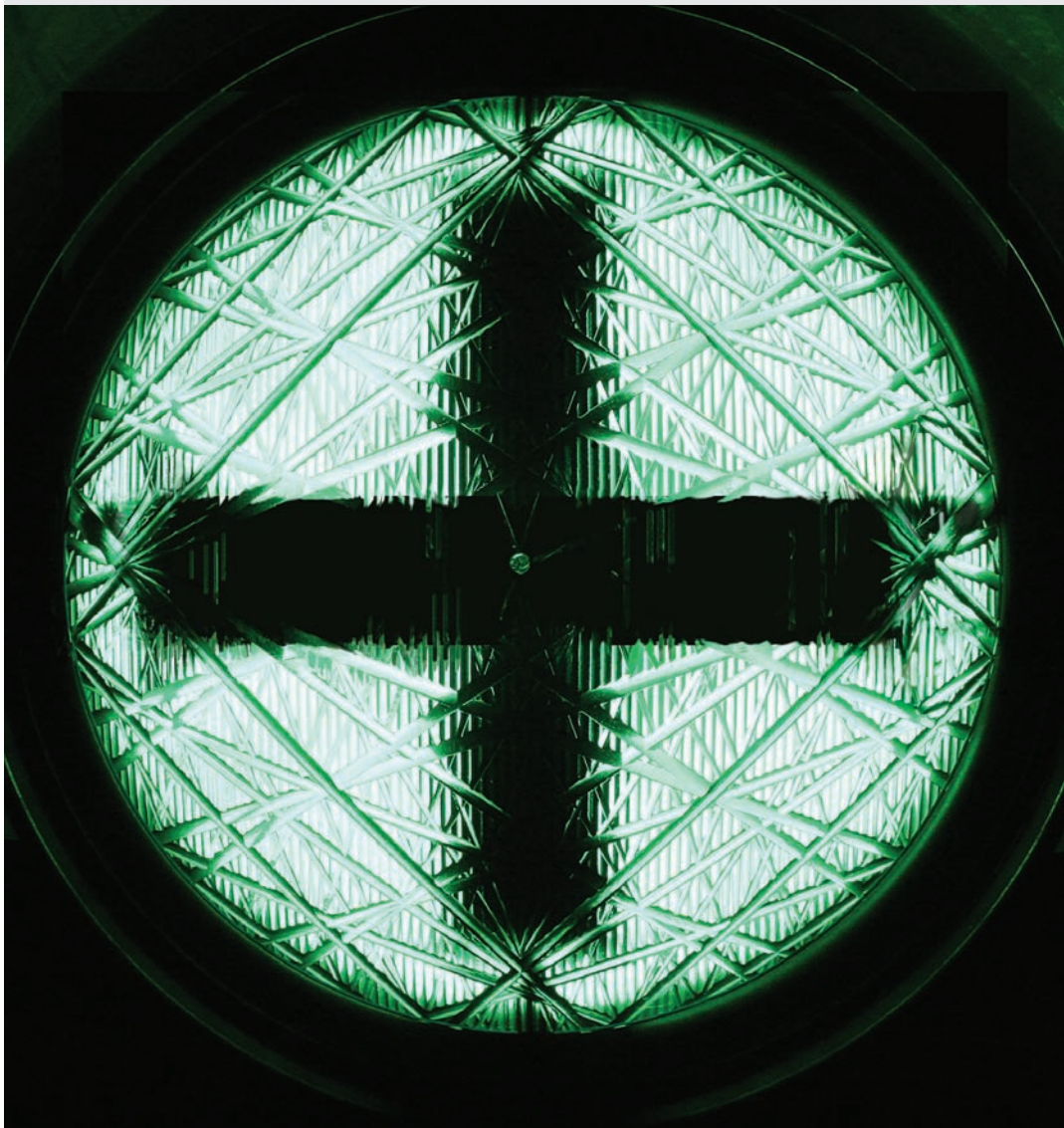
Journal *of the* American College *of* Dentists

Positive Ethics



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Mission

The *Journal of the American College of Dentists* shall identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. All readers should be challenged by the *Journal* to remain informed, inquire actively, and participate in the formulation of public policy and personal leadership to advance the purposes and objectives of the College. The *Journal* is not a political vehicle and does not intentionally promote specific views at the expense of others. The views and opinions expressed herein do not necessarily represent those of the American College of Dentists or its Fellows.

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The American College of Dentists, in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;

B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;

C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;

D. To encourage, stimulate, and promote research;

E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;

H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare–by conferring Fellowship in the College on those persons properly selected for such honor.

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Positive Ethics

Issues in Dental Ethics

Departments

Cover Photograph: Be a guiding light encouraging positive ethical behavior.

From the Editor

Positive Ethics

Do not take ethics for granted. Of course, no one is against moral behavior, and we are upset when we learn about fraud, overtreatment, shoddy work, and cheating. We pass the depressing newspaper articles and editorials with high commentary along to our colleagues to show our surprise and disgust. These people should have known better. We are upset when things do not go as they should. In a word, we take it for granted that professionals are ethical.

