a remarkably economically driven profession. The recently introduced course that integrates medical and dental students to

examine issues surrounding health care from the viewpoint of sociology of health care, ethics and community was seen as a first step in the right direction toward sensitizing students to social responsibility. Some of the participants who were educators had already begun to influence the dental curriculum to include educational experiences that enabled students to experience and reflect on social responsibility:

> **Dr. U:** One of my goals when I started here was to make some small affect on that change. I really wanted to promote a more professional, what I would call professional attitude, an attitude of responsibility, social or otherwise, within individual students. Now that requires a global approach to a class, to an undergraduate group or whatever, I think that's happening in general, I think there's been a feeling of, a pervading feeling among educators in dentistry that we needed to do that. I actually think that we're doing more of it here than in a lot of other places, in most other places. I believe that our old curriculum training structure encouraged individuals to focus on psychomotor skills which, you know, you can see the 'equal-sign' here, some good psycho motor skills, you know, quotations marks, good hands equals fast delivery of service equals reward financially on the outside.

Dr. U explains that traditionally students were trained to be technically superior, and that strong clinical skills enabled dentists to work faster and treat more patients, resulting therefore in higher earning potential. Students from this type of educational approach are required to know how to "cut a tooth," not how to be socially responsible. Furthermore, the stress associated with trying to complete clinical requirements was seen as relentless, pressuring students to think about nothing other than getting through their studies:

> **Dr. A:** The students who come into the program with values of their parents and other things that have happened around them and, you know, they're all fabulous people, but what happens in the middle, I mean the stresses to get through! No-one gives you a pass or a fail on a social responsibility type course, you've got to cut teeth! I mean I'd rather that you know how to cut my tooth than that you have a social responsibility! Not what you're going to

think about maybe and whether you're going to double bill me and all those sorts of things so unfortunately the curriculum doesn't ...perhaps the best is you turn a few students who start to think about it from a different, and perhaps take a different career path...

Dr. AA: You know in medicine, whether they are paid enough or not, people are not treated like human beings, they are treated as diseases its appalling. And dentists can do that as well, they look at teeth, they look at bridges and tongues and cheeks, and they don't look at people. There is no social conscience in that; it's people and their needs.

The focus of dental education systems, it was argued, is to ensure a clinically and technically competent practitioner, and this has produced dentists who think very little about social responsibility because they are busy thinking about the technical aspects of their work.

On the other hand, those who situated the dentist within social communities endeavoured to educate students differently. They taught that dentists are collectively responsible for the health of the community, and they created educational experiences for students that reflected this philosophy:

Dr. Z: It's part of the curriculum in my school. I explicitly talk about, I mean I teach the first year dental students and I also teach the first year medical students a course that's called social and ethical issues in dental practice and the medical school course is called medicine and society. Very similar courses! They are fairly intensive first year courses in which we talk about social issues but in the first lecture, the opening day we talk about the question of responsibility. What is your responsibility as an emerging professional? To become involved in the life of your community and in dealing with the issues that are faced by that community.

Dr. Z presents a novel approach to facilitate transformative experiences for students. He contends that students are very perceptive to what is required to succeed in dental school—they instinctively focus on the currency to graduate. To counter this required a meaningful program, one that could have a significant impact on students' orientation to social responsibility:

Dr. Z: I want to tell you about what we do at the school that I'm at because I think we are actually dealing with some of this issue. For instance, one of the things is that all dental students spend a significant amount of time in undeserved communities. They have to have at least two four week blocks where they are working not in private dental offices but in native American facilities, in a prison, in a community health centre, in another country. We have 120 sites with faculty members and we do clinical care on those sites. They are junior-senior dental students and it's the students' uniformly favourite experience in dental school, the alumni love it, the school can't touch it and when they're out there they love the experience, they love the sense of contributing, they're really involved in it! What I've started to do with it is I have been having students write about it. I have been playing with ways to teach students to think and to reflect on their community experiences, not just go in the world but how do you think about what you did in the world. So I have 10 students every summer who go to an orphanage in Mexico and work there, there are a thousand orphans they work with and they have been doing this for 13 years and I have more students that want to go than I can send. They have to raise their own money to go, we don't give them any money, they raise the money to go working together as a team and so last 2 summers we had them trained in photography, photographic documentation by a documentary photographer, and gave them disposable cameras, had them take pictures and when they came back I asked them to pick their best pictures and to write about their pictures, to write the story and to think about it and these are some of the stories that they wrote (hands me the reports). I have unbelievable material. I mean I have picked three of them here or 4 of them I mean the first treating of somebody with HIV, taking care of somebody who wanted dentures before he died, I just picked that out of a hat. There were so many, and then we have small groups where we bring the students together after they have done this and asked them to talk to their fellow students about what was it, what happened to them, what did it mean. So, it really fits exactly the issue of social responsibility!

Education, it was argued, must be reflective and purposeful if it is to have a meaningful impact. It is not only about immersing students in externships but integrating the experience with reflective exercises:

Dr. Z: Give them transformative experiences! I mean why not! The other thing about this is that I think that sending students just for experience doesn't work. I think that there is something about making them think about it, not just doing! Dental students are very, and this is true for medical students too, very instrumental—do do do do!! I mean that was the paper about...basically that you could almost mislead students you

know, for instance what did it say here, "dental rotational programs that merely place students into clinical settings to produce dental work run the risk of being more concerned with the clinical learning needs of the students than with community needs, furthermore such programs that merely move students to community setting but then don't enhance or enrich student appreciation or the cultural contexts may mislead students into thinking that culture or social settings are not important determinants of the clinical needs in peoples lives.

However, there was also a view that there is no evidence to indicate that outreach experiences change the way students will ultimately deliver care. Moreover, students as well as some faculty members were seen to have little regard for courses seen as irrelevant to the actual practice of dentistry:

Interviewer: Community Dentistry, Public Health Dentistry, do these have meaning within our dental health care system?

Dr. B: That's a really good question. I think that that's a question I struggle with. I struggle with that question because it is a little tiny area within dental education. A) it is not influential aspect of their educational experience B) it's very difficult to conceptualize putting there the experience that will actually have any impact and students know it, the faculty knows it. We haven't kinda bothered here! Instead of kind of, you know, fighting for some kind of a touchy feely community experience we just haven't gone there to a large extent because it's seen as fluff.

Interviewer: It's fluff to?

Dr. B: To students, it's fluff to faculty and there's no evidence to suggest that to have tremendous amount of outreach, of student's who are out there in the community being sensitized, there's no data that I've seen that suggests that it really changes the way these kids are thinking and behaving after they graduate. University of Denver, significant outreach experience and program, now that may in fact be having some desirable outcomes but I haven't seen it. I haven't seen any data that would suggest that this experience influences the way these kids act and behave once they graduate. It might be the case, but I don't know? .... There was a report on the future of dental education that spoke to the issue of community dentistry and the need for more social awareness and a lot of the big American schools foster big departments of Community Dentistry and a lot of people, a lot of energy, a lot of money flirted away largely, not much money left.

Interviewer: Why is that?

Dr. B: Cause it didn't have much impact!

Interviewer: Why is it not having an impact?

Dr. B: Cause it's peripheral to the issues that students see as important in their educational experience. Dental students come to dental school and they want to learn how to do dentistry and earn a living and Community Dentistry is peripheral to that, at least in the eyes of the student!

The currency to graduate was a clearly articulated feature in the discursive construction of social responsibility. The general consensus was that the focus of dental education has been primarily on the science and practice of dentistry at the expense of social responsibility.

Teaching social responsibility

Although the dental curriculum was not seen to address social responsibility in a systematic way, even if it did, there was concern about how the concept could be taught. It was generally felt that it is difficult to *teach* someone to be socially responsible and if it was to be done it had to be through example:

Dr. D: I don't think you can teach people social responsibility, I think you can lead by example.

Dr. L elucidates this point emphatically, reflecting on his own experiences:

Dr. L: I would teach that the social downtrodden be looked after. I well remember a fellow who came in who was on welfare, he had a tooth that couldn't be saved, so the only thing I could do for him to help him was to remove the thing, fruitfully put a wire into the tooth and stick it back joined to his central incisor and his canine by simple methodology with the modern technique of plastics and wire. Now I put that guy out of the practice a happy man, he didn't pay a damn thing, I just did it to help him, so that's the area from which I come. Okay, that's me, myself. Now I would preach that kind of thing to students!

Dr. L speaks passionately and holds firm to the view that the socio-economically disadvantaged have to be looked after, and the profession must take on this responsibility. Like Dr. L, some accepted this premise; and for others it was only with the caveat that payment for the service cannot be annulled. For Dr. L there are no exceptions, and the matter is seen as plain and simple, that is, those who are in need ought to receive care, regardless of ability to pay. He places the onus on the educational system and on educators to influence change through example:

> **Dr. L:** There's a great huge outcry about ethics within the profession, which has been going on within the last 5-10 years, maybe 10–15 years, I don't know. Ethics as an entity, as a discipline requiring a chair as is now established within (this university) is in my view, a wrong approach. I think ethics is taught to individuals, to students, to the developing profession, by leadership, by example. Its not something that you stand up in front of a class and lecture about, damn it! You may through a lecture elicit the principles, but you are coming right back to what you are talking about, you are coming right back to social conscience, you are coming back to things really that the profession is intended to do! Now since the profession is a product of education, then the educators have got a major role in the development of ethical policy, in the development of ethical example, in the development of an educational system that allows societal benefit to come out.

Dr. C, on the other hand, would disagree with Dr. L. Although Dr. C, like some others, felt strongly that dental health like health in general ought to be a right and not a privilege, and throughout the interview makes a strong case in support of those who do not have equitable access to care, he finds it problematical to support a position that is in effect excluded from existing institutional and economic structures. Although he espoused strong views earlier on the existing inequities within the dental health care system, he presents an insightful account pointing to the dissonance he faces trying to reconcile the conflict between the

way the dental health care system is structured and his views on social responsibility:

> **Dr. C:** Well, yeah. For instance, it would be inappropriate for me to give a talk on dental ethics. Only because the views I have are personal and I'm not a scholar in this area, I'm not a professional ethicist. By the way, an ethicist could easily give a talk on dental ethics. It doesn't matter whether it is medicine or dentistry. Ethics is ethics. So yeah, I have these personal views but I have to recognize the boundaries within which I can discuss those and the boundaries outside of that which really isn't all that appropriate. So I guess appropriate would be the best term. So to impose those issues on the profession would be, I think, wrong given the way it's structured. On the other hand, I mean if a group of dental students came to me and said we like going down to REACH[19], is there anything else we could do to help some of these people. You know, I would be quite willing to encourage them...if that's the direction they want to go then sure, anything you can do, provided it is within the structure of the profession. I don't know. Maybe I'm not making myself very clear on this.

