

Some orthodontists' experiences of volunteering for a community orthodontic initiative

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Introduction: In society, dental professionals, including orthodontists, are often viewed as being solely motivated by money. Nevertheless, numerous orthodontists volunteer for community initiatives where they provide free or heavily subsidized treatment for underserved populations. This study explores the motivations of a group of New Zealand orthodontists who volunteered for one of these initiatives, Wish For A Smile (WFAS), as well as the high and low points of this work. **Methods:** Qualitative telephone interviews were conducted with 11 orthodontists who volunteer for WFAS. An inductive data analysis of the data was undertaken and a descriptive qualitative method was chosen. **Results:** Most participants volunteered for WFAS because they desired to give back to the community. High points of their voluntary work were seeing patients' self-esteem, happiness, and future life chances increase as a result of treatment. Low points included seeing the challenging life circumstances of some WFAS patients and treating some adolescents who appeared not to qualify. A number of participants said WFAS patients were more grateful and cooperative than fee-paying patients, whereas others reported the opposite. **Conclusions:** There are many reasons why orthodontists volunteer for orthodontic community initiatives, although many may be motivated by a sense of social responsibility to give back to the community. (Am J Orthod Dentofacial Orthop 2019;155:552-9)

The increasing costs of dental and orthodontic treatment may lead to lower-socioeconomic-status (SES) families “missing out.”¹ For example, only one-fourth of dentists in the United States treat Medicaid patients, owing to reimbursement rates that are much lower than those of private insurance or fee-paying patients.²

Similarly to the United States, in New Zealand (NZ) orthodontic care is primarily fee-for-service (although the government does fund orthodontic treatment for some congenital conditions, such as cleft lip and palate³). There are no set limits on the fees orthodontists can charge and no demarcation of the severity of malocclusion that orthodontists should treat.³ Within this market-driven model of orthodontics, many

adolescents from low-SES backgrounds miss out because their families can not afford treatment.^{1,3} For example, one study undertaken in a financially disadvantaged region of NZ found that low-SES adolescents were less likely to seek orthodontic care after being advised by a dental professional that they needed it.¹ Another study found that lower-SES adolescents did not seek orthodontic treatment to the same extent as their more affluent counterparts, which the authors attributed to cost.⁴

There is a strong link between malocclusion and bullying, low self-esteem, social isolation, and school underperformance.⁵⁻⁷ Because a “nice smile” can affect a person's perceived attractiveness, popularity, and employment chances, an untreated malocclusion can have long-term negative impacts on an adolescent's quality of life.^{5,8}

Currently, there is a drive within dentistry to help address the oral health inequities experienced by disadvantaged populations.⁹ However, it is still common for dental training institutions not to include any material on social responsibility in their curricula, although many encourage students to volunteer for community dental initiatives with underserved populations.^{10,11} As part of their training, orthodontists will have likely

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participated in one or more health community initiatives with underserved populations. Participating in such initiatives does not necessarily ensure that dental professionals graduate with a desire to give back to the community.¹² Nevertheless, Dharamsi et al⁹ maintain that health professionals take “pride in offering a public service that promotes the public interest and the common good” (p. 326). This notion of promoting the common good or, alternatively, practicing social responsibility, may explain why numerous orthodontists in NZ and overseas volunteer for orthodontic community initiatives, such as Wish For A Smile (WFAS; NZ), Give Kids A Smile (USA), and Give A Smile (Australia).

Wish For A Smile is an orthodontic initiative where members of the New Zealand Association of Orthodontists (NZAO) volunteer to provide orthodontic treatment for adolescents from low-SES backgrounds. In return, adolescents (11 to 15 years old at time of application) must complete 20 hours of community work. Adolescents and caregivers also need to write a letter of application to WFAS in which they outline why they or their child desires orthodontic treatment. Caregivers must provide a summary of their weekly expenditure and contribute a small weekly amount toward treatment. All applicants need to have their malocclusion rated as severe by a dentist or other oral health practitioner.

