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Dentistry and Disability: from an Inclusive Perspective

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Received: 20 August 2025

Accepted: 19 November 2025

Cite as:

López-Morales PM. Odontología y discapacidad: desde una perspectiva inclusiva [Dentistry and Disability: from an Inclusive Perspective]. *Rev Odontol Mex*. 2025; 29(4): 17-22. DOI: 10.22201/fo.1870.199xp.2025.29.4.92634

ABSTRACT

Defining disability conceptually is a complex task and a subject of debate, as it involves various aspects and factors related to health. There are various theoretical models for addressing disability; however, the biopsychosocial model is the one that favours inclusion, autonomy, visibility and the recognition of universal human rights, such as the right to health. Oral health is considered an integral part of overall health. Therefore, it is essential to promote the teaching of inclusive dentistry that is reflected in the curriculum design of dental school programs and continuing education, in order to meet this need. Likewise, professional training should include not only clinical knowledge and skills, but also attitudinal aspects, empathy, and an understanding of human diversity. The purpose of this work is to describe the competence that must be developed by any dentist who decides to provide care to people with disabilities.

Keywords: dentistry, disability, inclusion, humanistic competence.



Conceptually defining disability is a complicated task and a frequent reason for discussion, since it is a complex and heterogeneous issue, which involves various ethical, social, cultural, economic, legal, political and health-related factors. This complexity lies in its constant evolution and the absence of a national agreement that can serve as a parameter to define this priority population¹. Unfortunately, the participation of people with disabilities in the creation of policies, strategies, programs and regulations remains (most of the time) limited and symbolic. For this reason, people with disabilities have had to demonstrate so that their rights are recognised and made visible.

It is very important to accept and appreciate how useful their experience and opinion can be to ensure their inclusion and transform environments, with actions that legitimately correspond to their needs, and not only statements of what is considered best for them². Hence the importance of the motto *"Nothing about us without us"*³. This argument is fundamental, since it is the people with disabilities, their parents and guardians, who have the knowledge and direct experience of the barriers and limitations that they face every day. Therefore, they should be taken into account, as their opinion is very valuable and important in decision-making and it is essential to be respected by health professionals, since they are experts on their own needs⁴.

The concept of disability has changed throughout human history, with patterns for defining, understanding, and addressing it, ranging from individualistic theoretical models (of disregard, traditional, religious, or moral) that consider disability to have an influence on generating unpleasant feelings and thoughts that have excluded, discarded, belittled, and relegated them, to the point of causing shame and feelings of guilt in families⁵. According to the medical, rehabilitative or individualistic care model, a person with a disability is synonymous with having a *defective* body, with some *limitation* or *deficiency* that must be cured, repaired or rehabilitated, because it conditions and restricts them from fully participating in life⁶. Based on the changes and innovations that have arisen in society with the recognition of rights and the understanding of functional diversity, the biopsychosocial model appears⁷, focused on inclusion, autonomy, visibility, and the recognition of universal human rights⁸. The main innovations that have favoured the biopsychosocial model have been the incorporation of international frameworks such as the International Classification of Functioning, Disability and Health⁹ (ICF), which was approved in 2001 and is part of the conceptual framework of the World Health Organization (WHO) whose function is to understand, reflect and reconcile the terms: functioning, disability and health. One of the characteristics of the ICF is that it is a universal classification, which uses a standardised language to explain the concept of health and the content related to it¹⁰. The ICF defines disability as *"a generic term encompassing impairments: as any problem that affects a body structure or function; activity limitations: as any inconvenience to perform tasks; and participation restrictions: as obstacles to socialising and participating in life situations"*¹¹.

Similarly, there is an international legal instrument considered to be the first treaty of the 21st century. Known as the Convention on the Rights of Persons with Disabilities (CRPD), it is aimed at people with disabilities, establishing the link between disability and human rights, and whose main objective is to change the paradigm of providing help and assistance to people with disabilities (welfare), allowing them to develop themselves in equal circumstances (autonomy), to influence their environment and the decisions that affect them by demanding their rights, as well as fulfilling their obligations (empowerment)¹². An interesting fact about this Convention is that Mexico was the main promoter and driving force behind its creation, as well as of the Optional Protocol, which were approved on 13th December, 2006 at the United Nations (UN).

Mexico signed on 30th March, 2007 and ratified its adherence on 17th December, 2007, thus becoming part of the States committed to providing protection and promoting the rights and dignity of persons with disabilities¹³.

