Building Moral Communities?
First, Do No Harm

Shafik Dharamsi, Ph.D.

Abstract: As concern for the oral health of vulnerable populations grows, dentistry continues to seek effective ways to respond. In August 2005, Dr. Donald Patthoff and Dr. Frank Catalanotto convened a national workshop at the American Dental Association headquarters on the ethics of access to oral health care. A series of papers were produced for the workshop and subsequently revised for publication. This one responds to the paper by Dr. David Chambers on moral communities and the discursive imperative for building community and consensus around issues affecting equitable access to oral health care. I explore three interrelated issues that ought to be considered when endeavoring to build moral communities: 1) the problem of power relations—a fundamental constituent within discourse that can impede constructive efforts; 2) the discursive disconnect between theoretical ethics and social constructs affecting dentistry; and 3) the bioethical principle of nonmaleficence as a priority in the desire for building moral communities. In essence, this article responds also to the call from ethicists who see a significant need for substantive interdisciplinary contributions to inform how people at different social levels react in ethically problematic situations in its broad social context.

Dr. Dharamsi is Assistant Professor, Global Oral Health and Community Dentistry, Division of Preventive and Community Dentistry, and Associate Director of the Center for International Health at the University of British Columbia. Direct correspondence and requests for reprints to him at the University of British Columbia, Faculty of Dentistry, 2199 Wesbrook Mall, Vancouver, BC, Canada V6T 1Z3; 604-822-7288 phone; 604-822-6989 fax; shafikd@interchange.ubc.ca.

Key words: access, ethics, vulnerable populations, discourse, framing, power, social constructs, nonmaleficence

In August 2005 various stakeholders came together at the American Dental Association (ADA) headquarters to discuss the ethics of access to oral health care in relation to professional and social responsibility, social justice, codes of ethics, and how to educate better the next generation of health providers to address related issues. A series of papers were generated and subsequently revised for publication. This one responds to David Chambers’s robust thesis on building moral communities and the imperative of open and honest communication for developing community and consensus on issues that affect them.1 Chambers provides us with a much needed foundation for dialogue and community building.

Moral communities are those that share ethical concerns, value pluralism, have a keen sense of social responsibility, and strive for a broader moral identification and sense of duty beyond social, economic, cultural, or political differences. I accept Chambers’s thesis that good communities need to build discursive relationships if they are to reach consensus around issues that have divided them generally. He argues well that to build moral communities requires a keen awareness of the impact of coercion and misrepresentation, the import of rhetoric on building ethical communities, and the value of persuasion if done well and done honestly.

I offer for consideration three interrelated factors that can have a profound effect on building moral communities: 1) challenges posed by power relations embedded in discursive and framing practices—I argue also that understanding discourse from the vantage of postmodern social theory is crucially important for addressing ethical quandaries affecting disparities in health; 2) the disconnect between ethical theories and social constructs affecting dentistry; and 3) the duty to consider the bioethical principles of nonmaleficence and beneficence as a fundamental constituent in building moral communities.

Dentistry and Vulnerable Populations

As concern for the health of vulnerable populations grows, dentistry continues to seek effective ways to respond. Vulnerable populations, acknowledges the ADA, “are often limited by physical disabilities, illness, poverty, and other socioeconomic conditions that impede their access to needed care.”2 In their detailed examination of the inequities in health and health care experiences among vulnerable populations, Shi and Stevens provide a broad definition of vulnerability to include various social, economic, political, environmental, or biological conditions that prevent people from protecting their own needs and interests.3 Vulnerable populations tend to experience worse health outcomes, they face bar-
Discourse, Framing, and Power