This is the default view of ethics: one is presumed ethical unless there is conclusive evidence to the contrary. Good character is defined as the absence of detected bad behavior. This two-position view favors language such as rules, punishment, teaching, and enforcement, and it gives place of privilege to lawyers and disciplinary bodies. This "neutral unless off" view encourages the practice of punishing offenders by requiring that they take courses in ethics or perform community service.

Focusing on the bad pays too much attention to the small downside of the profession; taking the good for granted undervalues the high standards by which most dentists live. Worse still, assuming the good leaves little room for the profession to realize ethical excellence.

What we need is a three-category framework for professional ethics—off, neutral, on. Negative ethics is inescapable, and we must identify cases where transgressions cause damage and then rehabilitate or remove them. The middle ground is occupied by habits of general acceptability that require little comment. The third category is active pursuit of the high ground, working to raise the standards for all, sacrificing for others, and making the world a better place and oneself more worthy than yesterday. There is a category of positive ethics and it deserves our attention.

The vigilance and sanctions involved with catching folks off base, as necessary as that may be, is insufficient to improve the dental profession. There are two reasons for this. A well-established principle in psychology proves that punishment does not decrease motivation to misbehave; it only alters the way inappropriate behavior is expressed. Deviants become more devious, hide their transgressions better, or turn to new forms of cheating. State board members spend much of their time with the same handful of repeat offenders. The more effective approach is called counter-conditioning. That means coaching and rewarding the desired behavior. If people are doing what is good in various situations, they cannot be doing what is bad in the same cases. Positive moral behavior is inconsistent with negative moral behavior, and we get the kind we pay attention to.

The second reason to focus on positive ethics is its promise as the best road to raising the standards for dentistry generally. There have been several dental school cheating scandals in the past few years; there were cheating scandals in the 1990s and the 1960s. It is right to dismiss or rehabilitate those who disregard the standards of the profession. But that has not done much to change the pace of unethical behavior. Systems theorists and quality engineers would not be surprised. If a system throws off 1% duds this year, it will throw off 1% next year—regardless of what is done with those duds. The only way to alter the rate of defects is to change the system. We accomplish that by focusing on positive ethics.

Two-category (negative and neutral) ethical codes of conduct inform members what is permissible; aspirational codes, such as the one used by the American College of Dentists, focus on positive ethics.

In the spring of 2008, the American Dental Education Association gave an award to Jim Milani for the best research paper written by a junior faculty member. He studied the clinical evaluation system used at the University of the Pacific, which focuses on the three areas of technical skills, clinical judgment, and patient management. In particular, Dr. Milani compared thousands of numerical scores from faculty members

with thousand of comments regarding the same behavior. Clinical instructors remarked on both positive and negative aspects of technique—"good hands," "nice margins," "too slow," etc. Positive remarks meant high scores; noncommittal or missing comments produced average scores; negative remarks were associated with low scores. Professionalism, by contrast, was seen in only two categories: negative or not worth commenting on. Only rarely did faculty members note "willing to help classmates," "goes the extra mile for the patient," or "exhibits high professional standards." Where such comments were made, they did not raise the numerical scores students received. Professionalism was assumed, meaning that the only way ethics was noticed was as a misstep.

Positive ethics means catching people doing things right and commenting on it. It involves coaching and mentoring; transparency; open discussion about alternatives; and acknowledgments of difficulties and willingness to work through them. "Please," "thank you," and "because" are big words in positive ethics, as is "let's talk about that." It is a program to help others, including those who are out of step. Giving awards is nice too. And I promise you, based on my own experience, positive ethics requires a toughness that far surpasses doling out punishment or talking with friends behind someone else's back about what they should or should not have done.

Why should we engage in positive ethics? First, it is the best way to effect real change rather than driving bad behavior underground. Second, it raises the overall standards within organizations and holds promise for reducing the proportion of individuals who behave badly.

There is also a bottom-line advantage to positive ethical behavior. In business studies, it has been consistently found that, compared with shady dealers and with those who are merely "not bad," organizations that strive for high ethics enjoy greater productivity, innovation, employee loyalty, customer satisfaction, and profitability. Firms with cultures of positive ethics have higher stock prices and are better cushioned against loss in down markets.

And one more thing: it is more enjoyable to be around people who are positive than to be around moralizers.

Positive ethics means catching people doing things right and commenting on it.

These Are Wonderful People

Phyllis Beemsterboer MS, EdD

Abstract

The position of academic dean in a dental school affords an opportunity to observe young men and women growing into professionals. I have seen numerous quite acts of thoughtful kindness and unselfish service. I have also witnessed the personal struggles of students working through their academic dishonesty and the challenges of balancing patients' needs with their own. Professional education is transformative, and faculty members play a key role as models and guides helping students become ethical practitioners.

