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COMMENTARY

Dental pain as social injustice: a Rawlsian perspective

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ABSTRACT

Dental pain reduces a person's quality of life and constrains the ability to perform routine day-to-day activities, yet its distribution in society is inequitable and significantly shaped by the social determinants of health. This paper explores this social phenomenon of dental pain using John Rawls' conception of justice as fairness. Several key concepts in Rawls' framework are examined, including the implications for: a person's right to fair equality of opportunity; a person's sense of self-respect; and, the dental profession's social contract. We conclude that the current distribution of dental pain in Canada and the United States breaks with the principles set out in Rawls' conception of a just society.

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Introduction

Pain is a central component of the human condition; almost without exception, every person will experience some form of pain during their lifetime. Although the exact distinction between acute and chronic pain varies and can be subjective or even arbitrary (Voscopoulos & Lema, 2010), in the context of dental pain, both forms interfere in a person's day-to-day life. Of course, pain is a personal experience, yet it is shaped by social, cultural and political forces that cause variability in how people interpret and describe pain (Svensson et.al., 2018). Dental pain, for example, primarily arises from untreated tooth decay and periodontal disease, and affects many people across society. However, its distribution across society is highly inequitable, disproportionately impacting those who are already worst off. For example, the 2007–2009 Canadian Health Measures Survey (CHMS) – the most comprehensive survey of Canadians' oral health taken to date – found that roughly 10% of Canadians reported experiencing tooth pain each year, but it is more commonly reported by those with a lower socioeconomic status (18% of those in the lowest income bracket), those who report financial obstacles to accessing dental care (23% of those reporting financial barriers to care), and those with untreated tooth decay (19% of those with untreated disease) (Ravaghi et.al., 2013).

These inequalities are ultimately a function of the social determinants of health: those social and economic factors that facilitate or constrain a person's health behaviours, alter the body's biological reactions through prolonged physiological stress, and expose individuals to risk factors that negatively affect health outcomes (Raphael, 2004). Importantly, tolerance from the general public for such manifest inequities – or inequalities that are deemed unfair, avoidable, and amenable to policy action – in addition to inaction and inattention from government and social institutions resistant to changing the status quo, leaves many to continue suffering with treatable and preventable pain (Holden, 2016; Marmot, 2017). These attitudes, in turn, lead to stigma, prejudice and discrimination, which has implications for a person's perception of their value in society (Moeller et.al., 2015).

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John Rawls, who is amongst the most recent scholars in contractualism, provides a useful framework from which to view and study dental pain in his *Theory of Justice*. In his theory, Rawls points to 'the social bases of self-respect' as essential to a person's 'sense of value [and] secure conviction that [. . .] his plan of life is worth carrying out' (Rawls, 1971, p. 440). Rawls considers the social bases those basic institutions within society necessary for citizens to have a sense of their own worth as moral persons. Circumstances that interfere with essential aspects of daily life can be damaging to a person's dignity, and Rawls contends that the state has a moral obligation to obviate preventable and unjust social factors which delimit a person's opportunities to realize self-respect (in other words, there is an obligation to address inequities).

Rawls also outlines two lexical principles in his conception of justice: the equal right to basic liberties and distributive justice, also described as the Liberty and Equality Principles, respectively. The latter principle, in particular, is important to a discussion of dental pain, as it contends that all individuals should have a fair equality of opportunity in a just society; it is reasonable to expect that, all things being equal, individuals will have the ability to minimize dental pain and its negative consequences. Furthermore, Rawls' Difference Principle, a precondition to the Equality Principle, requires that inequalities are permitted so long as they most benefit the least advantaged members of society, or the worst off. However, Canadians and Americans who need the most dental care tend to receive the least, a phenomenon analysts call the 'inverse care law' and attribute to the overwhelmingly private nature of financing and delivering care (Dehmoobadsharifabadi et.al., 2018).