As the discussion continues, Dr. C reveals his frustrations. He wrestles with his responsibility as an educator within a professional structure that precludes his definition of social responsibility. He finds it difficult to decide between taking the time to educate students and letting them complete their requirements without which students cannot graduate:

> **Dr. C:** In the traditional dental curriculum the issue of social responsibility is minimal. I guess the only thing I can think of is that, I guess, the question always arises if you're a student and you see something in a patient's mouth or in a radiograph or whatever. What is your obligation to tell the patient? And in the clinical setting here at the school I sometimes get the sense that students don't do that because it interferes with the process. So you occasionally see patients in a consult where there's been a problem or something has been found but they weren't told and the minute the student mentions it to the patient or mentions it to the clinician well then a whole bunch of things follow out from that and it tends to get in the way of other issues such as more common practical things.
>
> **Interviewer:** Can you give me an example?

[19] REACH is a community based dental public health clinic where UBC dental students have a choice to volunteer their time providing basic dental services to indigent patients.

Dr. C: You know, a lump in someone's cheek. 99% of the time we know it's benign and it's reactive and therefore we don't really need to deal with it. But, at the same time once the student says to the patient, "how long have you had the lump" and the patient says, "what lump?" Then you have to deal with the lump and you are in the middle of a pros(thodontics) block or an endo(dontics) block or something, you know, then everything has to stop. A referral has to be set up and it just kind of gets the worst-case scenario is with dentures when you get a problem. The problem has to be addressed before the dentures are completed. I've seen instances where students lose the case because the other issue interferes. So, I think since, currently anyways, in the traditional curriculum you're driven by requirements, it tends to, you know, I can see a student saying, "well you know, if I get into this it's going to interfere with my ability to complete treatment and get my credit."

There was the view that students then tend to see patients and their conditions as requirements to complete in order to obtain enough credits to graduate. Students and faculty felt pressured to ignore issues that were interpreted as interfering with the assignment at hand. This was seen to generate the attitude that the patient is a tooth to be fixed, not a complete person to be cared for. Interestingly, toward the end of the narrative Dr. C questions the ethical implications of this dilemma:

...The other aspect is my responsibilities. I mean my professional responsibilities as a, if you like, in quotations, dental educator. I guess on a very basic basis I have a contract with the university and the university has a contract with the student; so therefore, I have a responsibility to attempt to train that individual up to a reasonable level of competence. A student, let's take a scenario, finds a lump in someone's cheek, right, there's a superb opportunity at that point to teach that student something about lumps, tumors in mouths. So one can use that as a terrific teaching opportunity. On the other hand, recognizing that in fact this may interfere with the student's progress, it has potential to do that.

Interviewer: When you say progress what do you mean?

Dr. C: Progress with the case, with the patient. You know, every time you go out and see a patient, they're doing something for somebody, they're doing operative or prosthetics, they're doing something. And the patient has been scheduled in for that particular procedure and the consult

> generally comes as an after thought. So, you look at the situation and say well this is great chance to do some teaching here and I can come in and, but you're laying on a degree of complexity that while it's important for teaching purposes, I can't put it any other way, there's a sense that it is getting in the way! So although I do it and I know what the students are thinking. So, on a very practical level you do it and you do it minimally, you try and get as much information across at the time and you'd like to do more but there are practical limitations. Now whether that ever gets across to the student I have no idea. I don't teach ethics so I don't know whether the idea...(ends with a reflective pause).

Some participants argued that it is precisely this type of pressure that predisposes dentists to then treat patients as a means to advance the dentist's self-interests, whether it is economic or otherwise. The general conclusion was that education played an important role in shaping the way future dentists view their profession and their responsibilities as health care providers.

The value that begins to delimit the meaning of social responsibility is the societal obligation to those less fortunate, and the social significance of professional health service. As a result, the dental educational system had to focus equally on the role of dentists in society and in communities, and on social factors affecting health care as it did on the biomedical and technical aspects of dentistry.

Whose responsibility?

Most of those participants who reflected on the question, whose responsibility is it to care for the marginalized, relied on accounts drawn from an economic perspective to make their case. For example, if dental care was going to be seen ultimately as a necessary health service, someone had to pay for it. The economics of providing health care was seen an integral component.

Moreover, the existing and imposing fee-for-service structure naturally demanded it, almost beyond anyone's control:

> **Dr. P:** No matter which way you cut it, you've got to come down to the bottom-line that someone has to pay for the treatment and whether the individual practitioner or professional ends up paying for it out of his own pocket in the sense that he's not getting remunerated for it, or whether the patient finds some way to handle it, or the government handles it, there has to be a financial decision every time these types of people are treated and that's pretty much it and I personally don't feel that the patient can be blamed when the normal mode of operation is fee-for-service, and there is no fee for the service provided for these people (and) that puts it back on the individual person for their responsibility. The dentist then has to make his decision as to how he wants to handle the situation, but I don't think that society as a whole could turn around and say its your responsibility to treat these people when there is no financial return for doing it.

Notice here also how the indigent patient is portrayed. Although Dr. P sympathizes with those who cannot afford care ("underprivileged patients are not to blame for their predicament") the use of the phrase "these types of people" tends to create, perhaps unconsciously, a distanced view and the inevitable marginalization of the underprivileged patient. The question of who should carry the burden of social responsibility emerged repeatedly, and the view was that dentists could certainly not be expected to carry more than their fair share:

> **Dr. DC:** The social credit party brought in government dental to serve some children and some old folks. Within 8 months they figured out that it is you, me and everyone around us. Government doesn't have any money of their own, they simply redistribute our money, every five years we have a mini revolution, bloodless, and we have a new regime. They figured out that dental was going to be too expensive and they got out pronto!! Okay. How much can government, meaning the people, afford? Now we are getting into political arenas and allocation of resources. Boy, big deal, okay. I got the fee guide this morning, for the current year, and for the extraction of a first tooth in a quadrant is about $68 on the dental fee guide. MHR pays $41. That is 59% of the fee guide. Any idea what the overhead is for a dental practice!? Sure you do, more than 59%! If the dentist, then, goes and does a $68 extraction for $41 he has lost some money. Now he has a business, he pays income tax, he hires a staff, he

pays EI and CPP and a business license for that staff and now he has to pay another tax. How much tax should this individual have to carry? In the name of altruism, I don't know!? How do you trade that off?

What remains unsaid, however, is the system can be restructured to address the existing inequities; then again, some were clearly averse to restructuring it, and preferred means outside the system to resolve the issue. Dr. P provides an interesting insight to this effect, revealing another key finding of this study. He maintains that ethics are professionally coded, and the profession's social responsibility is already embedded within these codes. Treating those who cannot afford care is not within these codes for good reason, noticeable in demonstrable ways. The fact that dentistry was outside the publicly funded health care system was already a strong indication of society's position on dental health care. The corresponding organizational structures inevitably reflect what is normal for a private system situated in the free market. It is unacceptable therefore to expect dentists to accommodate matters that are not within their predefined purview. This is a powerful rationalization of that which constitutes what is acceptable and what is not within the community of dental practice:

Dr. P: You see I'd have trouble with the sense that we are lacking in social responsibility if these people aren't taken care of. I don't see that as social responsibility. The dentist's responsibility is to society and social responsibility infers responsibility for society and it could be taken as a definition and that definition is to conduct themselves ethically (and) properly to provide treatment at the appropriate level, to conduct his financial affairs with patients at the appropriate level, to be an upstanding member of society. And as such, to get involved with the grey areas, how much does he have to freely donate this time on top of everything else to help these groups. I would tend to suggest that I don't regard it as a dentist's responsibility to do gratis treatment or cost cutting treatment on these individuals, or to treat these people without proper remuneration. I think, ethically it has to deal with pain, and that is expected! But there (are) sufficient studies to show that you can function very adequately without

> your teeth. I don't think it's a dentist's responsibility to help these people retain their teeth, when the treatment is being done not for pain reasons but to, you know, I don't think that's his responsibility to do that for nothing. I do believe very much that fee-for-service means proper remuneration and if society is prepared to pay a labourer to dig a ditch or a school teacher to teach a school or etc., etc., then why in the hell do they expect dentists to go and do free treatment on people!

Notice also, how Dr. P invokes scientific evidence to defend his position ("sufficient studies show that you can function very adequately without your teeth"); and for this reason the dentist was not considered responsible for helping "these people" retain their teeth. Dentists' ethical responsibility to the indigent patient, as coded and confirmed in accepted professional standards, was to do no more than to alleviate pain. Although not expressed as explicitly as Dr. P does, those participants who pointed to this fact held firm to their grounds, and they stated adamantly that every dentist had a firm obligation to take people out of pain, even if they did not get paid for it.

The responsibility to alleviate pain

The ethical guidelines, according to those participants who raised this issue, indicate that the dentist has a moral obligation to treat patients who are in pain, and who seek care seen to be an emergency. To treat someone without proper remuneration for anything else was considered unacceptable. Dr. AD, in addition to all who raised this issue, takes a firm position to this effect:

> **Dr. AD:** I am someone who has this ideal that one should search for a contract that allows people who don't get access to oral health care to get access to care, I'd like to see that, but I can't in all conscience standby and allow dentists to be criticized unjustly. I mean a dentist who refuses to see a patient who has a Ministry of Social Services Plan when they have an emergency situation, unless they pay them up front in advance, I have no time for that! (It) is in contravention of the rules of this College. But I can't allow a dentist who says I'll do this for you, forget all the emergency stuff,

but who says I'll do this for you and this is the only way I can do it and then they get lambasted for suggesting what they are doing is illegal, it is not illegal!! And it is not immoral either!

What is also evident in this discursive construct is the anger some participants felt when dentists who, of their free will and goodness, accept to provide additional services at a reduced or no fee to the extent possible, are criticized for not being as accommodating as they could have based on standards that are not within the profession's existing ethical mandate. What is most pointing here, however, is that the dentist's obligation to keep people free from pain is, in effect, the *raison d'être* of dentistry. It was an ethic that many held untouchable:

Dr. B: The requirement from keeping somebody free from pain is the most basic element of that. Nobody should be in pain you should be able to alleviate dental pain.

Dr. M: When someone thinks that an ethical social responsibility to the public is going out and providing care *ad lib* to anybody that comes to them, I do not believe that that's what it's about. You do have the ethical social responsibility to take people out of pain and try to remove disease but not to do a whole lot more than that. If somebody comes to me in pain and says I can't pay then I'm not going think about money...I'll say, "let's take care of this and will talk about that later."

The most basic responsibility that dentists have, explains Dr. M, is to address pain and infection. It was considered by many of the participants a widely accepted code among dentists. Dr. C adds that it is also what constitutes the notion of basic care, to which everyone has an undeniable right, and to which the profession ascribes:

Dr. C: Basic dental care is to address issues of pain and infection, period!! Now, you can do that a number of ways. The most practical and easiest is by removing the offending agent, which is normally a tooth...all periodontal infection disappears, the pulpitis is gone, and the patient is free of pain. But they've lost a tooth. But they have no pain and there's no infection! That's it! That's it! It's cost effective, the patient is free of disease and they

> carry on. Now that's basic dental care. I can't think of anything else. Now, you can take that same scenario and you can do triple root endo and gold crown, and spend over $1500 bucks. Patient has their tooth, they're no longer in pain, and the infection is gone. In one case it costs $30 bucks or $40, and in the other $1500...