As the academic dean in a dental school, I get to peek into the lives of students and faculty members, some for four years and others for decades. This is a wonderful way to participate in the growth and development of my current and future colleagues as we journey together through our professional lives. If I am lucky, I get to see the courage and spirit of what a real professional is—a giving and inspiring healthcare provider.

Students very often come to dental school with impressive accomplishments and experiences: church service, travel to foreign countries, musical abilities, and academic grades that would gain them entrance to many elite institutions in any number of fields. Our dental program demands time and energy, yet I have seen many examples of kindness, generosity, and doing the right thing—usually performed quietly and without fanfare.

A group of dental students found out that one of their classmates had a broken-down car. He was walking a good distance to get to school every day because the bus line did not go out to where he lived. This small group of about four or five students decided that they would make repairing his car a fun project, and they set about to work together over a few weekends. They were sensitive to his needs and his need to feel good about his situation. This was beneficence and compassion quietly at work.

Helping others comes naturally to individuals who are attracted to a healthcare profession and that can be seen on a daily basis when students help each other with studying, cleaning up the technique lab, preparing the treatment room after a patient, or giving a lift home to a clinic patient who missed his or her ride. I was especially impressed when several students came forward to donate money to a family that lost a child to leukemia. The family had no insurance to cover expenses of a funeral. The students insisted that their gifts be anonymous—true charity and caring without fanfare.

Many students participate in service activities before entering dental school and continue to do so while pursing their dental degrees. One such student has traveled to Tanzania numerous times to assist a small group of catholic nuns who run an orphanage. She helped the resident dentist provide care for these children using only crude equipment and few instruments. It helped build her resolve to go to dental school. Travel to this site involves flying to Africa, taking a train for 13 hours, and then walking to the convent and orphanage. What is most impressive

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about this feat is the humility expressed by the student; she sees no great accomplishment, only the need and her ability to help.

On occasion I get an insight into the struggles that the developing professional faces. A new DS1 student came to discuss something that had been bothering him since he started dental school. In his senior year as an undergrad he had taken an organic chemistry class and cheated on the final. He had looked at another student's paper and copied some of his answers. Since that time, the transgression of his personal values had been bothering him and the talk the dean had given in the first week of the term really brought the issue up again. He wanted to know what he should do "to makes things right." Should he go see the professor at his old school and confess? Should he tell the dean of this transgression? To me, this is what professional ethics is about–the struggle to discern the correct path and to right the wrongs, if possible. This student was examining veracity and fidelity.

Another example of this struggle is the dilemma that dental students face as they balance the needs of their patients with the need to complete certain clinical procedures. This age-old problem has been improved with the advent of clinical competencies in dental education but it still can provide the learner with challenging choices. Keeping the needs of the patient above those of the dentist is the hallmark of a professional.

However, the pressures for technical excellence and demands of some faculty members can place the student in moral distress. Choosing to perform a procedure that the patient wants and values is what a professional person does, and sometimes it is not easy. Those who face this type of challenge and rise above it earn the respect of colleagues and faculty members alike and their own self-respect. That is part of our drive for self-consistency.

Education is a transforming activity and those who choose to participate as teachers find that they are changed by the teaching and learning process as much as the students are. Faculty members are often the unsung heroes in our academic environments. The students perceive the faculty member as all-knowing and powerful; the faculty member deals with the busy department chair and works within constraints of administration. Yet, all of these folks are involved in nurturing the character of the developing dentist. Role modeling is a 24/7 proposition and has a profound effect on the people around us. I am inspired by the simple things faculty members routinely do because they want to make sure students are growing and thriving. This includes the dentist who stays late to help with a difficult patient, the part-time faculty member who adjusts his or her schedule to accommodate the needs of a student or patient, or the person who pulls aside the student who has had a bad day to help him or her process the situation. Most faculty members are involved in a myriad of activities, both professional and personal, that advance the public good. However, it is their devotion to students in the little ways on a daily basis that reassures me as we all learn from observing others and the action they take or do not take.

I am inspired by the simple things faculty members routinely do because they want to make sure that students are growing and thriving.

Participating with students and faculty members in our professional life journeys enables me to examine and affirm my own values and the ways in which I would reflect those values. The chance to learn and grow in the company of those you admire is its own reward. ■

Hugo A. Owens

Dentist, Civil Rights Leader, Politician

James T. Rule, DDS, MS, FACD and
Muriel J. Bebeau, PhD, FACD

Abstract

For 44 years Dr. Hugo A. Owens was a distinguished practitioner and community leader in Portsmouth, Virginia. Besides his affinity to for dentistry, he was driven by two other passions: politics and civil rights. In 1970 he was one of the first African-Americans elected to the Portsmouth City Council. He was reelected for the next term and appointed Vice Mayor, a position he held for eight years. His political successes were preceded by his activities as a civil rights leader, which began in 1950 and lasted through the 1960s. In a remarkable series of negotiations and litigations, Dr. Owens was the prime mover in the desegregation of the City of Portsmouth. In all three 'careers,' Dr. Owens used dentistry as a home base for the expression of his activist philosophy of providing help for others when they were unable to do things for themselves.