The present article aimed to document the motivations of a group of NZ orthodontists who volunteer for WFAS and to explore the high and low points associated with this voluntary work. A further aim was to report how the orthodontists experienced working with WFAS patients. The following research questions guided the study:

1. What motivations do orthodontists have for volunteering for WFAS?
2. What are the high points and challenges associated with this voluntary work?
3. What experiences do orthodontists have with WFAS patients?

It is necessary to define the term “social responsibility,” which is used in this study. Brondani¹¹ defines social responsibility as “one’s sense of duty to the society in which one lives” (p. 609). Practicing social responsibility is closely aligned with professional attributes such as altruism and ethics^{2,13} and helps to bolster patients’ trust in the oral health professions. The term “social responsibility” is used here to explore why orthodontists volunteer for WFAS. For example, do they volunteer out of a sense of professional responsibility, in a feeling of social responsibility, or for personal or altruistic reasons?

MATERIAL AND METHODS

After receiving ethical approval in mid-2017 (University of Otago Ethics Committee reference 17/117), orthodontists who volunteer for WFAS were contacted via e-mail, and 11 agreed to participate. This was a purposive sample selected to ensure that at least 1 participant from New Zealand’s major cities and larger towns was represented. Qualitative telephone interviews were selected as the method of data collection because of their ability to stimulate detailed responses.¹⁴ Given that potential participants who volunteer for WFAS are geographically spread throughout NZ, telephone interviews were conducted. The initial interview schedule contained a number of semistructured questions designed to elicit detailed accounts of participant’s WFAS work. After gathering each participant’s informed consent, the first author conducted the telephone interviews, which were audiorecorded and lasted approximately 20 to 40 minutes.

The first step in the data analysis involved the first author immersing herself in the data by reading through the transcripts numerous times.¹⁵ As she was reading she was also identifying initial themes evident in each participant’s as well as across participants’ responses.¹⁵ The identification of themes was further influenced by the research questions guiding the study and the interview questions. Emergent themes were listed and specific excerpts that illustrated these themes were coded.¹⁵ Excerpts that ran contrary to these themes were also coded to ensure a more accurate account of the participants’ responses.

The findings are presented with the use of a descriptive qualitative approach, which is a commonly used method when researchers wish to engage their readers, as well as have them relate their experiences to the chosen topic.¹⁶ This approach was selected because of the scarcity of literature focusing on orthodontists’ volunteer work, as well as a desire for readers to relate their own voluntary work experiences with those of the participants. As a condition of ethics, participants were given the option of being named in the research or having their identity disguised. Some of the names used in the results are the participants’ real names and others are pseudonyms.

RESULTS

Demographic information on the participants, including sex, type of practice, years volunteering for WFAS, and the number of patients treated through the initiative are reported in [Table 1](#).

More than half of the participants said that they volunteered for WFAS out of a desire to give back to the

Table I. Demographic information on the participants

Participant	Sex	Practice type	Years of practice	Years volunteering for WFAS*	Patients treated through WFAS
Jane	F	Urban group practice	4	3	1
Kirsty	F	Rural group practice	13	6	4
Bob	M	Urban group practice	19	6	4
Andrew	M	Rural group practice	16	6	9
Steven	M	Urban corporation practice	23	4	10
Lisa	F	Urban sole practice	6	6	4
Mary	F	Urban group practice	10	4	9
Kevin	M	Urban contracted to corporation	34	No longer volunteers	1
Linda	F	Urban group practice	8	2	1
Ron	M	Urban and rural sole practices	31	6	5-6
John	M	Urban sole practice	38	6	4

*Participants volunteering for 6 years have been volunteering since the inception of WFAS.

community. For example, “It’s a nice way of giving back to the community” (Kirsty), “wanting to do good for the community” (Jane), “I think it’s good to do your bit for the community” (Andrew), and “It’s giving something back to the community” (Lisa). Of these participants, 2 made comments indicating that they felt a professional obligation to give back to the community, specifically to those unable to afford orthodontic care. For example, Steven said, “I think to some degree there is an obligation to provide services to people who can’t afford it.” John also reported that he felt a sense of professional responsibility to volunteer for initiatives with low-SES groups:

I do it off my own back but ... I see it as a professional responsibility, too, to be involved with the community in a broader sense. I mean orthodontics is how I make my living and it’s how ... I fund my very fortunate lifestyle. But I feel a responsibility to help other people ... who are less fortunate.