In the first section of our paper, we contend that inequalities pertaining to dental pain violate the principle of fair equality of opportunity as set forth by Rawls. Next, the implications for the 'social bases of self-respect' are discussed. Then, using Rawls' Difference Principle, we turn to the role of the dental profession in perpetuating and entrenching inequalities by highlighting its institutional failure to mitigate such inequities. We conclude that the current distribution of dental pain in Canada and the United States breaks with the principles set out in Rawls' conception of a just society, again pointing to the important stewardship role of the dental profession.

Dental pain and its implications for equal opportunity

Rawls' conception of justice is guided by his perceived failings of utilitarianism (as advanced by Locke, Bentham, and Kant, amongst others), arguing that justice denies that 'the loss of freedom for some is made right by a greater good shared by others' (Rawls, 1971, p. 3–4), and that justice does not allow 'that the sacrifices imposed on a few are outweighed by the larger sum of advantages enjoyed by many' (Rawls, 1971, p. 4). Instead, Rawls defines justice as 'a characteristic set of principles for assigning basic rights and duties and for determining what they take to be the proper distribution of benefits and burdens of social cooperation' (Rawls, 1971, p. 5).

Rawls' theory importantly includes the Equality Principle, which states that: 'social and economic inequalities are to be arranged so that they are [. . .] attached to offices and positions open to all under conditions of fair equality of opportunity' (Rawls, 1971, p. 302). It maintains that citizens with the same talents must have the same opportunities regardless of economic or social environments. In fact, Rawls suggests that any social advantages obtained through chance – by birthright or natural endowment – are actually unfair (Rawls, 1971, p. 72). In this regard, it is important to emphasize the difference between health inequalities, which refer simply to differences in health without ascribing moral pretense, and health inequities, which are differences in health that are unnecessary, avoidable, unfair and unjust (Whitehead, 1991).

Rawls recognizes that people's perceptions of entitlement – and so too of justice or fairness – are inevitably shaped by their own backgrounds and interests. Given this, Rawls maintains that his principles must be observed in the 'original position' (Rawls, 1971, p. 17), a thought experiment requiring that parties develop the systems of a fair society while situated behind a 'veil of ignorance' (Rawls, 1971, p. 136) where they do not know what social position and thus what

benefits they will hold in society. This, Rawls contends, lays a foundation which offers each person a fair chance to pursue what he describes as the good life.

A person's basic human liberties are directly connected to their fair chance of opportunity and their autonomy (Cherry, 2014), yet any form of suffering surely undermines a person's right to self-governance (Palpant, 2014). Given this, it is important to consider the crippling effects of dental pain on a person's quality of life. Dental pain can limit food choices and alter sleep patterns, even leading to damaged social relationships and depression (Health Canada, 2011). Dental pain thus restricts a person's ability (or opportunity) to fully participate in aspects of life that can provide meaningful satisfaction.

There are also those who contend that what holds the most meaning for people is their freedom to function in characteristically human ways, or what can be termed *capabilities*. Nussbaum (1992), for instance, suggests that a just society must guarantee each person the freedom to carry out the basic human functions necessary to fulfill a human life. Sen (2006), in contrast, argues that different individuals may be more or less capable of enjoying particular freedoms, but good health is ultimately foundational to the opportunity to do so.

Given this, the state must have a role in guaranteeing that individuals have the resources to achieve good health by removing the 'the physical, mental, and social handicaps of illness, disease, pain, and disability' (Cherry, 2014, p. 340). Sen's most basic functions consist of adequate nourishment, overall health, and avoiding premature death, all of which can be compromised, albeit to varying degrees, by the experience of dental pain. Sen's more composite examples of functioning include less measurable experiences: being happy, having self-respect, and community participation. There can be little doubt that dental pain negatively impacts on these critical life functions: those suffering with chronic and untreated dental pain are less likely to smile, laugh, or relax; more likely to experience greater difficulty when eating, speaking, or socializing; and, overall, indicate a general reduction in life satisfaction (Settineri et.al., 2017; Svensson et al., 2018). In short, dental pain can have debilitating effects on a person's autonomy and ability to function in characteristically human ways, thereby restricting their pursuit of the good life.