In 2005 we published Dentists who care: Inspiring stories of professional commitment (Rule & Bebeau, 2005). It contains the interview-based stories of ten dentists nominated by their peers for actions that extended far beyond their own self-interest. We think that the story about Dr. Hugo Owens is important because it embodies the theme of positive ethics selected for this issue of the *Journal of the American College of Dentists*. It exemplifies an aspect of professionalism that, in our opinion, deserves more attention in the professional community than it receives: community commitment.

Dr. Owens' story shows the importance of connectedness between professionals and their communities and how one person can make a huge impact in an important community social issue—in this case civil rights.

Hugo Armstrong Owens was born in 1916. His name was the result of a negotiated agreement. His father wanted him named Samuel Armstrong Owens, after Samuel Armstrong, the president of his father's alma mater. His mother liked Armstrong, but balked at Samuel. She said that no one would call her son "Sambo"—or any other moniker that would undermine his self-esteem and identity. Both parents liked the symbolic reference to academe conveyed by the name of Armstrong. So they compromised and named their son Hugo, after James Hugo Johnston, president of Virginia State University, his mother's alma mater.

The pursuit of higher education and accomplishment was a tradition in Owens' family. Most notable was his uncle, George Melvin, who had become a lawyer. Melvin lived across the street from the Owens family, and with his imposing stature, fiercely intense eyes, and booming voice, had a powerful influence on the aspirations of Hugo Owens and his siblings. He predicted greatness for Owens and told him: "If you were a white man, you would be governor of Virginia." Especially unforgettable is a memory of an event concerning Owens' Uncle George that occurred when Owens was only five or six years old. To get to work, Melvin took the streetcar every day. Dr. Owens recalled, "Many a night he came home bloodied because he refused to move to the back of the streetcar or get up to give whites a seat. I can still see him come in the house bloody, and my mother would say, 'What in the world happened to you?' That's the kind of thing I grew up witnessing." Even today, Dr. Owens feels the force of his uncle's influence. "He helped shape my

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character, forced me to set goals, and inspired me to excel in everything I did." And his uncle's courage under fire remains a paradigm for courageous, vigorous, and principled action. Dr. Owens says, "When I did civil rights, I was my Uncle George."

Equally important in Dr. Owens' development was his family's involvement with the church. Both parents taught Sunday school, and his father was Sunday school superintendent for as long as Dr. Owens could remember. In addition, his father became a deacon and later a lay minister. Everyone loved his elegant, colorful sermons and his outgoing personality, which the younger Owens happily possessed in full.

Always open to life's opportunities, Dr. Owens says he also took inspiration from people he called the "Giants." These were orators who had messages both of practicality and of great depth. He listened to their speeches as often as he could and contemplated their messages. The "Giants" included: Mordecai W. Johnson, president of Howard University; Carter G. Woodson, historian and founder of the Negro History Week; Benjamin Mayes, president of Morehouse College; Howard Thurman, dean of the chapel at Howard University; and C. C. Spalding, a founder of the North Carolina Mutual Life Insurance Company. All were African American men who had achieved success and who had retained a sense of obligation to their roots. Their message, as Dr. Owens has distilled it, was this: "First excel, then help others."

After graduating from high school and delaying college a year to take care of his ill mother, Owens entered Virginia State University. As a senior, he ran for student body president and was elected. It was in that office that he discovered something about himself that has been his hallmark ever since. It gave him great satisfaction to do things that others needed to have done but could not do for themselves. And he began to judge himself according to his success in making things happen. Dr. Owens says, "When people say something ought to be done, I say let's do it."

For three years after graduation he taught chemistry and physics, and when World War II broke out, he married and then enlisted in the army. Years later, as the time for discharge approached, despite earlier dreams of becoming an endocrinologist, he decided to cover all his options and applied to medical schools, dental schools, law schools, and schools of meteorology. His first acceptance letter came from Howard University School of Dentistry and he enrolled there. A week later, acceptances rolled in from the other disciplines. But he stayed in dental school and has never regretted it. In dental school, unsurprisingly, he again ran for office and was class president all four years.

Soon after Dr. Owens graduated, he bought a practice in Portsmouth, Virginia, where he remained for 44 years, not retiring until 1991 at the age of 75. He enjoyed his practice immensely. He loved his patients and enjoyed the challenge of doing things for them that others could not do. He excelled at the technical side of dentistry and did most of his laboratory work for bridges and inlays. According to the dean of Howard University, he was highly regarded for his clinical excellence.

Their message, as Dr. Owens has distilled it, was this: "First excel, then help others."