Moreover, John stated that although WFAS is beneficial for low-SES families, it was also good for raising the public profile of orthodontists:

It’s a worthwhile thing to do for the poorer section of our ... people. And it’s ... also been a very good part of our publicity campaign. It’s been perhaps the most important thing that we’ve done as far as public awareness of what we do.

Other participants who said they volunteered for WFAS out of a desire to give back to the community reported that this voluntary work was more akin to a personal choice, which they associated with favorable qualities including helpfulness and caring. For example:

Lisa: I was bought up to ... give back and help others that need help ... and I don’t think everyone can afford to have orthodontic treatment so it’s nice to do something for those who can not.

Although Lisa framed helpfulness as a personal quality, Mary and Kevin suggested that orthodontists volunteer for initiatives such as WFAS because they are generally caring people. At the same time they, like John above, mentioned the financial aspects of their chosen profession. Although Mary’s and John’s comments specifically refer to receiving “fortunate” or “good” lifestyles from their chosen career, Kevin’s comment is more ambiguous:

Mary: I think that probably the nature of most of us that do it ... we’re sort of caring people and we do want to give back to the community ... we’ve got a good lifestyle from it and ... we know it makes a difference so that’s why we want to do it.

Kevin: I think we [volunteer] off our own back ‘cause ... it’s a lovely job to have even if we’re getting paid for it because we’re taking care of people ... the wonderful thing about it is it’s intellectually very interesting ... and ... everyone likes to take care of people in one way or another.

Despite more than half of the participants explaining that they volunteered for WFAS out of a desire to give back to the community, there were other motivators. Andrew explained that he volunteered “out of respect for the people who established [WFAS].” He went on to explain: “[These] are people ... who I’ve got a lot of time for ... and if they take the time and effort to go to setting up something like this ... I feel obliged to support it.” Linda stated that she liked the idea that those accepted for treatment through WFAS must engage in community work in return for their treatment. She framed this as a form of “paying it forward ... to someone else.” Bob stated that although he had no “particularly reasons” for volunteering for WFAS, he did so because he considered it was “the right thing to do.”

Moreover, all but one of the participants said that they treated some low-SES adolescents under other community health initiatives, on a pro bono basis or that their clinics had systems in place whereby low-SES families could repay the costs of orthodontic treatment at minimal cost over an extended period. For example:

Jane: I've ... previously had a patient whose friend ... wanted braces but ... she couldn't afford it. So ... I said ... I'm happy to do it for half price ... and I ... waive the exam fee and I always try to give them a payment plan.

Nevertheless, Linda said that she was unable to provide subsidized treatment because of her recent employment in an established partnered practice.

All the participants said that they did not treat WFAS patients any differently to fee-paying patients, because "they did not want to stigmatize them" (Mary) or treat them "better or worse" (Andrew) than other patients. The participants also commented that there was variation in WFAS patient's cooperation, which they attributed to the individual personalities. In other words, the participants described their experiences with WFAS patients as being a "mixed bag" (Lisa).

In stating this however, several participants reported that there were some general differences between WFAS and their fee-paying patients. Five participants commented that WFAS patients or their parents were generally more grateful than fee-paying patients. For example, "we notice it particularly ... with the parents ... who are so grateful ... that they're able to receive this treatment through WFAS" (John). Of these 5 participants, 2 said that they considered WFAS patients or their caregivers to be more grateful and cooperative than fee-paying patients because they had to "earn" their treatment. For example:

Kirsty: They really are incredibly grateful and so are their families ... they are very, very compliant ... nothing is a problem. If they're told to wear elastics all the time, they will wear elastics ... If they're told to brush more, they will brush more ... I think that comes from the process they have to go through with earning a WFAS position.

Bob: These patients are really ... appreciative of what you're doing, so ... they'll be a little bit more involved perhaps in their treatment and a little bit more enthusiastic, more compliant ... than maybe your average patient ... who get dragged in here against their will ... they've had to work for it, perhaps realize that it's ... an opportunity for them ... so ... they tend to be a little more appreciative.