Anything more than basic care as Dr. C explains, is considered a luxury for those who can afford it. To extend the definition of basic care to anything more than simply removing the noxious agent and relieving pain was considered inappropriate, at least from an economic viewpoint:

> ...The latter is a luxury! Now, it's a luxury because they can afford it. Theoretically, that's what should be done, because we are able to do it! You know, you and I have the expertise and the technology that we can do that, all things being equal. So we can affect great biological change in that area because we've got the training, blah, blah, blah, blah blah...however, when you get down to basics, I can relieve your pain and I can relieve your infection and it's gonna cost $50 bucks and it's gonna remove your tooth. I have the expertise to do that too. Question is, where do you go from the $50 to the $1500 and where, you know, if that's basic care then that addresses the issue, the health issue. Now they've lost a tooth and you say well they're disadvantaged cause they've got one less tooth. Yes, but they can still eat, still function, still go to work, still pay taxes...it doesn't really alter anything, right. So, basic care! That's it!

Just as Dr. AD was angry about the insinuation that dentists were not meeting their social responsibility because they were not going beyond what was ethically and legally expected of them, Dr. C held firmly to the position that under no circumstances could dentists absolve themselves of their responsibility to alleviate pain. The underlying point here is that regardless of the moral argument, existing ethical codes could not be compromised. For example, Dr. C points out that some dentists were refusing to uphold their ethical obligation to alleviate pain by ascribing to a moral standard in a manner that presumably superseded what was defined within existing professional codes.

Dr. C: Your obligation is to relieve the patient of pain and infection, that's what you need to do. You can do it in several ways. You explain to the patient all of the options and the patient says, I think you'll have to take it out. Now, I know dentists who, or at least, I used to know dentists, who would say no I won't take it out, go some place else. Because, I ethically cannot do that...I cannot ethically remove this tooth because it doesn't have to be removed. The patient, on the other hand, is saying yes but it's my tooth and it's driving me crazy and you tell me it's infected and I want it out!! And so, ethically and personally speaking, I would remove the tooth because my job as a professional in health care is to address this patient's basic health need... at this time he's in pain...severe pain! If you've ever had an abscessed tooth you know what it's like. And he's got infection, which could, I know, because of my training, conceivably cause a tremendous amount of problems. He could end up with an acute sinus problem, could end up with osteo-necrosis, he could also...all sorts of nasty things could happen. So, I know that, so I simply tell him that this is what you need and if you can't afford the crown and root canal, then we'll extract the tooth. And I would do that and feel good about that. Now, I used to know some dentists who would refuse to extract the tooth because they would say, ethically that's wrong and I have very high standards and therefore you're going to have to go someplace else if you want to have this tooth out.

According to Dr. C, therefore, there is no ethical basis to refuse basic care as encoded within existing professional standards:

(...) Well, what right do you as a dentist have to say to this patient, sorry I'm not going to help you!? What right do you have to say that!? This patient has come to you for help. You're the trained professional; your job is to help this individual. And I think that by refusing to help this person because you have some sort of higher ethical standard is wrong! Personally, it's wrong!

Dr. C explains that the profession has a set of codes, which define dentists' responsibility, and they are expected to abide by them. The codes indicate that it is the dentist's obligation to alleviate pain, even without payment if necessary, but not anything beyond that. The conclusion that is drawn here is that just as the dentist cannot refuse to take someone out of pain, even if he were not being paid

for it; and by the same token, society could not impose ethical parameters onto the dentist regarding a social responsibility that lay beyond their purview.

Yet there was also a feeling that if a dentists did not have the time to see patients who could not afford care but needed to receive basic care, at the very least, there was the view that the right thing to do when confronted with this situation was to refer the patient to someone else, preferably to someone who "sees these types of patients" and "can make a decent living from it; " this was seen as the socially responsible thing to do:

> **Dr. I:** The other thing I would say is that really in this case and in trying to put forward that if you're making the choice between two different patients, one that's going to be able to pay and one's that not going to be able to pay that what one does in that type of situation is (to ask), "do you have an obligation to find somebody who would treat that patient?" I mean you're obviously, if your practise was so filled with paying patients that you didn't have any time to take any time off to spend any time with anybody else, there's obviously some other people in your community that probably have some time who would be able to take these and take a lower fee at that and do quite well with it, you know, and that sort of thing so, so there may be an obligation for the practitioner to say, I'm sorry, I can't take you as a patient, its just not possible at this particular time, I have a closed practice, basically you say and, but, my nurse will find somebody who can really look after you so...

Dr. I reveals an attitude that many alluded to. It is one that is patterned on a relationship of privilege and status. The dentist holds the privilege of deciding who will be treated and under what circumstances; and paying clients are given first priority. As a result, a pattern of behaviour is established that reinforces itself through professional and social interactions and adopted roles that eventually institutionalize expectations.

'SOCIAL RESPONSIBILITY' AS A POLITICAL AND ORGANIZATIONAL DISCOURSE

During their reflections on social responsibility, many participants touched inevitably on the politics of dental health care. The issues they raised focused on unresolved political differences between what is considered a fair allocation of resources to dental health care in particular, to provide a reasonable compensation to providers and an adequate range of services.

Resistance toward government

Aversion to government was a commonly expressed point to legitimize differences of opinion on the structure of dental health care system and how it should operate. Dr. W indicates that profession's political orientation determined its predisposition to resistance:

> **Dr. W:** The other thing it seems to me with the profession that's interesting is that if you took the average political bent of a professional individual, they tend to lean towards the right. They sort of on the one hand say I want less interference, they don't want interference through the licensing bodies, they don't want interference from their association, they don't want interference from the government, you know and so they want all these things that are consistent with, in a sense, regulatory groups of any type getting out of their way and just letting them do what they do best and that includes sort of even at the clinic, you know. Again at the broader level, they usually get ticked off about high taxes and high burdens of whatever.

Dentists were generally seen to be resistant to any type of interference that affected how they conducted themselves as dentists. Underlying this resistance were issues of economic viability and professional autonomy. Some of the participants indicated that the single worst thing that most dentists despised was the idea of being tied to government. Being under government meant that the

control over the financial and to some extent the professional arrangements of dentists would be dictated and restricted by an outside force, and this would be disastrous for the profession:

> **Dr. A:** Well you see that's, I mean, disaster! Dentists would hate, I mean they'd vote a hundred percent against it to be salaried and to be a part of government. I mean it's the last great bastion of sort of private enterprise.

Dentistry was seen critically by some as the last great bastion of private enterprise, with exclusivity to practise, to dictate how much to charge for treatment, and to be able work in a monopolistic setting without outside interference.

> **Dr. M:** I think the profession has tried to retain its autonomy and that was part of staying out of the Medicaid/Medicare thing in the US and trying to keep separate from the system to avoid the control.

The government and health policy makers were seen to be concerned more about control over dentists than the oral health of the public. As a result, political efforts that even remotely hinted at compromising the profession's financial capacity and its power and control over the dental health system were strongly resisted at all costs.

> **Dr. C:** Well, if you go back to the early sixties when the health care, Medicare system was being debated in this country, there was a sense that all health care would come under the aegis of the health care system, including dentistry. And there was great fear that if it happened that way it would be too expensive. So, somewhere along the line the decision was made to exclude dentistry. So the idea of dentistry becoming a part of the health care system in Canada was sufficiently strong that it drove provinces to build very expensive institutions. Now that quickly faded, of course, because I think the government of the day realized that it would be too expensive, or they may have said look we'll phase it in, we'll bring medicine in first. Although it's curious that the health care system insurance pays for a number of paramedical procedures but, dentistry's always (pause)...I think once dentistry realized that they would not be part of this, they would be still private, they took some sense of satisfaction in

> that, at least we're not tied to government, you know, we're not doctors, they're really government employees if you like, living off the aegis of the government.

What is noteworthy in Dr. C's quote is the momentary realization that the publicly funded health care programme covers a number of paramedical procedures but not dental care. A few participants alluded to this issue but the overall feeling was that neither were dentists wanting to be "tied to government," nor was the government ready to accept an increased cost to the health care budget.

The government's dealings with physicians proved to dentists that the government was really an antagonist. As a result, the profession did not want to "get in bed with government":

> **Dr. J:** Well, I mean just to show you another example of that, when the (dental association) participated enthusiastically in the mid 70s to try and get a children's dental program here and they had a public involvement and they worked with the government, but I think at the time that Medicare seemed to be getting a little bit out of hand and there were some restrictions on the physicians and the dental profession said, "oh I'm not sure we want to get in bed with government cause the same thing will happen to us!" It is perceived by those folks as, 'you guys are out there to get us, you're big government!'

The bottom line, according to some of the participants, was that dentists were specifically averse to external control in general and over fees in particular; they "liked their private enterprise" and they did not want anyone to dictate how much they are to be paid:

> **Dr. AD:** The general perception among dentists is that they don't want to be part of a system they see their physician colleagues in. Dentists on the whole like their private enterprise that they are able to undertake because they can control their own things and they can get on with their own lives and theoretically they are not dependent on others in the same way they perceive physicians being dependent on government. Government which funds the Medicare system basically gets into negotiations and has the authority to set fees and because it is universal and that is its great

strength and very few people work outside of it, but someone else is in control of a *significant* (vocal emphasis placed on word) aspect of your professional life; because they say how much you will be paid for different procedures.

One view was that there are understandable reasons for the profession to insist on independence and economic control since dentists are "in it for business reasons," however, the profession was seen also as having a responsibility to ensure universal access; but it was difficult to reconcile the two, and it became the "big dilemma":

Dr. AA: And our colleagues are very independent kind of guys and they see what has happened with medicine and they are very, very reluctant to get involved. But it is a dilemma because if you don't have the government involved what else are you going to have. You know our colleagues were reluctant to get into bed with the insurance companies. I mean that didn't come so easily and smoothly, I mean they fought that because the insurance company wanted to control the fees, you know. I mean it's understandable, it's not palatable but it's understandable. I mean they got into this for business reasons and there had to be limits and so yeah it's a problem. It's a problem, and I'm not suggesting that dentistry comes under the same scheme as medicine. I'm not suggesting that and I don't think that they would anyway because I don't think it would work. But I'm talking about the segment of the population that needs help. It's not an easy thing to do or to create and to negotiate with the profession and you would have a lot of grumbling and complaining, the same kind of problems that we have now but greater than that I am sure. But somehow, as a profession that's the essence of our profession is to help, I mean what about the Hippocratic oath!? Money or no money you have to provide services and that is the big dilemma!

Despite the dilemma, the prevailing norm was first to thwart any attempts at educational or dental health care reform if perceived to constrain dentists from controlling the economics of dental care:

Dr. F: I think it's a very important topic and if you want any evidence of how important it is it's the fact that the IOM report on the future of dental education is not being discussed. It's being ignored. It is actively opposed by the ADA. It is seen as some kind of vehicle for taking control of dental financing.