As Dr. Owens got to know his community, his activist tendencies emerged in full. His awareness of community issues sometimes came from his own observations, but often through the eyes of his patients. In 1950, three years into his practice, one such patient, a long-time caddie at the city golf course, came to his office and told Dr. Owens that he had had his fill of injustices in the town. He complained that, being black, he could carry someone else's golf clubs around the golf course, but he was banned from using it for his own enjoyment. So, together Dr. Owens and his patient

devised a plan. A group of five would-be golfers, including Dr. Owens, requested admittance to the Portsmouth Golf Course. Only one of the men had ever even swung a golf club. Their request was rejected.

Led by Dr. Owens, the group then embarked on a series of negotiations with the City of Portsmouth at progressively higher levels. Everyone they spoke with wanted to know if they could actually play golf, figuring that the probability was about zero. Dr. Owens would respond, "How in the hell do we learn how to play golf? We don't own golf clubs. We don't have a place to play." The officials would then want to know why they wanted to play golf if they did not know the game. Dr. Owens pointed out, in logic that was to become the pattern for future negotiations, that their ability to play golf was not the issue. Their concern was that they were paying taxes to the City Treasurer. The city budgeted part of that money to operate the golf courses. And although some of the tax money had been theirs, they were prohibited from using the very facilities they were supporting. Nonetheless, every attempt at negotiation failed. Dr. Owens then switched to litigation. Using the same logic in court that he had in his negotiations, Dr. Owens successfully led the first lawsuit against the city to open its parks and golf courses to African Americans.

A year later, Dr. Owens negotiated with the city of Portsmouth to authorize the first-ever Alcoholic Beverage Control store that was managed by a black staff. Again it was a patient who pointed out that every ABC store in the entire city of Portsmouth was manned by whites, even those in black neighborhoods.

Then in 1953, Dr. Owens headed a group of citizens who put pressure on officials to upgrade streets and install curbs in the black part of town. Under the threat of litigation, the city yielded. Also in 1953, he won a lawsuit against Portsmouth that forced the city to stop its policy of maintaining white-only cemeteries.

Dr. Owens paid for that lawsuit out of his own pocket, as he often did. However, he sometimes got help from a few benefactors for these substantial expenditures. And occasionally unsolicited well-wishers arrived at his office with a few dollars for the cause. The word was getting out: if you had a problem, Dr. Owens was the man to see. Requests for help proliferated, and he was invited to speak all around the region. His work in civil rights kept him out of his office for about one-third of his time.

In the 1950s Dr. Owens spearheaded a lawsuit that eliminated segregated housing and organized a conference of leaders who recruited black students for formerly all-white schools. Soon after, he was elected president of the Portsmouth chapter of the NAACP, as his father had been before him some 15 years earlier. While president, he focused public attention on job discrimination at the naval installations in Portsmouth, resulting in a federal investigation and ultimate change—again avoiding a lawsuit. And during the same decade, he became president of his state dental society and published an article in the *Journal of Prosthetic Dentistry*.

In 1960 Dr. Owens initiated a lawsuit against the city to desegregate the public library. It would prove to be his most satisfying experience, mainly because, thanks to his leadership, violence had been avoided. In this effort, Dr. Owens became involved in a series of escalating discussions with the library board, the city attorney, the mayor, and the city government. Only after it was clear that the discussions were going nowhere did he initiate a lawsuit. Once again the federal judge agreed with him,

"When people say something ought to be done, I say let's do it."

proclaiming, "The Portsmouth library must admit Negroes or close up—lock, stock, and barrel."

Whereas the decade of the 1960s was a time of civil rights conflict for the nation as a whole, many of Portsmouth's struggles were already behind it—largely due to Dr. Owens. Nonetheless, issues continued to surface. In 1964 Dr. Owens headed a group of local medical and dental practitioners that successfully negotiated the desegregation of the city hospital. In the same year, he organized public demonstrations that led to the desegregation of other public facilities, including restaurants and department stores. Finally, in 1965, when civil rights activists walked the 54 miles from Selma to Montgomery, Alabama, as a response to weeks of violence, Dr. Owens organized and led the largest Selma sympathy demonstration in the country.

During the 1960s, Dr. Owens also turned his attention to more traditional forms of community leadership. He served as a bank director, a director of the local United Fund, and a vice president of a public broadcasting corporation. Always there at the start of things, he became a founding member of: the Southeastern Tidewater Opportunity Project, the new Eastern Virginia Medical School, a regional Council on Human Relations, and a local chapter of the Congress of Racial Equality. Within his profession, Dr. Owens became interested in the new field of preventive dentistry and published two papers in state journals on that theme. His activities became known beyond Virginia, and he became a founding member and the first vice president of the American Society of Preventive Dentistry.

By 1970, 23 years after starting his practice, Dr. Owens was in full swing. Having moved to nearby Chesapeake, he was elected to the city council. He was re-elected in 1972 and appointed vice-mayor, in which position he served for eight years before he retired undefeated. During this period his community service expanded to higher education. In 1972 Dr. Owens was appointed by the governor as a member of the Norfolk State University Board of Visitors, serving as its secretary until 1980. This was to be the first of three such appointments on boards of visitors. On two of them he served as chairman of the board.