The social bases of self-respect

Rawls considers the concept of self-respect integral to a person's pursuit of the good life. According to Rawls, self-respect is a primary social good – something that every rational person is presumed to want (Rawls, 1971). Specifically, Rawls believes that self-respect is critical because it reflects a person's feeling of self-worth: '[w]ithout [self-respect], nothing may seem worth doing, or if some things have value for us, we lack the will to strive for them. All desire and activity become empty and vain, and we sink into apathy and cynicism (Rawls, 1971, p. 440).

Building on this, DeGrazia (1991) argues that self-respect is tied to a person's perception of disrespect from others. He asserts that the provision of health care to those in need improves their self-respect not by restoring or protecting their opportunity or well-being (though it may do so), but by demonstrating a social commitment to one another. Hoffmaster (2014) echoes this sentiment, suggesting that the loss of dignity caused by indifference and apathy is amongst the worst forms of human suffering.

And yet, those who are worst off are required to navigate uniquely challenging obstacles to receive appropriate and timely care for tooth pain. For instance, those with lower incomes, less education, and less job security report far greater financial, geographic, transportation, and language barriers when accessing dental services (Freeman, 1999). These problems compound the injustice of existing differences in oral health among social groups. Surely, a dental care system in which access to treatment is unreasonably challenging for those who are already worse off contributes, at least in part, to existing oral health inequities.

Despite this, both clinicians and the general public too often attribute inequalities to individual failings, minimizing or dismissing entirely the impact that social factors may play in shaping

a person's health status (Watt, 2007). By doing so, mutual responsibilities are abdicated, and a pattern of indifference and apathy towards those in need is exhibited. Indeed, a restricted focus on 'lifestyle' interventions amounts to a form of 'victim-blaming' (Watt, 2007), by ascribing structural and collective problems of the entire society as manifestations of behavioural failures or character deficiencies.

Rawls argues that such excuses damage a person's self-respect by inducing feelings of shame:

> Some virtues are joined to shame in a special way, since they are peculiarly indicative of the failure to achieve self-command and its attendant excellences of strength, courage, and self-control. Wrongs manifesting the absence of these qualities are especially likely to subject us to painful feelings of shame [...] we are struck by the loss to our self-esteem and our inability to carry out our aims: we sense the diminishment of self from our anxiety about the less respect that others may have for us and from our disappointment with ourself for failing to live up to our ideals (Rawls, 1971, p. 446)

As long as these gross inequities are tolerated with social inaction, we collectively condone injustice.

The difference principle and dentistry's social contract

Rawls' Difference Principle maintains that in a just society, 'social and economic inequalities are to be arranged so that they are to the greatest benefit of the least advantaged group' (Rawls, 1971, p. 302). Rawls suggests that this principle effectively forms a rudimentary social contract by developing a system whereby the distribution of resources favour those who suffer most. Importantly, a social contract in the professional world is an unwritten and dynamic agreement between a profession and society, in which society is assured the services of the healer (that is, an expert who will treat the sick and those suffering ill-health), along with their competence, altruism, morality, accountability, and promotion of the public good. Health professionals, in turn, are granted trust, autonomy, self-regulation, a monopoly, participation in public policy, and elevated social status (Cruess, 2006).

Welie contends that a professional status can only be granted as *part* of the 'social contract,' with several criteria required for the designation, including: 'high levels of expertise, virtuousness and trustworthiness (Welie, 2004, pp. 529–530). Indeed, the hallmarks of professionalism includes rigorous training, demonstrated competence and aptitude, and professions are further differentiated from occupations through codified moral and ethical standards and pledged altruism (Welie, 2004).

Yet, Bertolami (2004) argues that altruism is absent in much of the dental community. While this claim may be a harsh generalization, there is certainly a general reluctance among dentists to routinely treat those who experience the greatest burden of disease and dental pain in our society: the geriatric population, those with special needs and cognitive disabilities, and those living in poverty, for instance (Locker et.al., 2011). While there are many explanations for this behavior, one could argue that it is an inevitability in a system which naturally privileges those who are better off and have the ability to pay for care. This is exactly the nature of the tension in dentistry as a commonly-viewed propriety versus a regulated health profession *qua* its social contract (Nash, 1994).