Awakening the government

Some felt that the profession had the responsibility to "wake-up" the government to be more sensitive to the needs of the poor. One way to do this was to stop honouring the social contract because it was seen as inadequate for meeting the needs of indigent patients:

> **Dr. T:** Well this is, I mean this is the difficulty. We spend years working with government trying to...they kept coming back with the levels of coverage to the point where I mean the level of coverage today is so low that if a person has all of their own teeth, but ends up with abscess and needs a one tooth root canal treated it doesn't cover everything associated with that so what their message basically is, poor people's teeth aren't important, take it out, you know, well, and the profession found itself in this position of saying we're effectively agreeing with government that dental health isn't important. (...) The kind of mentality of government started to say well, this is as many dollars as we're putting into the pot and what happens when that gets carried too far and that's the stage when the Association basically said to the dentists, you know, you don't have to honour this contract anymore because the coverage is so ridiculous that this doesn't provide health care, this is simply something to get people out of pain, that's all there is to it and it was an attempt to wake-up the government to the fact that what they're providing is just simply not health care at all...

Dr. T argues that the government's payment plan was adequate only for treatment to alleviate pain, and this did not fit with his conception and expectations of adequate oral health care. In protest therefore, the Dental Association advised dentists to stop honouring the government-funded contract to provide care for under-resourced people. It was argued that the profession was not willing to enter into a contract that was seen in effect to compromise the patient's dental health:

> .... I mean it's been a source of frustration to the dental profession. I mean we've two minds about being covered by government in that you know historically every government health care scheme starts to get under funded over time and that's true whether its in Europe or New Zealand or

Australia or wherever, this always has been the case. If you look at dentistry in the United Kingdom, for example, it got so bad that, in fact, the only thing that dentists felt they were properly compensated for was removing teeth and making dentures and amazingly the bulk of the adult population had all their teeth out and had dentures so we, we really, in one way we didn't want to get in bed with the government from that perspective, but on the other hand we realize that there are segments of the population that aren't going to be able to access the care they need unless there is some sort of program that can be subsidized or supported by the public purse.

Dr. T presents a noteworthy construction of the problem—if the government is not going to take responsibility for funding oral health care adequately, that is, beyond treatment for pain alleviation, then the profession had to opt out of the arrangement altogether. In doing so, however, the profession was then taking the position that no care is better than some care:

Interviewer: You know how that's perceived, its perceived not so much as the government's fault as it perceived as if the profession is out to look out for its own interest, and dentists are very well to do and they want every buck that they can get so that's how its being perceived. And then when you speak to the profession its usually, well, you know, it's the government that's not coming to the table in a fair way. So how do you, what do you do with these...?

Dr. T: Well this is, I mean this is the difficulty, I mean we spend years working with government trying to, I mean they kept coming back with the levels of coverage to the point where I mean the level of coverage today is so low that if a person has all of their own teeth but ends up with abscess and needs one tooth root canal treated, it doesn't cover everything associated with that so what their message basically is, poor people's teeth aren't important, take it out, you know, well, and the profession found itself in this position of saying we're effectively agreeing with government that dental health isn't important. And it's a no-win situation for everybody because of the circumstances, but this all, if, if they had, if they would follow the advice of the profession, I mean we were quite prepared to show them how to save enough money on the plan that they still could provide essential services for people and cover the group that they, they've covered but its dollars and cents, they weren't interested in our input or anything else and we, it wasn't like we tried once and gave up, I mean this over many, many years to the point where ultimately the professions says, you know, we don't want to be party to this kind of thing,

> giving people the concept...now the trouble with all of that is for the person with the problem, they don't, could give a dam about the philosophy or the attitudes of the ideas about why or who is responsible but, but unfortunately, you know, it gets to the point where the profession ultimately says, you know, we just simply can't so then its down to each individual dentist having to decide for themselves what they wish to do.

Despite the challenge that the perception among some members of the public was that the profession was more concerned about its own interests, most participants still felt that it was the government that did not really care about the dental health of society. The government, it was felt, was not willing to allocate adequate resources for meeting properly the dental needs of the poor. Moreover, the issue of adequate reimbursement was much too important to relinquish easily (i.e., not being "properly compensated"). Dr. AD presents an insightful narrative that elucidates further this point. His tone is forceful and stern:

> **Dr. AD:** I find nothing wrong in dentist saying to a patient I'm more than happy to treat you, but I must tell you that I only get this amount from the government and my fee is this amount. And that fee has to cover my expenses and give me some income and that is my fee. At the present time there is no contract around, and so I'm going to tell you what my fee is and I expect you to pay me that fee because the government unfortunately is being very, very problematic about it; and it is! The way the government is acting at the moment makes it impossible for any dentist to actually try and treat patients. (...) What you would like to do, if you have a social conscience I suppose or if you feel that you'd like to help these people, but you feel that you deserve the fee you normally get, you say to them listen, you pay me the difference between what the government would pay and what it costs me, what I'm charging, and I would be happy to collect the money from the government. The government won't play ball!! Now we get a lot of complaints at the College of Dental Surgeons that there are patients who are very unhappy with dentists taking this approach!

From this viewpoint, the primary concern for the profession and for individual dentists is the issue of being reimbursed properly for services rendered. The

government was seen to be unreasonable, in that they were unwilling to allow dentists to collect fees from patients to compensate for the shortfall in funding. The differences of opinion were irreconcilable:

> ...The Ministry will not reimburse to a patient. If I'm a dentist and I charge a hundred dollars for a procedure and they are only prepared to pay $75 and if a patient pays me a hundred dollars and I send it to the Ministry of Social Services and say the patient has paid me a hundred dollars please reimburse them the $75, they will not do it!! Because they are used to the idea of getting a claim form and sending $75 to the dentist and they go around saying, or many of them do, that it is illegal for the dentist to charge more, but it is not illegal for the dentist to charge more. That's why people who come to us with complaints, they don't find much satisfaction. And now there is no legal contract. The College of Dental Surgeons negotiated with the Ministry of Social Services and there was a legal contract and any dentist that chose to accept patients under that plan was required to take direct reimbursement from the government. The contract expired and negotiations have not been able to put a new contract in place, there is no legal contract. So there is absolutely no contractual obligation on the part of dentists and it's very unfortunate that those patients who are entitled to benefits appear to be getting short changed. When I don't see anything wrong to say to the patient, you pay me and I'll tell the government how much you paid me and they should reimburse you, they refuse to do that.

Although the Dr. AD asserts that all people should have access to dental care, it could not be at the expense of the profession's principles and values regarding reimbursement. This was an underlying feeling among many of the participants who supported this view:

> ...The fact that there is this struggle that occurs and it is multifaceted and I'm not trying to necessarily defend dentists, but I don't want the dentists to be made out...all to often...you must understand that I am someone who has this ideal that one should search for a contract that allows people who don't get access to oral health care to get access to care, I'd like to see that, but I can't in all conscience standby and allow dentists to be criticized unjustly. I mean a dentist who refuses to see a patient who has a Ministry of Social Services Plan when they have an emergency situation, unless they pay them up front in advance, I have no time for that...that is in contravention of the rules of this College. But I can't allow a dentist who says I'll do this for you, forget all the emergency stuff, but who says I'll do this for you and this is the only way I can do it and then they get lambasted

for suggesting what they are doing is illegal, it is not illegal!! And it is not immoral either!

Although SP feels strongly that what the government is doing is wrong, and that attempts at recovering adequate fees are not inappropriate, dentists, he argues, still have the obligation to attend to emergency cases, even if they are unlikely to be paid. This point came out clearly in most all of the interviews, thus reinforcing the central point of agreement among mostly all of the participants—all dentists had a social responsibility to alleviate pain, regardless.

Society's (and therefore government's) indifference to dental health

There was also the view that society was generally unconcerned about dental health, and that governments merely reflected societal priorities. Dr. V provides an insightful response bringing together issues that affect an orientation to social responsibility:

Dr. V: Don't forget governments are elected politically and you know political agendas are driven by societal demands, and societal demands are driven by their education or perception of the health needs. I mean it (dental care) just goes to the lower of the societal demands and the government doesn't need to respond to that, they have so many other priorities. If your asking (governments) to readjust their own natural priorities to meet it, they'll say well first before we have to worry about that, I've been elected here, and I'm going to get re-elected, because I've helped to stop floods and earthquakes, plagues and all that sort of stuff. But it comes back to my original point: the social demand starts to determine the sense of social responsibility of those who are in a position to manage social responsibility. Don't forget that traditionally, the professions don't have a universal social responsibility mandate. Traditionally, professions were provided on a one-to-one, individual relationship. Which in essence is a private relationship. In fact, traditionally, many medical and particularly dental schools were not driven by government schools. The government had no sense of providing public education for dentists. Well, what does that tell you? It tells you right away that society doesn't value dentistry as a universal need. It's not a high enough priority to be a universal need. It's easy to blame the profession and say you don't have a sense of social responsibility. At a certain level,

> social responsibility is being driven by the society around them, if society refused to let dentists get away, I use that term loosely, from not treating people who do not have access to dental services, they'd do something about it. They would demand that they would be taxed higher, so that the government would have plenty of money to pay for a new social welfare or social services. But the government knows that if they went to the public and said were gonna all raise your taxes by 2%, so that we have enough money to give everybody dental care they would probably lose the next election. So there are certain issues that the politicians have to deal with...

Dr. V points out that society ultimately dictates how public resources should be allocated. Social responsibility, therefore, is a function of what society believes is important and the government, as manager of this responsibility, determines social priorities. Since society does not consider dental care a high priority, governments do not allocate resources to address related issues. If society considered dental health as important, then the government would have taken up the responsibility for its provision. Others felt that the government was abrogating its social responsibility by throwing the problem back onto the dental profession, and that was unreasonable:

> **Dr. P:** Well its no different to the medical profession or any other one, the government has to provide on a social level the ability for the various professions to deal with these people's problems, whether its legal, dental, whatever, but the moment the government steps away from its responsibility in a lot of these areas and tries to throw it back at the professions, the professions say I'm sorry, there's a limit to what we can do as a profession!

Moreover, the government was seen to have subversive tendencies—programs were being set up inefficiently to prevent too many patients from accessing care and increasing cost:

> **Dr. AF:** Well, I see babies with rampant caries and I don't see us with a huge prevention component in our health care system. When our healthy kids program came out first, the community health nurses came to me and

wanted to know what it was all about. I wonder sometimes if the government sets these things up so that people don't use them, so it is very hard to access. It is extremely hard for parents to access the healthy kids dental program.

Dr. B: Oh I think that the government's...part of the problem of low fees are part of the process, part of the structure to keep the cost under control. If in fact they paid full fee there would be far greater services provided and far more money spent. The government knows how to reduce the cost of that plan—pay crappy fees and there's poor access and the patient can't get care and they don't get treated!

The government is depicted here as being disingenuous and conspiratorial.