When Dr. Owens left city politics, he concentrated on professional politics. He became increasingly active in the National Dental Association, and in 1982 he was elected speaker of the House of Delegates. In 1988, three years before his retirement from dental practice, he served as its president.

Throughout his life, Dr. Owen has tried never to let an opportunity to act productively slip by. He believes that a failure to take advantage of an opportunity has unfavorable moral consequences. When Dr. Owens was 18, he heard a speech by Benjamin Mayes, whose message he has never forgotten: "The inevitable result of waste is want." For Dr. Owens that means, "If you waste your moral upbringing, you will die corrupt. If you waste your time, you will suffer lost opportunity."

Owens is a remarkably positive person. He appears to bear no grudges and observes, "I've seen people literally destroyed because things didn't come out the way that they wanted to. I've seen people miserably hurt by things that are hurtful. But you have to be tough enough to withstand them, and I think perhaps that is the one thing that has made it possible for me to be able to survive in some very hostile conditions. I get the greatest pleasure out of being able to help people overcome things that they couldn't deal with themselves. I think more than anything else that's why I got involved in civil rights and certainly why I got involved in politics."

Commentary

Even without Dr. Owens' extraordinary contributions to his community, his professional career must be judged as outstanding. He loved his practice, was respected as a clinician by his peers, and was a leader in his profession for decades. But it was the way he integrated these two components of his life that is especially noteworthy. What sets him apart from many respected and accomplished practitioners is his willingness to identify moral problems within his community and to act upon them. These characteristics, coupled with his activism, require additional commentary.

Dr. Owens' propensity for action is a fundamental part of his nature, which he first fully recognized while serving as undergraduate student body president during his college years. He loved doing things that others could not do for themselves—and he was good at it.

In contrast, his interest in dealing with moral problems is more complicated. It is an example of what Pellegrino and Thomasma (1993) define as practical wisdom, or what the ancient Greeks called phronesis. Phronesis encompasses essential internal processes that give rise to morality (Rest, 1983). These processes include sensitivity, judgment, motivation, character, and competence. Collectively they promote a practical kind of moral insight, which Dr. Owens displays as he elicits the stories of racial injustices from his patients. He is able to discern moral choices that are justifiable and is then motivated and committed to right the injustices. More remarkable is his practicality. He consistently devises

A failure to take advantage of an opportunity has unfavorable moral consequences. If one wants to benefit others, one must first become competent. In this respect, competence is the greatest virtue for a professional.

highly effective courses of action to achieve his goals.

As Dr. Owens grew to be a young man, everyone expected nothing but excellence from him. And, undoubtedly they also assumed that his talents would, in some way, be expressed through his community. After all, his primary role models—his parents and his Uncle George—were themselves participants in the world beyond their own doorsteps. And considering the power of George Melvin's legacy, how could Dr. Owens not have been involved in civil rights?

These early influences, combined with the distilled message of the "Giants" to "first excel, then help others" shaped the direction of his entire life. It made him realize that integrating his practice with worthwhile, morally based opportunities in the larger community was not an option for him: it was an obligation.

This meaningful phrase helps illuminate some important lessons for all of us. It points to the obvious truth that if one wants to benefit others, one must first become competent. In this respect, competence is the greatest virtue for a professional. But the words also suggest that before helping others, one must first satisfy one's own basic needs for security. In other words, it is prudent and important to place boundaries on one's sense of responsibility to others. Without them there is a risk of becoming resentful.

With respect to the concept of boundaries, the Dr. Owens call to "first excel, then help others" also has grounding in contemporary developmental theory (Kegan, 1982). This describes ongoing transformations in the concept of service during and after professional education. Neither Dr. Owens nor several of the other moral exemplars we interviewed (Rule & Bebeau, 2005) began their practices with a fully mature notion of what service meant to them. Instead, early in their professional lives they focused on the development of competence and the satisfaction of basic human needs. Initially, their sense of service was the provision of care, because that is what a professional does. With time and varying experiences, their sense of service deepened. In our series of exemplars, for example, Dr. Owens increasingly focused on community moral issues. Another exemplar, Whittaker, came to view himself as a provider who cares rather than simply as a care provider. And a third, Rumberger, promoted the idea of organized dentistry playing a leadership role in helping meet community-based oral health needs.

Reflecting on Dr. Owens' lifetime accomplishments, we see an individual who is a leader in the achievement of social justice without attracting negative notoriety. In all he does, he clearly demonstrates fortitude in his expressions of courage, resilience, and staying power. However, he also shows a fine sense of prudential judgment, where prudence represents the ability to discern the most appropriate means to achieve a particular end—a most practical virtue.

Dr. Owens is most well known for his leadership in civil rights, his role in city politics, and his various other activities at the local and state levels. However, everything he does revolves around his life as a professional—which is, remarkably, a life that shows extraordinary balance. He is first and foremost, a technically competent dentist who takes great pride in his ability to provide his patients with excellent care. He also stays abreast of the evolving scientific basis for his profession and contributes to that body of knowledge through publications in scientific journals. And finally, he participates fully in the monitoring and self-regulation of his profession. He joins his local dental society, helps create a new society, and rises to the top of his national organization.