Indeed, Welie claims that the roles and responsibilities of a professional are simply incompatible with the ethos of a businessperson (Welie, 2004). Welie is careful to note that business people can be highly moral and ethical in both their private and public lives. He simply contends that the foundations of professionalism are mismatched with the guiding principles of a business. Nash (1994) further argues that this has led to a growing tension between the proprietary and professional cultures of dentistry. What is more, as the profession becomes increasingly viewed as a commodity, those with the means to afford necessary or elective treatment receive deference to other groups (Quiñonez et.al., 2009).

As such, Rawls' Difference Principle is contravened by the existing dental care system which has been shaped and maintained through organized professional resistance to the entry of other

modes of delivery or alternative providers (Quiñonez, 2013). Granted, dental professionals frequently offer *pro bono* work to those who are worst off, and a majority of dentists even support tax incentives to encourage greater levels of *pro bono* care for marginalized communities (Quiñonez et al., 2009). However, some contend that acts of charity simply mask system failures, allowing people to tolerate systems that would otherwise be considered unacceptable (Robinson, 2018). Thus, charity is not a substitute for altruism. Altruism, in the context of a social contract, is not an elective choice, but an obligation that binds each and every member, individually and collectively. Social contracts are institutional arrangements that play out at the individual level, and as such, reflect what dentistry as a profession privileges and accepts from its members. Thus, the power and responsibility to redress these ills lies both with the individual dentist and the profession as a vessel of organized representation (associations, regulators, etc.).

In his original position, Rawls imagines the social contract is developed by rational people behind a veil of ignorance in which 'no one knows his place in society, his class position or social status' (Rawls, 1971, p. 137). It challenges those who have been ascribed elevated status and power in society to imagine a world in which they are considerably less advantaged, and to design a social system in which they feel their needs would be adequately met regardless of their circumstances. Surely, the existing dental care system, given its inequities and obstacles to care for so many, would scarcely find support among dentists behind a veil of ignorance.

Policy implications and conclusion

This paper explored the injustice of dental pain from a Rawlsian perspective. Our arguments strive to engage dentists, other health professionals, government officials, social activists, and indeed, the general public, to resituate the discussion of oral health away from a misguided focus on personal responsibility towards a more comprehensive approach to addressing the structural issues that influence dental health. To some extent, our discussion of dental pain is limited in that it fails to include normative conceptions of health or self-governance – for instance, the ethical and professional considerations of treating those with advanced dementia or severe cognitive impairments. As well, although we draw on a host of international literature in our analysis, our arguments are most relevant to societies that primarily rely on the market to distribute social goods, individualizing problems that require a collective response.

The Canadian and U.S. context is critical in this regard, as inequities become exaggerated within these societies, as they tend to privilege individual responsibility over health, and support systems of dental care that are almost exclusively financed and delivered through private means. Certainly, it is known that dentists and the dental profession have strongly advocated for this system (Quiñonez, 2013), and thus hold responsibility for systematically addressing inequities of oral health moving forward. However, society is also partly complicit with the profession, in that broader society has permitted (and frankly, enables) the social determinants of health to exist as they do. A renewed social contract must therefore involve resolve from both parties to create a fairer and more equitable society.

While Rawls does not specifically identify a place for health or pain in his theory of justice, his conception of a just society necessarily includes freedom from unnecessary pain and access to the resources required to minimize suffering. Ultimately, given the implications of dental pain for a person's dignity and self-respect, their opportunities to fulfill the good life, and their ability to function more broadly, providing the means by which a person can improve their oral health is an imminent professional and social responsibility.

Ethical Statement

Our study is a theoretical and philosophical exploration of dental pain as a social phenomenon. According to Article 2.2 of the Canadian Tri-Council Policy Statement (TCPS) regarding ethical conduct for research involving human

participants, our research project does not require ethics clearance provided by a Research Ethics Board (REB) as no human participants were included in its design or conception.

Disclosure statement

No potential conflict of interest was reported by the authors.

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