The profession's indifference to dental health

The dental profession too was seen by some to have a political agenda. It was seen to use inappropriate propaganda to dissuade dentists from accepting reforming models on the delivery of dental services to disadvantaged populations. Dr. D was very critical of the profession's blatant lack of concern and social responsibility and it inordinate attempts to protect the status quo:

Dr. D: I mourn the lack of compassion, the lack of understanding, the manipulative approach, the dishonest approach, the propaganda approach that the Canadian Dental Association has taken. It's been disgraceful! The publicity around the implementation of pre-determination was vindictive and irresponsible. The headlines that were produced, the communication documents that were produced were intending to create fear and suspicion in the hearts of dental care providers and I don't know whether there was a belief that Health Canada was looking to change the nature of dental practice in Canada to open up other models of managed care, because that too is part of the mission of the dental collectives like the CDA and the provincial dental associations. The effort goes into protecting fee-for-service dentistry and not into exploring other, other models. I'm talking about the political propaganda that's not juried, that's not scientific, its entirely political and its very selective and very biased and also inaccurate and to respond to that kind of propaganda sometimes just gives it more attention than it deserves. I was very surprised to see how irresponsible, how far a national organization would go and continues to go...it seems to me the entire operation is geared around fees-for-service.

The general consensus was that there was no political will to change, partly because dental health care was not seen as essential health care, and partly because it was too expensive for society to embrace, as well as for the dental profession to accept. Dr. C acknowledges this reality and realizes also that the issue is also not as simple as that. Dentistry has taken a place in society and within the general health care system to become something exclusive and he has difficulty reconciling this:

> **Dr. C:** There's no political will. There's no political will to change public health care policy to include dentistry in the global health care system. And I guess one would argue that perhaps it's not essential health care. It's always fascinated me. I guess I use the issue of ophthalmology as a standard. Ophthalmologists are eye specialists. They only deal with diseases that affect the eyes. And albeit the eyes are a complex neuropsychological organ, nonetheless, it's a relatively small area. Now the mouth is, in my view, another anatomical region that has a significant degree of complexity attached to it, and the jaw is a parallel structure. As a matter fact it's much larger than the eyeball. And yet eye treatment, if you lose your sight you're blind and that's quite a significant deficit. If you lose your teeth you can still function quite nicely, you may not look as nice or chew your food as well, but you can get along okay. You still have your sight and hearing, etc. So I guess one can argue that eyes are more important than the mouth. But, on the other hand, you know, ophthalmology is a bona fide, well-respected specialty of medicine. I have always had a problem once I got into dental education as a student as well as educator, so I've seen this business from all ends. I've always sort of wondered why dentistry is so different, in some ways a whole separate profession, a whole separate training program, everything quite different. And yet we do surgery, complex surgery, etc. And now it's even getting more sophisticated. So I've always kind of wondered why, and I guess it's historical, in North America anyways. But, when I was in practice I would not make decisions for patients but would simply say you can have this or you can have this and then it was based on money and, they would pick the least expensive. And I would do it and they would go away feeling okay and everything was as healthy as I could make it. But it always seemed that there was this issue of money...it was always there...but if you had something wrong with your eyes (snaps finger to indicate immediacy) no problem! I mean in most cases, other than changing the shape of eyelids and that sort of thing...plastic surgery. Anyways, so my personal view is that it should be totally funded, it should be part of the health care system. But, dentistry prides itself in being entrepreneurial and private. So, you know, I might feel that way, you know, I

> will still function within, you know, I pay my license fees and practise my specialty and I, you know, I do that to the best of my ability, ethically, etc. But, I still have this personal thing that says that maybe, you know, in another world, a perfect world I would have it different.

On the other hand, the social net is so small that a private-for-profit health service, like dental care, remains aloof to many on social support. Although the dental profession expresses a collective desire to address the issue, for the individual dentist the task seems untenable, thereby the burden rests ultimately on the government or on the dental profession as a collective. However, the tension between the profession and government in determining what constituted a fair allocation of resources to dental health care in particular, to provide a reasonable compensation to providers and an adequate range of services, was irreconcilable. The problem is also rooted in resistance, as manifest in the overall aversion to government and the associated political indifference to dental health care.

Resistance toward the study

Although I anticipated that the topic of social responsibility might be sensitive to some because it is raised within the context of access to dental care and can be perceived as a shortcoming of the dental profession, I never anticipated outright animosity. One participant (Dr. X) refused to grant me an interview, yet spent close to two hours speaking to me about my thesis, interrogating and chastising me for researching what was considered slanderous to the dental profession. When the discussion began, I was immediately confronted about my true intention for studying such a topic. I was questioned

about my qualifications and academic integrity to conduct such research. I was asked when and where I completed my dental degree. When I revealed that in addition to holding another professional degree and a graduate degree I was also a dental hygienist, Dr. X exclaimed with acrimony and indignation: "Hold on, hold on, so, you are a dental hygienist!!" I was told that my intentions were purely political and that dentists should "play no part in aiding and abetting dental hygienists in the pursuit of destroying dentistry." I was seen along with my thesis committee as having ulterior motives, both political and economic, for the sole purpose of discrediting the dental profession. I was said to be representing the "enemy" to dentistry. Dr. X denigrated the study, the thesis committee, and most of all, me. I said very little and I listened carefully. I was labelled "stupid" to think that I would receive support for the study. Dr. X wanted no part in it. I was seen as a "nemesis" that could not be supported to achieve higher educational and ultimately political aims.

From the point of view of the research, the encounter was invaluable. It gave me an insight into some of the deep political and professional tensions within dentistry. At the very least, the encounter assured me that I was right to begin each interview honestly and openly, that is, without hiding the context and nature of the study.

CHAPTER SIX

SOCIAL RESPONSIBILITY RECONSIDERED

"...it is essential to recover the vision of what is possible in actual practices today in order to discover the mandates for reshaping our institutional structures, environments, and economics to serve attentive, sustaining and healing relationships."

Phillips & Benner 1994

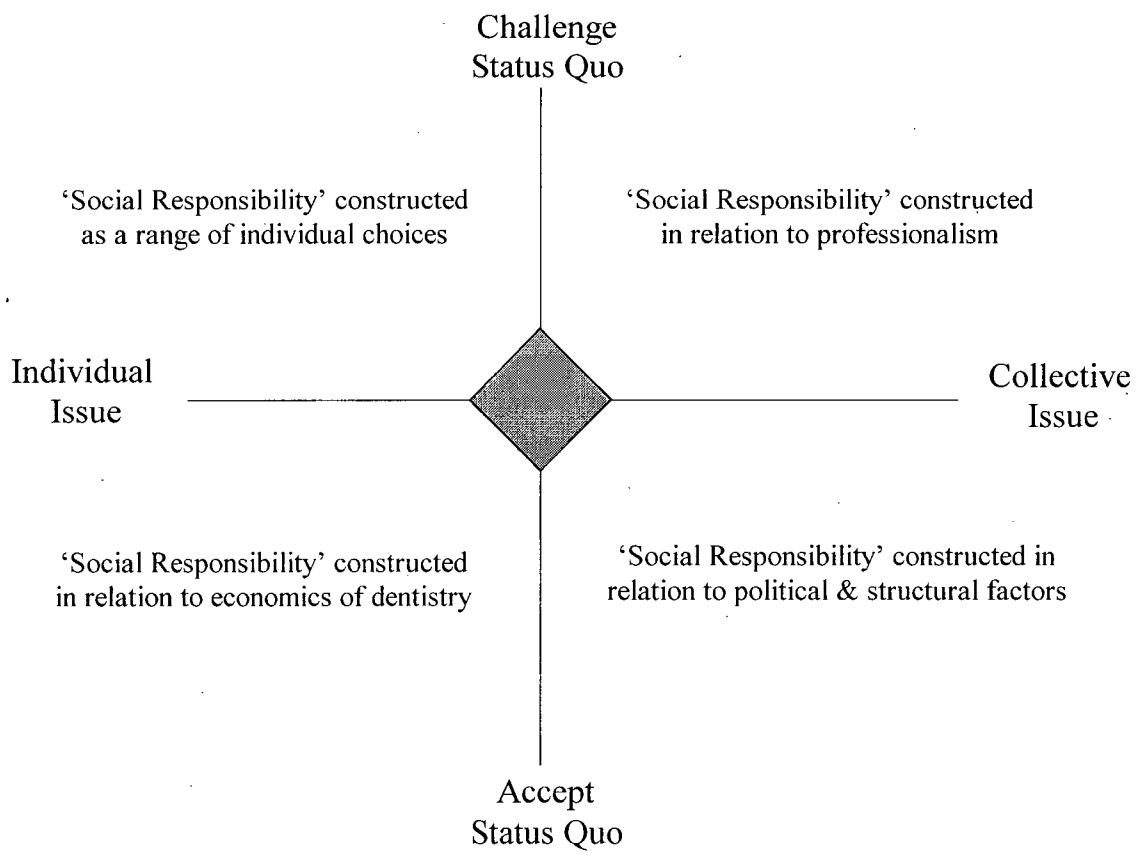
Mapping Accounts of Social Responsibility

The discursive constructions of social responsibility are presented through the contexts within which the participants work and live, and are influenced by their values, beliefs, and social practices. No participant, therefore, speaks entirely free of social and cultural contexts and affiliations. As a consequence, any discursive construction of the concept of social responsibility is, in part, that of the participant, and also part of a larger discourse. In this study, discourses become noteworthy when they point to 1) accounts of what some see as unproblematic that others see as iniquitous; and 2) the differences in ways the participants frame their role and responsibilities in relation to their sense of social responsibility.

My analysis reveals four competing discursive constructions of social responsibility in dentistry that are situated within a discursive space intersected between individual and collective notions of social responsibility on the one hand,

and the acceptance and challenge of the status quo on the other (see Figure 1 below). Each space occupies the range of accounts that the participants provided to explain, rationalize and justify their views in accordance with how the dental health care system is seen to operate or should operate. These accounts refer to the moral and practical explanations the participants construct to justify their views, position and role, and how they try to legitimize why it makes sense to see and do things in one way and not another.

Figure 1 – Discursive Spaces



Structural variation in discursive accounts of social responsibility

The different ways social responsibility is constructed reveal the ways participants communicate and understand their experiences, and how they constitute their role and identity within what is communicated and experienced. The boundaries between the four quadrants are permeable and they do not confine the participants within one particular space. Most of the participants moved within and between discursive spaces as they talked about their own inability to resolve the issue of social responsibility. A key part of my analysis, therefore, centres on the tensions between the different discourses of social responsibility. As a result, I focused my analysis on how participants at times shift their position and the underlying premise of what they see as reasonable and justifiable in one instance, and replacing this with an opposing position that is seen by them as equally reasonable and justifiable. It is here that one sees a tension between the different constructs of social responsibility. My analysis reveals, therefore, the constraints and challenges of accepted and dominant norms (the *status quo*) within dentistry, as well as the implied sense of rights and responsibilities within the discursive spaces, both of which I explicate below.