In everything Dr. Owens does, he moves forward—cheerfully, compassionately, and competently, with temperance and prudence—in service to others, even in the face of rejection. Hugo Owens, like his own heroes, has become a "Giant" in our time. ■

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A Student-Initiated Movement toward a More Positive Ethics

Alvin Rosenblum, DDS, FACD

Abstract

Today's dental students can be counted on to solve problems, including ethical ones. This article documents the beginning of a student-initiated ethics club at the University of Southern California's dental school—SPEC, the Student Professionalism and Ethics Club. The organization and activities of SPEC are discussed, as is the interest this group has generated in helping form similar clubs at other dental schools.

There have recently been allegations of cheating by dental students on the National Dental Board Examination. As a response to that and other published accusations of misdeeds in the profession at large, there is a reinvigorated interest in preventative ethics. One such effort is the formation by students of a national organization dedicated to the enhancement of applied professional ethics in dental schools and beyond.

Much has been written over the past 25 years on the subject of applied professional ethics in dentistry, primarily as scholarly writing that explores ethics theory and moral philosophy as it relates to the oral healthcare disciplines. Such writing has been used in our dental school ethics courses and in our professional organizations' deliberations about ethics. It is an attempt to provide the theoretical basis for debates about right and wrong and duty and obligation in our profession. Many disciplines have contributed and this has been an essential extension of the profession's long tradition in the promotion of honest and responsible public service.

There is another way of writing about "ethics" in dentistry. That is the more popular, anecdotal writing directed toward general audiences. That journalistic style can focus on either positive or negative aspects of the profession. This issue of the *Journal of the American College of Dentists* came about because of the notion that wrongdoings in dentistry and dental education get a disproportionate share of readers' attention.

We are all afffected by the negative publicity our profession attracts in varying degrees from time to time. Media coverage, especially the type focusing on the catastrophic, creates problems rather than fixes. We are doing ourselves, the profession, and the public a disservice by not calling attention to the power of the positive.

All of us who take pride in our profession rightfully feel damaged by the inappropriate behavior of some who do not live up to professional standards. We are aware of what we believe to be moral failings, and much of that awareness occurs in response to real events that demonstrate lapses of ethics and professionalism. We are inundated with stories about how greed, selfishness, and striving for personal advantage are occurring in practice and in our dental educational institutions. We are incensed, and despite our disdain for such behaviors, we often perpetuate them by writing and speaking of them. Not infrequently stories are embellished in the retelling as in the child's game of telephone.

The negative incidents that seem so prevalent pale in number and impact compared to the stories of behaviors by our fellow professionals that exemplify the highest standards of the profession.

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We are doing ourselves, the profession, and the public a disservice by not calling attention to the power of the positive.

I believe our profession mirrors the greater society, and that both are better than the bad-news brokers would have us believe.

An Example of Student Initiative

It is my pleasure to contribute to this issue of the *Journal* which focuses on "positive ethics." Our profession is replete with situations of a positive nature and I would like to share the following story as one example.

As the chair of our school's ethics committee, I frequently have students come to me with moral concerns. Most often they use me as a resource for their research on ethics in dentistry for their Problem Based Learning cases. Occasionally they come with a question about the behavior of another person in our school's community or about a difficult interaction with a patient. On a day in March 2007, students approached me on two separate occasions. One, a hygiene student, expressed interest in ethics theory. She wondered if there was a way for her to participate in an ongoing study of ethics. We spoke for some time, and she suggested the idea of an "ethics club." Shortly after that several other students who are part of the elected leadership of our student body engaged me in conversation. They expressed some concerns about ethics enforcement and about some behaviors related to student-faculty interaction that they regarded as "unethical." After listening to their concerns, I suggested that we arrange a meeting to include the hygiene student and I shared with them her idea for an "ethics club."

That meeting, and all the activity that followed, was student initiated and student centered. Students expanded their initial numbers to form a planning group and they asked me to act as their advisor. They held several brainstorming sessions during which they decided to formalize their organization and call it SPEC, the Student Professionalism and Ethics Club.

Shortly after the students' decision to formalize their organization, I was invited to attend a meeting of the Board of Directors of the American Society for Dental Ethics. At that meeting I shared the progress the students had made. The board of ASDE was very encouraging and asked to be kept apprised of future developments.

SPEC was named on May 2, 2007, and at the two following meetings a plan was formed outlining the club's major goals. On June 7, the 13 SPEC members present, in conjunction with myself and co-advisors, Dr. Eugene Sekiguchi and Mrs. Diane Melrose, voted to accept the mission statement that appears as a sidebar.