Andrew and Mary also reported that, although WFAS patients were often extremely grateful for their treatment, their life circumstance may make it harder for them to maintain good oral hygiene and regular clinical attendance.

Andrew: Because of their personal situation, they're often carrying extra burdens. So it means they might not be ... the best toothbrushers and they might miss out on appointments ... but generally that's ... because ... there's all this other stuff going on.

Mary: The reality is for some of these families, that getting [to] appointments can be a logistical thing 'cause if the car does not start ... there may not be money to get a bus ... Life's complicated for some of these families.

In contrast, Lisa said that WFAS patients were generally "more prone to breakages" than fee-paying patients. Similarly, Ron stated that WFAS patients were less cooperative and prone to breakages.

Ron: Cooperation and breakages ... they're not my super patients ... You have parents that pay a lot of money, between 7 and 8000 dollars for a treatment, they tend to give support to the kid, they motivate the kid. And if you've got people from a lower socioeconomic status, they don't have that kind of family support sometimes ... they have to do without their family support that's so necessary for a successful orthodontic treatment.

All but one participant (Ron) reported that they found their WFAS work rewarding. However, Ron said that he did not distinguish between the rewards he experienced from treating WFAS and fee-paying patients. The remaining participants made similar comments, in that seeing their WFAS patients' self-esteem and happiness increase as a result of orthodontic treatment was rewarding. For example, Kirsty, talking about WFAS patients in general, and Jane, mentioning a particular WFAS patient, said:

Kirsty: Feeling [the patients] being so delighted as they see the changes starting to occur ... and then removing their braces and them seeing the finished result ... they're often in tears. It's really, really lovely.

Jane: I think you always get a high ... helping people and ... seeing them appreciating it. And ... throughout the process ... she's obviously noticing a change and ... seeing her happy with how things are progressing. It's always ... making us happy.

Mary and Andrew stated that seeing a patient's happiness and future life chances increase as a result of receiving treatment was particularly rewarding. Andrew linked a brighter future directly with being accepted for treatment through WFAS.

Mary: Seeing that transformation of becoming young people that you can see are going to have ... a good potential future ... they've not got something that's going to set them back and ... I can definitely remember ... just watching them become comfortable young adults.

Andrew: You know seeing a kid ... who would not have got the treatment elsewhere ... and ... it's made a difference ... further down the track, you see that they are doing really well in life.

Nine of the 11 participants also reported that there were low points that accompanied their WFAS work (2 participants said that there were no low points). Unlike the rewards mentioned above, which were primarily similar, the low points were more varied. Two participants said that not receiving the desired treatment outcomes for some WFAS patients was disappointing.

Bob: Given the malocclusions that we're faced with, sometimes not getting quite what you're hoping to get would be ... a low point for me ... in other words ... you embark on ... treatment, but for whatever reason, what you thought your end point would be, [you] did not quite get there ... not achieving the desired outcome.

Andrew: I think probably that, making slight compromises on cases that ... have severe skeletal discrepancies and ... were really surgical patients ... We were treating to a comprised situation right from the start.

Jane and Mary said that seeing the life-challenges experienced by some WFAS patients was a low point for them. Jane went on to explain how seeing the background situations of some WFAS patients was sad, and Mary pondered whether the life path of a particular WFAS patient might have been different if she had received orthodontic treatment earlier:

Jane: Just looking at what they're going through as a teenager. I mean ... people who've got disabled family and there's parental support ... But ... you can see that psychologically they're ... probably not as perky as the other kids so you can always tell ... [there's] always something ... they're looking that depressed and dark and ... that's always just sad to see.

Mary: The day [a young woman] came in she had a gang sweatshirt on ... She was crying ... I wonder ... if she'd ... had treatment two or three years earlier ... her life might have been different ... Who knows? But ... it does ... go through [your mind,] that thought process.