Accepting vs. Challenging the Status Quo

The status quo was seen to be influenced in particular ways, thus interpreted differently among the participants. For example, for some it was embedded in issues of economics and for others it was socio-political. Implicit in the different discourses is the notion of whether it is reasonable to keep the status quo or to challenge existing practices. The distinction lay in whether one

has taken *action* to challenge the status quo or whether one sees it as *reasonable* to take action to challenge privileged places within it. For example, those who disputed the status quo defended vehemently ideas of social responsibility to ensure equitable access to care, but believed they could not actually do anything about it because they felt (some with a deep sense of despondency) that their views were too much in the minority to make a difference. Yet, some of them considered it quite reasonable to take action to challenge others because they found it difficult to take on the conventions, the norms and dominant position of economics in their beliefs about and understanding of social responsibility within the practice of dentistry. However, as much as some of the issues were presented as obvious, and participants spoke passionately about them, some were grappling with competing moral demands they could not easily reconcile as they tried to accommodate incompatible constructs of social responsibility. As a result, the emerging sets of related accounts conveyed a dissonance between competing socio-economic, professional, educational and political expectations and realities within dentistry. The participants took the "imperatives" or necessity of reasoned justification as legitimate, almost instinctively and as a means of self-legitimation, although they did not always make explicit the basis of their positions (because these are based in unarticulated normative criteria (see Johnston & Kandermans 1995)).

Individual vs. Collective Responsibilities

In examining the nature of the discursive spaces it becomes apparent that two of these assume a collective responsibility, either on behalf of the profession

or on behalf of society. However, both were referred to from the viewpoint of *collectives*, although, the idea of 'collective' was not interpreted in the same way by all of the participants. Similarly, the left side of the X-axis is anchored by the rights of the individual that in some of the accounts refers to the dentist, while in other accounts the individual is referenced to the patient. What is not apparent within the different quadrants is the exact nature of 'collective' and 'individual'. Nevertheless, the X-axis continuum enables and accommodates two distinct and oppositional approaches toward reasoned justification as present within the different accounts of social responsibility within dentistry. The discursive spaces, therefore, provide a way to understand reasoned justification for why a dentist acts in certain ways and takes certain viewpoints in relation to the rights of the individual or the responsibility to the collective, whether from the point of view of the profession, the individual dentist, society at large or the individual patient.

Common Commitments (pain/suffering)

In the centre of the four discursive spaces where the two axes intersect there is a space wherein lies the *raison d'être* of dentistry—the social responsibility to treat pain, regardless of compensation. It is the common ground of commitment voiced by participants when they spoke of patients in pain. It was referred to as an ethic that was held sacrosanct, and considered a widely accepted code among dentists generally and within dentistry in particular. It provided an agreed upon discursive space in talking and thinking about social responsibility. For the most part, taking patients out of pain overruled any personal justification and account of social responsibility.

The Dominant Discourse (economics of dentistry)

In the space moving outward from the intersection of the two axes particular discursive constructions of social responsibility become more hegemonic and take on a sense of what is considered as so 'normal' and conclusive as to be unassailable from any other position. The *accounts*, located in the periphery of the discursive spaces and that also delimit the different discursive constructs, begin to establish an increasingly dominant position to which others must respond if they are to give good reason for their own accounts. It was clear from the transcripts and my analysis that the dominant discourse centred on the economics of dentistry. It pervaded the other discursive spaces, at times very subtly, but mostly quite conspicuously. From the viewpoint of those participants who were overtly critical of the status quo, therefore, the matter seemed obvious and economics was seen as a significant point of resistance. For those who for the most part accepted the status quo discussions reached an impasse with the emergence of issues that presented a tension between economic agendas of the individual dentist and the profession and their individual and collective social responsibility to enable equitable access to care. As much as it was expressed clearly that the dental health care system ought to be an equitable and universally accessible one, it was unrealistic for many of the participants to ignore economic sensibilities affecting the dental health care system in light of how private dental practice is structured.

The different ways the participants in this study attend to social responsibility and their expressions and impression of it shape the boundaries

that define what to them is acceptable and unacceptable within the community of professional dental practice. Clearly, the moral resolve to provide dental care for the poor, the aged and the disabled is seen to be affected by the different ways dentists, dental educators, and those involved in the governance of dentistry experience the economic, educational, political and professional realities of the system, and how they position themselves within it. One conclusion that can be drawn is that those who control the discourse have the influence to define the position of others, as well as of the dental health care system. Within dentistry, those in a position of power and privilege and who have the political and economic influence to inform policies and decisions affecting the dental health care system are ones who will control the discourse.

It is important to note that the diagram (Figure 1), although very simplistic for such a complicated concept and for such a broad and complex phenomenon, are intended here to provide, at the very least, a modest and readily accessible sense of the juxtaposition of the different constructs of social responsibility identified in this thesis. It is important to recognize, also, that the participants speaking from a particular discursive space are not defined by that space or even located in it per se; it is their accounts that are located there. In other words, this thesis is not so much about the participants more so than their reasoned justifications. It is these justifications that provide readers an insight into the different ways social responsibility is accounted for and more significantly, the larger discourse from which they are appropriated. Others can learn from this study by comparing presented accounts with their own experiences, and taking

what they learn to different settings where they can relate the findings (Krefting 1991).

Implications

This study is the first of its kind in dentistry. It establishes the nature of knowledge needed to examine how dentistry might consider its approach to issues of access to oral health care to meet the needs of society for the common good (DePaola 1994, 1998). It has been six years since the time dentists in British Columbia chose to refuse treating socially assisted patients without payment from them up front. The dispute between the Provincial Government and the Federation of Dental Societies is still unresolved. My study provides a glimpse into why this has yet not happened and what needs to be considered to address the problem. For instance, if social responsibility is constructed from within an economical discourse, then the dental health care system will be shaped predominantly by individual and collective concerns over economic priorities. The practical implication is that under the existing dental health care system, with its business-like organizational and institutional structure, financial concerns will influence the policies and decisions on how dental health care is delivered, thus determining who will be able to access care. Correspondingly, if social responsibility is constructed from within an individual choice discourse, then accessibility will depend on the way the system is structured—in the health of individual patients through individual dentists versus the health of communities through a community of practitioners. If it is constructed from within a

professional discourse, then accessibility will depend on whether professionalism includes the principle of "commitment to society", which extends also to those who are socially and economically disadvantaged. Likewise, the politics of dental health care will also influence issues of accessibility. From the perspective of social responsibility as a political and organizational discourse there remain unresolved political differences between what is considered a fair allocation of resources to dental health care in particular, to provide a reasonable compensation to providers and an adequate range of services. All things considered, therefore, my study provides a beginning for examining further how different stakeholders can be more sensitive to the discourses that inform what is aspired to and what is actually practised.

Implications for theories of justice in health care

Much has been written about issues affecting equity and access to health care within the context of social justice (Anderson 1972; Barry 1989; Bole and Bonderson 1991; Block 1996; Bryant, MacEntee and Brown 1995; Chapman and Talmadge 1971; Daniels 1979, 1985; Dharamsi and MacEntee 2002; Frankena 1962; Kluge 2003; Outka 1974; Ozar 1994; Roemer 1996; Sherwin 1992; Van Doorslaer, Wagstaff, and Calonge 1992; Veatch 1991; Whitehead 1992, 1999). The outcomes of such works are being widely applied in different health care settings. My aim here is not to enter into a theoretical examination of the different applications of various principles, nor is it to take sides amongst the various schools of thought. Rather, I wish to point out that most applications of these theories, particularly in dentistry, and from the context of this study, do not

account for the messiness and complexity of human relations and the range of influences on human thought and action. They seldom account for situational constraints, societal expectations, and the culture of the organization within which people work—more generally the social, political, and economic forces that influence decisions and actions. It has been argued that when examining complex situations theorists "often appear grandly oblivious to the social and cultural context in which these occur...nor do they seem very conscious of the cultural specificity of many of the values and procedures they utilize when making ethical judgements" (Weisz 1990, pg. 3). The notion of social responsibility is a complex one and to understand complex problems requires an understanding of the real world of practice (Hoffmaster 1993). My findings, therefore, ought to enable all those who deal with the dental health care system to begin to appreciate some of the human factors that influence it, and to appreciate the significance of discourse in the production, maintenance, and change of how things should work or ought to work (Fairclough 1989).

A primary implication of my study, therefore, is that justice in health care is a complicated human matter that requires a more inclusive investigation. The notion of justice is influenced by a range of viewpoints (recipient, provider, society), and is subject to multiple influences (political, professional, economic, philosophical), all of which surfaced in my analysis. Theoretical approaches have not accounted for these multiple interactions nor declared related limitations appropriately.

The fit between theories and discourses

Many scholars are beginning to argue more forcefully that it is time to settle disparate views and to induce positive change in the provision and delivery of dental health care. My study points out that it is difficult to settle a view, but it is not difficult to acknowledge it and to work toward a consensus in the best interest of all of the stakeholders. Theoretical discussions in the literature about equity, accessibility and justice are beginning to encourage some thinking around the delivery and scope of oral health services (Formicola 1988; Schoen 1992; Epp 1986; Atchison & Schoen 1990; Rosenthal 1992; Bradshaw & Bradshaw 1995; ADA 1995; Hill 1996). The debate on health care as a moral right, rooted in traditional social and religious concepts of charity, beneficence and compassion (Chapman & Talmadge 1971), is now taken as a more inclusive view of equity in health care (Whitehead 1992), and there is a growing sensitivity to certain principles of social justice in efforts to distribute health care equitably (Whitehead 1999; Barry 1989). The distribution of benefits and burdens in society based fundamentally on the principles of social justice relies on the concept of distributive justice and offers moral directives to a just allocation of resources, a fair compensation to providers, and a reasonable range of services (Daniels 1979). It is precisely here, in the social dimension of health care, that the question of distributive justice as an allocative principle becomes critical because it is designed to allocate resources in limited supply relative to demand (Fletcher 1976). In other words, when there are insufficient resources, distributive justice is concerned with how they are to be allocated among those who are in need. For

the most part, deciding factors depend on "what goods are subject to distribution (income, wealth, opportunities, etc.); on the nature of the subjects of the distribution (natural persons, groups of persons, reference classes, etc.); and on what basis the goods should be distributed (equality, according to individual characteristics, according to free market transactions, etc.)" (Lamont 2002). My thesis suggests, however, that the problem extends well beyond theories of supply and demand in relation to various principles of distributive justice. It is simplistic to believe that there are never sufficient resources for health care and that the problem relates solely to resource allocation. I question whether theories on social and distributive justice explain how key stakeholders in dentistry think and reason in relation to social responsibility. I have found that professional, political, and economic discourses can and do influence decisions on who deserves what, how much, and who has the power to decide, issues that theories do not adequately consider if at all.