In his thesis on moral communities, however, Chambers avoids the power dimension of discourse.12 It is a concept that emerges in the scholarship of several notable educators and social scientists.13-19 Discourses play a significant role in articulating, preserving, and enforcing relations of power in society. Discourses affect all social institutions and are adopted and adapted in ways to allow us to make sense of our actions and reasoning and to actively shape and order our relationship to the social world. It is a concept that is reflected also in the theory of framing: the use of language to fit a particular worldview and serve to structure how we define, interpret, and understand reality.20 Framing, explains Entman, “is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation.”21 Take the terms “pro-life” and “pro-choice,” for instance. The implications embedded in them are quite powerful. Those who embrace “pro-life” take a determined moral position against abortion. The term “pro-life” implies that its opponents are “anti-life” or “pro-death.” No one wants to be labeled as “anti-life,” hence the emergence of “pro-choice,” a counter-frame. The same can be applied to “dental auxiliaries” versus “allied dental professionals” or “radical” versus “innovative.” In essence, we do not speak a language more so than it speaks us. Those who study discourses and framing focus on vocabularies of speech or writing and their implications in social relationships. They examine how speech embodies the beliefs, values, and categories that constitute a way of looking at the world and experiencing the world and how, within the communicative context, particular ideas are reified. They study how discourses and frames reflect prevailing ideologies, values, beliefs, and social practices and how they inevitably permit certain claims while marginalizing others.

Apartheid provides an obvious and pointed example. Those who observe its tenets have come to view their practices as part of common sense. They hold a dominant place in society and have the power to frame the issues at stake. They interpret as legitimate their conceptions of how society works or should work, and they talk about and act in that society in determined ways, embedding their ideas in various social, political, legal, and economic institutions and accepting unreflectively that who they are and what they do are natural and true. It is a socially constructed reality.22 Their discourses and ways of framing issues and related practices become hegemonic and harmful as they promote unreasonable but dominant ideas and activities as normal.

Discourses and frames are not casual or transient; they are determined and prescribed. The language is powerful and expressed through strong and confident voices belonging to those who hold privileged positions in society and who have developed a legitimacy to speak and to be heard. Not all members of the community are given or can assume this privilege or have the opportunity to respond; it depends on the standing one has within a community. Those who can and do control the discourse have a protected place at the table and have the power to define the position of others. Chambers suggests, however, that the many differences in common sense values can be negotiated in the process of building moral communities.1 Nevertheless, the direct and indirect influence of framing can have a significant impact on the negotiation and its outcome. In dentistry, for instance, mostly professionals have tended to occupy seats at the decision table, and they have controlled the discourse on how issues of access are...
framed and how the oral health care system should be structured. When building moral communities, this is a factor not to be overlooked.

Chambers proposes also that we ought to be concerned first with the process we engage in for talking, even before we consider the moral weight of the topic of discussion. The emphasis at this stage is on how different groups come together to talk. The process is meant to facilitate mutual consideration of proposed alternative meanings for various intentions and actions that matter. For this to happen, however, all of the stakeholders have to have a place at the negotiating table, including the voices of those historically silenced. In addition, those who have historically controlled the discourse need to acknowledge this from the outset, and they need to take an active role in creating a more equitable system. This is an essential step for building moral communities and a shared and mutually beneficial agenda. Most importantly, the process cannot remain oblivious to the principle of nonmaleficence; in fact, the process must also embrace beneficence.

The Disconnect Between Ethical Theory and Practice

There is growing discussion using various principles of social justice in efforts to consider equitable policies and distribution of health services. Although discussions about equity, accessibility, and justice are beginning to encourage broader thinking around the delivery and scope of oral health services, there are concerns among some educators, policymakers, and practitioners that this is not translating effectively into permanent and sustainable change in everyday dental practice settings. In relation to issues of access and care for vulnerable populations, there is an observable and acutely felt disconnect between theoretical bioethics and the professional, socioeconomic, and political factors that influence dentistry. For example, patients on social assistance historically have in many instances felt unwelcome and have been rejected by some dental and medical practices. The literature is replete with other matters bringing to light the professional, political, and economic factors that can and do influence decisions on who deserves what, how much, and who has the power to decide—issues that conventional theories in ethics do not adequately consider.

As Weisz points out, theorists, when examining complex situations, “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 judgments.” Without opportunity for practical social applications of theoretical ethics, dilemmas and conflicts are more likely to remain unresolved, and moral communities can become increasingly difficult to build.