Others listed hurdles of working with particular WFAS patients as low points of their work for the WFAS initiative. These ranged from when "they come in with all their breaks" (Lisa), through to treating a patient who Steven suspected was ineligible for treatment through WFAS. For example:

Steven: I had one patient ... it struck me that ... they were kind of reasonably financially off ... and I thought ... there must be people more needy ... The example I'll give you, [in] the final check consultation ... [the patient and mother] both had to put away their iPhones.

Linda mentioned that her own lack of knowledge on what to do when a WFAS patient had not "done any voluntary work at all" during his nearly completed treatment was a low point. Linda did not attribute this to the patient concerned, but to her own lack of knowledge regarding what to do in this circumstance.

DISCUSSION

Brondani¹¹ maintains that dental professionals may find it hard to practice social responsibility because they are practicing in a business-driven model of oral health care. In the present study, all of the participants were practicing social responsibility by volunteering for WFAS and other community initiatives. Consequently, the participants appeared to have no difficulty balancing their business costs with their desire to give back to the communities in which they practiced. Moreover, because 82% of all orthodontists who belong to the NZAO volunteer for WFAS, Brondani's¹¹ claim seems to be unwarranted in a New Zealand context.

The notion of social responsibility is linked with "the professional obligations and privileges of dentistry" (p. 35).² In the present study, the participants who said that they considered orthodontists to have "an obligation" (Steven) or "professional responsibility" (John) to give back to the community and had obtained a "good lifestyle" (Steven) from their chosen career could be considered as reproducing conventional understandings of social responsibility.

At the same time, however, more than half of the participants who said they were motivated to volunteer for WFAS because they wanted to give back to the community framed this as a personal choice rather than a

professional obligation. Zmetana¹⁷ lists qualities such as “integrity, caring, community focus, and commitment to excellence” (p. 54) as hallmarks of professionalism. Consequently, even though the decision to volunteer for WFAS was considered a personal choice, this choice may have been influenced by those qualities that are demanded of orthodontists and the oral health professions. Moreover, the fact that the overwhelming majority of their peers volunteer for WFAS, and that esteemed colleagues established the initiative, may mean that some orthodontists feel some degree of professional and peer pressure to volunteer (as evidenced by Andrew’s comments).

However, 3 participants commented that orthodontists are generally caring and/or helpful people. All but 1 of the participants also reported that they treated some low-SES adolescents either on a pro bono basis, at minimal cost, or with scheduled payments over longer periods. Such comments contrast with the common societal perception of dental professionals as being wealthy self-serving individuals who are solely motivated by profit.¹⁸

In North America, repaying large student loans has been identified as a barrier to recent graduates volunteering for community health initiatives.¹⁹ Although this may or may not be the case in NZ, 1 participant said that she was unable to arrange longer repayment schedules for low-SES families because of her recent employment in a partnered practice. This suggests that established orthodontists have more flexibility when it comes to choosing to engage in such socially responsible initiatives than younger practitioners and those recently employed.

John’s comment that WFAS has been a “very good part of our publicity campaign” can be read in numerous ways. For example, WFAS can be considered to raise the awareness of orthodontists, which might be a profession that is not well understood by the NZ public. Moreover, John may also be referring to raising the awareness of the NZAO, whose members volunteer for WFAS. Although John was not asked to follow up on this comment, his statement implies that although WFAS was established to help low-SES adolescents, it also has a number of positive “spin-offs” for the orthodontic profession.

Orthodontists have reported that they experience the delivery of care, relationships with patients, staff, and colleagues, and the respect that accompanies being a member of a profession as the most satisfying aspects of their career.²⁰ Most participants said that a high point of volunteering for WFAS was seeing a boost in the happiness, self-esteem, and future prospects of their patients following treatment. Seeing these positive

changes that occur in WFAS patients could be seen as something that is linked with the delivery of care and therefore supports the findings of previous studies. Numerous studies report the negative effects of malocclusion on an adolescent’s overall quality of life,^{5,7} as well as how patients’ self-esteem and happiness often increase after receiving treatment.^{21,22} However, few studies report on the rewards that orthodontists experience from seeing such changes in their patients, especially those from low-SES backgrounds. More research is needed in this domain.