Challenge to extant theories

My findings suggest that the problems addressed through theoretical conceptions of justice are also not always able to respond to the discourses that develop on a regular basis in relation to both micro and macro levels of economic, political, and professional influences. For example, based on my findings and what is emerging in the literature there is a view that policies and practices within dentistry reflect health care increasingly as a monopolized commodity serviced extensively for profit (Dickerson 1999; Evans, Barer, et al. 1993; Feldstein 1988; Forbes 1985; Jamous & Peloille 1970; Relman 1992;

Salmon 1995; Woodstock Theological Centre 1995; PEW Health Professions Commission 1993). The conventional approach in the literature in responding to these types of problems is to situate them within the different theories on distributive justice and to pitch one against the other—libertarianism vs. egalitarianism vs. contractarianism, for example—in the hopes of arriving at a fruitful solution (see Dharamsi and MacEntee 2002; see also Ozar 1994). What goes unexamined when filtering such problems primarily through a theoretical lens is how economic, political and professional discourses play a part in influencing how things work. The Canadian health care system, for instance, professes a health service to all without inequalities or disadvantages (Naylor 1988). Looking at it through a theoretical lens one sees that it is based on egalitarian principles that hold that everyone should have an equal claim on all available resources, and that health is a necessary precondition to enable equal opportunity in life (Outka 1974). It supports the idea of sharing all health resources equally as a social responsibility (Veatch 1991). Although this theory has much utopian appeal, it does not translate well into practice. It does not respond adequately to growing concerns about public debt, or related professional and societal concerns. Health care expenditures in affluent countries already run close to 10% of the gross national product (USA 14%; Germany 11%; Canada 9%; Australia 9%; and UK 7%) with the emerging view that the demand for health care is a bottomless pit (WHO 1999). It has been argued recently that problems of resource allocation have come to dominate and at times mystify approaches to resolving important ethical problems (Roemer, 1996;

Storch 1994; Scanlon 1997; Van Doorslaer, Wagstaff and Calonge, 1992; Watson 1994). From the standpoint of the different discourses of social responsibility, one can begin to appreciate some of the underlying accounts or reasoned justifications that influence unresolved professional, political and economic differences between what is considered a fair allocation of resources, a reasonable compensation to providers and an adequate range of services. My study points to a messiness that cannot be tidied by the theoretical ideals of social justice in health care.

Implications for policy makers, educators and practitioners

Although the participants accounted for a lack of access to dental care differently—whether it was because of economic reasons, or the way the dental health care system is structured, or the education process, or a dominant individualism in society, or a poor sense of what it means to be a professional, or even a political indifference to dental welfare—the central point that emerges from my study is that there is agreement in the literature and among most of the participants that social responsibility within this context ought to be addressed seriously and immediately. What is not agreed upon is *how* it ought be addressed. This thesis can serve as a possible point of departure for understanding how different stakeholders might approach the role and responsibilities of individual dentists, of the profession at large, of society, and of government, relative to the different perspectives on social responsibility.

Policy

At the very least, this study calls for the need to 'awaken' policy makers, educators and practitioners to differentiate between 'ideal' and 'actual' notions of social responsibility. There is a need to recognize oppositional views (discursive constructions), to resist focusing on any one particular discursive construct of social responsibility, to focus on a plurality of views, to acknowledge the prevailing dominance of one discourse, and to engage key players within policy, education and practice toward an acceptable solution.

Furthermore, 'ideal' notions of social responsibility will inevitably be absolutist and incontestable. Idealism does not account for the messiness, complexities and dilemmas encountered and experienced in daily life. Many participants expressed the difficulty in trying to accommodate ideal notions of social responsibility in light of practical realities. It seems that many health professionals have a general sense of what the issues are and know what they want: "we want, as participants in institutional culture, to be able to notice our moral problems and to cope with them with sensitivity and integrity and to keep our health care institutions responsive to their moral goals" (Jameton 1990).

Discourses are ways of thinking and deciding about what is right, what is reasonable and what might be considered normal. They provide subconscious justifications for how we reason and act. The discursive constructions of social responsibility in this study provide insights into the ways in which dental professionals think about access to care. The economic discourse that dominated my interviews evolved from a number of complicated economical,

professional, and political factors that have shaped the dental health care system in Canada. Clearly, the market plays a fundamental role in the discourse that they appropriated as they gave reasoned justification for their action or inaction related to social responsibility. Entrepreneurial and market forces have given rise to an increasing discomfort about the nature of dentistry as a health profession and about the professional identity and development of dentists. The existing professional identity of dentists is a problem to some of the participants. The problem of access to dental care is obscured by the influences of entrepreneurialism and by liberal individualism—seen by many as central tenets of western capitalist societies (Frank 1999). This individualism predominates among the more privileged members of society who also hold a more dominant social place within it. The crux of the market ethos lies in its effects on the individual's "agential capacity" over the integrity of the social collective (Wagner 1994). As a result, the outcome of the dominance is a pervasive hegemonic world-view that is accepted by the whole of society as natural and normal (Bocock 1986). The dominant discourse, therefore, requires careful interrogation. This study challenges us to take this discourse beyond the research context through which the language is presented. Through further research, we might be challenged to understand better its roots, how it has been advanced over time, the ideological environment that has facilitated it to gain such dominance, and who benefits and who loses. It becomes essential, therefore, to determine whose account is being heard and whose is being silenced; which ideology or theory is being invoked and put forth and which one is being dismissed.

For instance, in Canada, dentists have been celebrated as among the pioneers within the fabric of its "universal" and "comprehensive" health care system that boasts proudly of its accessibility to all (Lang 1999; Jecker 1995). Some dental scholars, including some of the participants in this study, caution that the celebration can easily be marred by the influence of a particularly aggressive entrepreneurial and commercial ethos where issues of equity and access are being dominated by a priority on profits (Jacobs 1982; Schwab 1998; Salmon 1995; Relman 1992). Health service policies and practices increasingly reflect health care as a commodity like any other product in a free market. Yet, ironically, the health professions have the privilege of monopolizing their sphere of practice, which violates the principles of a free-market system. The problem arises when the least advantaged, the uninsured and the under-insured are denied a claim to dentistry. The commercial view of dentistry does not have to be a representation of the profession today because there is a strong sense that "the vast majority of dental professionals and the vast majority of the community at large do not accept the Commercial Picture of the dental profession any more than they accept it for any of the health professions" (Ozar 1994). Although entrepreneurial thinking is a vital ingredient for the everyday running of a dental clinic, and some of the decisions taken by clinicians are often clearly business oriented, this does not have to translate into a defining construct of dentistry. It must be acknowledged that while dentists aim to maximize the oral health of their patients, the economic dimension of their strategies will exert its pragmatic influence (Nettleton 1992). For example, although no one I interviewed denied

the importance of sustainability, not every participant placed a greater priority on profit over a social responsibility to ensure access to care. Although this raises the question of how much of what was said was a version of the 'party line', my analysis does point out the difficulty some participants had in reconciling social responsibility within the context of a private dental health care system. On the one hand they spoke forcefully and forthrightly about the discrimination within the existing system, and on the other, they either felt powerless to do anything about it, or that the prevailing fee-for-service and for-profit structures and norms were seen as far too deep-rooted to affect change. Moreover, it was argued that dental services are not considered as part of the protected set of health care services seen as necessary and available to all in a modern society. Dentistry has traditionally been excluded also from the limited set of primary paramedical services for which care is offered to all irrespective of income or social status. Many of the participants stated also that part of the problem is that it is viewed popularly and politically as a secondary health service reserved primarily for the affluent and generally healthy citizen, a problem also confirmed by the literature (Bolden, Henry, et al. 1993; Damiano, Shugars, et al. 1992; Evans & Williamson 1978; Locker & Leake 1993; MacEntee, Thorne, et al. 1999; Wilson 1992).

Education

This study makes a contribution to dental education. For example, in discussing efforts of various dental schools to adopt a "service-first" philosophy (Formicola 1988; O'Neil 1993), a tenet that dental professionals should meet the

needs of society at large rather than only those who can afford to pay, a few dental educators raised some key questions:

> Do these efforts to create dental professionals who not only feel a commitment to community services, but also are culturally and socially accepting of those members of society who do not fit the traditional stereotype of a private practice patient? Are the students willing to learn about the realities of poverty, homelessness, disability, illiteracy, or ethnic diversity? Can they do so on a more than theoretical basis, accepting and appreciating these patients first as individuals and trying to decrease some of the barriers to care and to oral health? If they are able to demonstrate these qualities during dental school, will they continue to do so as practitioners after becoming immersed in operating a business? (Entwistle 1992).

Dental professionals have been challenged to address these issues (Field & Jeffcoate 1995; Glassman, Miller, et al. 1996; Wilson 1992). Discussions focus on the inadequacies of the traditional educational model within health care systems gripped by economic priorities and fraught with inequities (ADA 1990; Kantrowicz, Kaufman, et al. 1987). The Pew Health Professions Commission and the Institute of Medicine in the U.S. both argue that most dental schools fail to produce graduates who will, or indeed can provide services to poor, disabled, or otherwise disadvantaged populations. They and others continue to call for an urgent change in dental health service and education to address this problem (Field 1995). Educators contend that the pre-professional educational experience should allow students to explore issues that help to build a strong sense of ethics and provide an interdisciplinary focus on societal concerns within health care (Connor & Mullan 1983; DePaola 1994; Hendricson & Cohen 1998; Schon 1987;

WHO 1995; Williams, Butters, et al. 1990). It is argued that dental education ought to help students define their professional identity based on social awareness (Hershey 1994; Nutting 1986). Ernest Boyer, the former U.S. Commissioner of Education, indicates that the crisis of our time relates to the disastrous divorce of competence from conscience. He states that once professionals begin to practise, they stop thinking beyond the technical aspects of their work. He suggests that professionals must be able to make judgments that are not only technically correct but also ethically and socially considerate (Boyer 1987). Part of the problem has to do with the broader socialization of dentists. If future dentists continue to be recruited without concern for their past social and educational experiences then it will be difficult to change their attitudes about their responsibilities. In response, the Institute of Medicine (IOM) adopted eight policy and strategic principals for dental education among which the following are significant to the problems indicated: 1) oral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care; 2) dental schools have a responsibility to serve everyone, not only those who are economically advantaged and relatively healthy; and 3) efforts to reduce the wide disparities in oral health status and access to care should be a high priority for policy-makers, practitioners, and educators (Field & Jeffcoate 1995). The implications of the IOM report are being discussed extensively (Catalanotto & Heft 1996; Chambers 1996; Glassman, Miller, et al. 1996; Libert 1996; Nash 1996; Reed 1996; Tedesco 1996; Grembowski 1997), but it is argued that little progress has been made to

translate this into the dental curriculum, or to improve the delivery of dental health service (Chen, Anderson, et al. 1997; DePaola 1998; Field & Jeffcoate 1995; Greenlick 1995; Ismail 1996; Jones 1998; Milano 2002; Mueller, Schur, et. al. 1998). This study suggests what some of the constraints might be to achieving stated educational goals, particularly from the perspective of the dominant discourse. It provides an insight into how some dental educators might respond to the challenges posed, and what the oppositional views (discursive constructions) are.