Regarding the presence of disability worldwide, it is estimated that 1 in 6 people have some type of disability or multiple disabilities, approximately 1.3 billion people (which is equivalent to 15% of the world's population). The average life expectancy of people with disabilities will be reduced by approximately 20 years compared to the general population, and unfortunately it has been calculated that they have twice the risk of developing diseases such as: diabetes, stroke, depression, asthma, obesity and oral health problems¹⁴. The Instituto Nacional de Estadística y Geografía (INEGI) in the 2020 population and housing Census, identified 20,838,108 Mexicans with disabilities (4.9%), with limitations in daily activity (11%) and mental health problems (0.6%). This represented 16.5% of Mexico's total population¹⁵.

Regarding the dental treatment provided to people with disabilities, it is essential to emphasise professional training in dentistry, which includes not only technical and scientific aspects, but also considers the attitude of the students within the competence. Studies^{16, 17} have shown this attitude to be decisive and fundamental to the success of the treatment. It is important to remember that the parts that make up health competence are: knowledge (knowing), skills (knowing how to do) and attitudes/values (knowing how to be), although more complex models also include motivation (wanting to do) and aptitude/resources (being able to do)¹⁸.

Consequently, it is vital that professional training be comprehensive, promoting dignified, respectful treatment with empathy and understanding of human diversity, regardless of the patients' condition, always considering their characteristics and promoting equity. These skills will allow the dentist to offer humanistic care, focused on the person and oriented not only to solving oral problems, but to improving the quality of life and general well-being of the person with a disability.

It is crucial that future dentists are able to adapt their practices and environments to promote accessibility, eliminating architectural barriers, implementing personalised strategies, sensory adaptations of the clinical environment, and specific protocols for each type of condition. These have proven to be fundamental in improving patient cooperation, reducing negative responses, and, if not considered, will be the causes that have traditionally limited access to oral health services for people with disabilities¹⁹. Each patient with a disability may present very specific challenges during the consultation, ranging from motor²⁰, sensory²¹, intellectual²², and neurodevelopmental²³ impairments that may hinder communication and cooperation²⁴, to medical conditions that may involve a systemic commitment²⁵ requiring adaptations to care protocols. Likewise, professional training must guarantee knowledge regarding human rights, the importance of patient autonomy, and collaborative work involving close participation with family members, caregivers, guardians, and other professionals (of health, education, sports, and recreational activities, etc.) in order to achieve a multi- and interdisciplinary approach that guarantees not only the safety but also the well-being of the patient.

To provide comprehensive dental care to people with disabilities, it is essential to conduct an individual assessment, gathering information on medical history, the degree and type of disability (physical, motor, sensory, intellectual, psychosocial, multiple), the type of communication used (verbal, non-verbal, gestural), the levels of support required, the adaptations of the clinical environment needed, and the most appropriate behavioural strategies for each case²⁶. This is based on the recommendations issued by the American Academy of Paediatric

Dentistry²⁷, which offers the necessary teaching and learning tools to identify and manage complex situations, adapt treatment techniques, use auxiliary devices, and establish effective communication that takes into account the particularities of each person with a disability.

In this sense, dental education must provide care to patients with disabilities, and this is an important aspect to consider within the curriculum design of training programs in faculties and schools of dentistry²⁸, as well as in continuing education to meet this great need^{29, 30}. Dentistry students would benefit from a clinical rotation focused on treating Patients with Special Healthcare Needs, in order to provide greater contact and interaction with patients with disabilities during their university training, which would encourage a greater willingness to treat this population in future practice³¹.

Therefore, the dental approach to patients with disabilities requires not only specific clinical knowledge and skills, but also motivation, so that professionals who wish to deepen or begin in the proper and correct oral health care of this population, do so from an inclusive perspective.

CONCLUSIONS

In recent decades in Mexico, the number of people with disabilities has increased significantly, and so have their oral health needs. It is vital to foster a culture of inclusion that is reflected in professional training and dental clinical practices. Dentistry in Mexico is facing the challenge of transcending the medical model and adopting a comprehensive vision towards the biopsychosocial model, where awareness, training and constant updating regarding the treatment and approach to people with disabilities are promoted. Inclusion should not only be understood as an abstract principle, but as a cross-cutting axis that guides the training and daily clinical practice of dental students in training. It is essential that dentistry students develop skills that allow them to identify and eliminate physical, attitudinal, and communication barriers, with ethical and humanistic values, oriented towards inclusion, respect, and dignity for people with disabilities, always promoting equal opportunities in access to quality oral health services, thus establishing fairer and more participatory environments. Only in this way will it be possible to respond, from an inclusive dentistry perspective, to the challenges involved in guaranteeing the right to oral health for all people with disabilities, where every smile has the right to shine regardless of its functional diversity.

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