November 2006 ● Journal of Dental Education
Moving from Discourse to Practice: First, Do No Harm

While dental professionals and governments continue to debate issues of access or other social determinants of health, there are communities waiting for care, and they have not been invited to the debates to voice concerns and to be heard. Yet, if the issues are to be addressed effectively and ethically, there must be a genuine willingness to understand and ultimately resolve differences through a truthful cooperative discourse and toward a consensus moral view among all of the different stakeholders. Moreover, discussions cannot be oblivious to paternalism, and most importantly, we cannot ignore harm.

The bioethical principle of nonmaleficence is a tenet that is accepted and respected in most communities of professional practice—first, do no harm! It is not about a mere theoretical discussion of harms. The widely accepted imperative in dentistry to do no harm is not only about a negative duty of nonmaleficence; it is also about a positive duty of beneficence, positioned within fiduciary obligations vested in the health and human service professions generally. It seems untenable, therefore, to remain at ease about harm while building moral communities. If we allow harm to continue while we are in discussions and negotiations about social, political, and economic differences that divide us, then we have in fact ignored the principles of nonmaleficence and beneficence that most learned professionals hold sacrosanct.

There are other examples. A poll of 4,000 Canadian dentists in the late 1990s found that 16 percent would not see people with AIDS; 37 percent would not see patients with Hepatitis C; 18 percent would not see homosexuals; 35 percent would not see patients who inject drugs; 18 percent would not see people with STDs; and 10 percent would not see patients who have had blood transfusions. Factors associated with refusal to treat were associated primarily with lack of ethical responsibility and fears related to cross-infection. As this survey was taking place, patients in dire need of dental treatment continued to go untreated. To address this problem of nontreatment, we may next want to bring the various stakeholders to the negotiating table in search for principled as well as practical solutions. Again, during these discussions, patients will go without treatment. What is different in this case, however, is that unlike issues of access to care due solely to socioeconomic factors, those providers who do elect to treat do so in fear despite the risks of medical harm to themselves. There is little evidence to suggest that dental ethics in practice has managed to address these difficulties. One might argue that, first and foremost, dentists have a professional duty to treat as well as the duty to protect patients from harm that may arise because of a failure to treat.

Health care providers, it can be argued, enter their professions knowing the risks, just as do firefighters and police officers, who do not have the liberty to choose whether they will attend to a particularly bad fire nor the liberty to select the type of criminals they will deal with. While these are obvious assertions for some, as Levine duly points out, “one cannot argue coherently that there is a duty to be unafraid...one cannot coerce empathy.” These are complex situations and do not lend themselves easily to conventional or normative solutions.

When building moral communities, therefore, we need to determine if socially constructed differences that divide stakeholders are avoidable. Surely, interpretations of inequity and fairness are not solipsistic and without common ground so that they cannot be carefully assessed within the context of shared principled practices in society generally. Yes, there are divisive differences that are inevitable (biological variations, for example); however, there are differences that are avoidable and therefore unacceptable. According to Whitehead, inadequate access to health care and social services is an example of what is unnecessary and objectionable. Inadequate access to care contributes to further socially disadvantaged already vulnerable populations. It is within this context that the tenet of first, do no harm carries significant weight.

In Closing

Responding to issues affecting oral health disparities and promoting equity for vulnerable populations requires an understanding of context, discourse, framing, power, and the communities within which the problems manifest. When issues of access to care confront political opposition, especially in highly polarized political environments, we need to be aware of the frames that are used to sway public opinion and to perhaps introduce and scrutinize appropriate counter-frames in an effort to communicate on a more level playing field. Building moral communi-
ties requires communicating with open cards—an exercise that seeks consensus in ways where no one is undermined. The challenges we need to address during this process are the inevitable elements of power, the disconnect between theoretical ethics and social constructs, and the risk of ignoring the tenet first, do no harm, all of which can militate against the process of building moral communities.

Both Chambers and I have endeavored to respond to the call from various ethicists who see a significant need for substantive interdisciplinary contributions to inform how people at different social levels react in ethically problematic situations in its broad social context. The intent of this article is to help all those who deal with health care systems and health disparities to begin to appreciate and address some of the broad social constructs that influence the issues and to appreciate the significance of postmodern social theory in understanding the production, maintenance, and change of how things work or ought to work.

REFERENCES
33. Canadian Association of Public Health Dentistry. The need for an examination of, and recommendations to address, inequities in oral health and access to oral health care in