Some dental professionals consider low-SES patients to be unreliable (not turning up for appointments) and less committed than either fee-paying or other underserved populations (for example, disabled patients).^{23,24} In the present study, however, some participants reported that WFAS patients were more cooperative than fee-paying patients because they had to work for their treatment. Two participants also stated that if WFAS patients have poorer oral health and miss appointments, then this is more likely a reflection of their family’s background circumstances than a sign of lack of commitment to their orthodontic care. These participants appear to have some understanding of the practical barriers to accessing orthodontic appointments that accompany a low SES.

In comparison, some participants’ comments could be viewed as framing low SES adolescents in deficit terms. For example, Jane’s comment that WFAS patients are “depressed and dark” serves to position low-SES adolescents as “psychologically troubled” rather than active and resilient individuals (who have secured orthodontic treatment through their own initiative). Ron’s comment that WFAS patients often “have to do without their family support that’s so necessary for a successful orthodontic treatment” can also be viewed as constructing low-SES families as dysfunctional. Nevertheless, other participants’ statements about WFAS parents being extremely grateful for their children’s treatment appear to contrast with Ron’s comment. Parents of WFAS patients must write a letter supporting their child’s application as well as provide a summary of their weekly financial expenditure. Consequently, we suggest that many parents of WFAS patients are just as likely to be supportive of their younger relative’s orthodontic care as their more affluent full-fee-paying counterparts.

Two participants maintained that a low point of their WFAS work was being unable to achieve the desired result from treatment. As stated previously, in NZ orthodontic care is not funded by the state and therefore low-SES patients are unlikely to be able to afford orthodontic care, even for the most severe malocclusions that need orthognathic surgery. Orthodontists volunteering for

community orthodontic initiatives in countries where orthodontic treatment is primarily fee-for-service need to realize that they may be treating for the best possible outcome rather than a perfect occlusion.

One participant said that a low point of volunteering for WFAS was treating a patient who appeared too affluent to meet the criteria for acceptance. This patient was likely treated in the early years of the initiative before the application criteria was tightened to include supplying proof of a governmental-supported benefit. Moreover, Linda explained that she was annoyed at herself for not knowing how to deal with a patient who was nearing the completion of his treatment but had not undertaken any community work. Currently, WFAS has no policy regarding this issue, and they need clear guidelines so that orthodontists, such as Linda, are supported in their interactions with these patients.

This report has numerous strengths and limitations. All the participants were (or had been) volunteers for WFAS. Consequently, it was not possible to compare their motivations for volunteering with other orthodontists who chose not to volunteer. Moreover, 3 participants had treated only 1 patient each through WFAS, so few conclusions can be drawn from their experiences.

Research focusing on why orthodontists volunteer for community initiatives, as well as the rewards and challenges of doing so, is rare. Owing to this paucity of literature, as well as the relatively small sample size, the present findings can not be generalized to other populations of orthodontists. Consequently, the research should be considered as a conversation starter on the reasons why orthodontists volunteer for community orthodontic initiatives, as well as on the positive and negative aspects they experience in doing so.

CONCLUSIONS

The study highlights how some orthodontists experience low-SES patients and their caregivers as more cooperative and grateful for their treatment than their full-fee-paying counterparts. Others may view low-SES patients as more challenging than fee-paying patients owing to breakages or a perceived lack of compliance or family support. Nonetheless, some orthodontists appear to gain pleasure from the increase in the self-esteem, happiness, and future life chances of their low-SES patients that accompanies treatment. It appears that, like low-SES patients, orthodontists are a heterogeneous group.

The participants' responses also showed that they had mixed experiences treating WFAS patients. Some reported that WFAS patients were more, and others less, cooperative than their full-fee-paying

patients. Orthodontists need to be aware of framing low-SES adolescents and families as a homogeneous group and in a deficit manner. There is diversity among low-SES patients and families. Treatment goals should be informed by patients' individual circumstances as much as their malocclusion characteristics.

This was a small study with limited scope. More research is needed on orthodontists' participation in community initiatives. Ideally, the publication of such material can encourage more orthodontists to engage in community initiatives to address the oral health inequities experienced by underserved populations, including, but not limited to, financially disadvantaged adolescents.

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