Practice

Ultimately, there is a need to engage key players within policy, education and practice. A wide range of stakeholders (dentists, dental educators, those in the governance of dentistry, representatives of the public, those marginalized from care, and government officials and policymakers) need to participate in open, honest, and constructive dialogue and debate on an array of issues, many of which have been identified in this study. The dialogue must *first* take place among the leadership of individual stakeholder groups and facilitated by respected leaders from within. There must be a genuine willingness to understand and ultimately resolve the existing inequities. This requires a truthful cooperative discourse toward a consensus moral view among the different stakeholders (see Habermas 1992):

> "Only an intersubjective process of reaching understanding can produce an agreement that is reflexive in nature; only it can give participants the knowledge that they have collectively become convinced of something (pg. 67).

To arrive at this intersubjectively held consensus requires the involvement of key players within various stakeholder groups who can begin an examination of the range of discourses that influence the potential and real impacts of various decisions and actions. The process must take into account also the differences in each stakeholder's economic, social, political and professional (dis)advantages (Lewis & Unerman 1999; McCarthy 1984). The Canadian health care system is undergoing significant reform (Evans 1990; Rachlis & Kushner 1994; Storch & Meilicke 1994; Romanow 2002). The key forces that are said to be creating the impetus for change are situated around issues surrounding the aging population, new technology, an emphasis on the determinants of health, and the consumer movement (LeFort 1993). These forces have created sensitivity to a range of ethical issues (Denton & Spencer 2003; Kluge 2003). It is argued also that if Canada is to preserve its five fundamental health care principles of universality, accessibility, portability, comprehensiveness and public administration, it must focus on the responsibility and accountability of all stakeholders as central to reform movements (Barer & Evans 1992).

Possibilities for future research and concluding remarks

Future research ought to examine specific institutional practices that reproduce inequities. A few of the participants pointed to the affects of professional socializing forces as a significant factor in influencing interpretations of social responsibility, something that has not been established in the dental literature as extensively as in medicine. It seems that the prevailing processes of

professional socialization in dentistry are similar to what Becker (1961) observed in medicine over 40 years ago. It has been established that medical students, for instance, experience a significant identity change as they go through medical school. Initially, students identify more closely with patients, seeing themselves as caregivers and patient advocates but, nearing graduation, they identify with their professional colleagues and differentiate themselves from lay society as they develop a primary allegiance with members of their profession (Hass & Shaffir 1987; Konner 1987; Shapiro & Lowenstein 1992). Professional socialization is a powerful phenomenon. If it influences notions of social responsibility, then there is need for research to understand better how institutional practises influence dental students.

There is a need for a more sophisticated sense of the impact of what is seen by some as oppressive practices in dentistry. Looking at the notion of oppression from the viewpoint of McLaren and Lankshear (1994)—"a constraint to living more fully, more humanly: constraint born of social contingencies of power; of discursive regulation through interested and contrived social practices carried out so as to privilege some at the expense of others" (pg. 1)—it may be possible to see how and why people's oral health care needs vary inversely with their power and privilege within society. It is not sufficient just to notice the effects of poverty on health but it is also necessary to consider who is at risk of becoming the victim of poverty (Sherwin 1992). Future research in dentistry needs to consider the experiences of other disciplines about how the poor are

frequently oppressed, and how oppression itself can be a significant determinant of health (Sherwin 1992).

As medical and dental schools across North America move towards a Problem-Based Learning (PBL) curriculum there is an opportunity to examine the extent to which the curriculum shift influences not only an orientation to social responsibility but also the beginnings of a formation of a new and related professional identity. The new curriculum has been designed in part to respond to the call for a certain social responsibility, and to promote change in existing (taken-for-granted) doctor roles rooted in retrospective identities. Under current calls for change in how the dental health care system is structured, and how dental students are educated, issues around professional identity can be examined through Bernstein's (1996) thesis on *retrospective* and *prospective* identities. The notion of retrospective identity is one that looks to the past in order to affect the on-going formation of identity for the present and for the future (Bernstein 1996). Retrospective identity formation is thought to proliferate the status quo. Prospective identity, on the other hand, is a look into the future, on the basis of which there is a concerted effort to shape what ought to be. In effect, the idea of prospective identities is an attempt to change the basis for collective recognition and relation (Bernstein 1996). Prospective identities are said to be an outcome of social movements, and the creation of a new and different discourse. In the case of dentistry, it suggests a new and different way of engaging with economic, professional and political realities to enable the development of new ways of looking at the dental profession and its place in society. At UBC, the

course *Doctor, Patient and Society* attempts to enable medical and dental students to explore more broadly the relation between health, health professions and society. It is a course that tries to promote an identity that is formed over time through a different world-view. Having taught within it, I would now suggest that the PBL curriculum ought to try to achieve what Beane and Apple (1995) see as an integral part of democratic schools:

1. The open flow of ideas, regardless of their popularity, that enables people to be as fully informed as possible.
2. Faith in the individual and collective capacity of people to create possibilities for resolving problems.
3. The use of critical reflection and analysis to evaluate ideas, problems and policies.
4. Concern for the welfare of others and "the common good".
5. Concern for the dignity and rights of individuals and minorities.
6. An understanding that democracy is not so much an "ideal" to be pursued as an "idealized" set of values that we must live and that must guide our life as people.
7. The organisation of social institutions to promote and extend the democratic way of life.

(Beane & Apple 1995)

The hypothesis is that those educated in "democratic schools" are more like to engage in what Dr. Z, one of the research participants, describes as transformative educative experiences that enables a prospective professional identity formation. Educators in such schools are enabled to look not to the past but to the future; they are enabled to adopt a counter hegemonic discourse and to engage in an intense examination of how practice relates to various economic,

professional and political norms and attitudes. They are enabled to help students examine what is unspoken and taken-for-granted, and how the tacit can create inequities and injustices within any particular system (see Mezirow 1990). These efforts, it is argued, can lead to a new and different community of practitioners (Mezirow 1991). Educating for social responsibility enables practises that account first for the common good while at the same time respecting diversity and individuality (Nemerowicz & Rosi 1997). To this effect, a number of dental schools in North America have initiated a community-oriented service learning experience in their curriculum (Desjardins 1996; Galbally, Boehmcke, et. al. 1999; Williams, Butters, et. al. 1990), however, little is known about the long-term impact of this experience on practitioners. There is a clear need, therefore, for longitudinal research in this area that examines the influence of service learning experiences on dental practice following graduation.

As a first inquiry into social responsibility in dentistry, this study opens various possibilities for further research on this phenomenon. I have learned through this study that change will be difficult to achieve through humanistic principles or ideological positions alone no matter how 'obvious' they seem. This thesis provides a link between research and practice in the area of social responsibility. It encourages additional study of the relationships between health and health care. At least one of the participants portrayed "health" (not health care) as a fundamental human right, although it is a concept with emotive as well as ethical and moral values (Susser 1993). It responds also to the call from

ethicists who see a significant need for substantive contributions from social scientists to the health disciplines:

> First, they can provide ethicists with data, ranging from descriptions of the historical origins of current ethical debates to information about how people in different cultures and at different social levels actually behave in ethically problematic situations...[and] second, the perspectives they utilize may in fact subvert traditional schemas of ethical analysis...[and]...seeing an ethical problem in its broad social context may necessitate its recategorization from the ethical to the political domain...(Weisz 1990).

Approaching ethical problems from within a broader social context enables an engagement that calls for a critical examination of accepted discourses. It calls for a critical examination of existing discursive foundations, and to examine the roots and history of these foundations. It calls also for an examination of future directions that have been charted from existing foundations. Examining the past and the future in this way are challenges that dentistry faces in the present.

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APPENDIX A: CONTACT LETTER

Title of Doctoral Thesis:	Discursive Constructions of Social Responsibility
Principle Investigator:	Shafik Dharamsi, PhD Candidate Institute of Health Promotion Research The University of British Columbia
Thesis Committee:	Dr. Michael I. MacEntee Dr. Dan D. Pratt Dr. Elvi Whittaker Dr. Arminee Kazanjian

Dear _____,

We are studying how dentists, dental educators, administrators, and policy makers address the concept of social responsibility in the health care system, with a particular interest in dentistry. Although the term "social responsibility" appears in the dental literature and in various national and international policy documents, we are unclear as to how it is considered and enacted. On the other hand, we do know that dentists are challenged to address the needs of the poor, disabled, and other disadvantaged groups in society. The findings of this study may provide valuable information that could be used in health service delivery and policy planning.

Shafik Dharamsi will conduct this study in partial fulfillment of his requirements for a doctoral degree. Please note that your involvement in this study is voluntary and that you are under no obligation to participate. Moreover, if you decide to participate, we understand that you may withdraw from the study at any time without jeopardy. Shafik will conduct an informal interview on one or two occasions lasting about one hour each, at your convenience. Subsequently, the recorded interviews will be transcribed and analyzed by him and his thesis committee.

If you have any questions about your rights and treatment as a research participant, you should contact Dr. Richard Spratley, Director of Research Services at UBC (822-8598) at any time.

Michael I. MacEntee
Professor, Faculty of Dentistry, UBC
Thesis Committee Chair

Shafik Dharamsi
PhD Candidate

APPENDIX B: CONSENT FORM

Title of Doctoral Thesis:	Discursive Constructions of Social Responsibility
Principle Investigator:	Shafik Dharamsi, PhD Candidate Institute of Health Promotion Research The University of British Columbia
Supervisory Committee:	Dr. Michael J. MacEntee Dr. Dan D. Pratt Dr. Elvi Whittaker Dr. Arminee Kazanjian

This study will examine how dentists, dental educators, administrators, and policy makers address the concept of social responsibility in the health care system, with a particular interest in dentistry. Although the term "social responsibility" appears in the dental literature and in various national and international policy documents, we are unclear as to how it is considered and enacted. On the other hand, we do know that dentists are challenged to address the needs of the poor, disabled, and other disadvantaged groups in society. The findings of this study may provide valuable information that could be used in health service delivery and policy planning. Shafik Dharamsi will conduct this study in partial fulfillment of his requirements for a doctoral degree.

I have been advised that my participation in the study is voluntary, and that I can withdraw from it at any time without jeopardy. I will participate in up to two interviews each lasting about one hour at my convenience, and each interview will be tape recorded and transcribed for analysis by Mr. Dharamsi and his Supervisory Committee. During the course of each interview, I may at my discretion refuse to answer any questions. All of the tapes, written notes, and transcripts from my interviews will be coded to conceal my identity that the research group will hold in strictest confidence. I have been assured also that my identity will not be revealed in any reports or publications of this research. Ultimately, the tape recordings of the interviews and the transcripts will be destroyed when the research is complete.

I have been advised that I can contact Dr. Richard Spratley, Director of Research Services at UBC (822-8598) at any time about my rights and treatment as a research participant. I can contact the Supervisory Committee for additional information as required. At this point, all of my questions have been answered to my satisfaction, and I have received a copy of this consent form.

Signature of Participant Thesis Committee Chair	Shafik Dharamsi