At the July 26, 2007, meeting of SPEC, the mission statement was incorporated as the "purpose" in the organization's constitution. On that day the bylaws were codified. Also, there were discussions about a possible affiliation with the America Society for Dental Ethics (ASDE) and about helping develop other chapters at other schools. Other topics of discussion included scheduling a national symposium for dental students on ethics in dental education and inviting guest speakers to SPEC meetings.

In the time that has passed since these developments, many members of the oral health community who have become familiar with the efforts of SPEC and have devoted their careers to fostering professionalism and ethics have begun encouraging the formation of chapters of the Student Professionalism and Ethics Club at their own institutions. They do so with the belief that empowering students will advance the cause of professionalism across all disciplines in oral health care.

Since July of 2007 the Student Professionalism and Ethics Club at USC has gained the support and endorsement of both the American Society for Dental

Ethics and the American College of Dentists. The SPEC students have written bylaws and a constitution, and SPEC has now been recognized as an official organization of the University of Southern California. The founding chapter now has a membership of more than 60 at USC and itsmembership continues to grow.

Over the past six months, despite busy school schedules, students have undertaken several projects. They held an "open house lunch and learn" to attract new members. It was attended by more than 100 students. SPEC students were heavily involved in the orientation of the entering freshman class. They facilitated an ethics case discussion and introduced the class of 2011 to the tenets of professionalism. They have hosted two exemplars in dental ethics, the president of the American Society of Dental Ethics and a past president of that organization, who have met on separate occasions with SPEC members as their initial guest speakers. The students found those meeting exhilarating, and the talks by Dr. Larry Garretto and Dr. Bruce Peltier encouraged the students to further their plans for a nationwide symposium of students on the subject of dental ethics and professionalism.

SPEC students are in the process of electing individuals from within their membership to form the "student-centered committee" mentioned in their mission statement. Members of that group, now called the Professional Standards Council, will be taking mediation and dispute resolution training and will act to resolve conflict rather than acting as an enforcement body.

Expanding the Reach of Student Ethics

At the University of Southern California we have an Ethics Committee that is distinct from SPEC and that is made up of selected students and faculty. This committee acts as a hearing and judicial body for reported violations of USC's code of ethics. The ethics council of SPEC in no way intends to duplicate that function of the Ethics Committee. It will, however, have the ability to refer cases to the Ethics Committee if that is deemed necessary.

USC students have created a start-up kit that contains information designed to provide guidance for students at other dental schools to help in the formation of their own chapters of SPEC. The information provided in the kit will help others understand why SPEC was initiated and that they have the whole-hearted support of the founding chapter in the creation of their chapter and in gaining acceptance by their university. The start-up kit is intended to save those other schools months of work and to provide them the help needed in advancing the cause of ethics at their schools and in the profession at large.

Representatives of SPEC have made presentations at the Council of Deans meeting of the American Dental Education Association and at the American Student Dental Association annual meeting. In March of this year, one year since SPEC's inception, there was a presentation made at the annual meeting of the America Dental Education Association during which other schools were informed about SPEC's progress and were given the start-up kit.

The history of the Student Professionalism and Ethics Club and its ultimate goal to create a national organization of dental and dental hygiene students devoted to advancing ethics in our profession should instill pride in all of us and lead to a more positive view of ethics in the dental profession. ■

SPEC Mission Statement

The purpose of the Student Professionalism and Ethics Club (SPEC) is to increase the overall level of ethics and professionalism at the USC School of Dentistry. By uniting the communities of students, faculty, and staff of USCSD, SPEC will promote lifelong thought and action in the arena of dental ethics. Through various programs and associations, SPEC aims to foster an environment where ethical and professional behavior issues can be addressed in an open, unbiased forum. SPEC aims to further the ethical education at USCSD of every student and to help achieve the development of ethical and professional behavior in the educational setting that will accompany students throughout their professional careers. SPEC also aims to form a student-centered committee, which will be available to mediate issues that may arise between students or between students and the school.

Through the formation of SPEC, we hope to provide an environment that both attracts and molds the future leaders of dental ethics and to lead other dental schools along the same path towar preserving the integrity of our profession.

Ethics in a Postgraduate Program

Hans S. Malmstrom, DDS, FACD

Abstract

Experiences with residents in a general practice residency parallel the recent literature on academic integrity among dentists. Based on this background, a planned integrated ethics and professionalism program is outlined for the University of Rochester School of Medicine and Dentistry.

Masella (2007) states that the most important mission of dental education is the development of student professionalism. He continues by stating that altruism, integrity, caring, community focus, and commitment to excellence are attributes of professionalism. Do the residents entering our postgraduate programs in the United States demonstrate these attributes?

Educational Process: How Should We Teach Ethics?

There is no shortage of demonstrated approaches for enhancing ethics curricula in dental schools. Berke (2001) writes that the teaching of ethics has moved beyond the pure lecture format to become a more interactive and relationship-driven curriculum that promotes introspection and self- knowledge on the part of students and instructors. Dibbern and Wold (1995) suggest that medical students' ethics training is best conducted in a workshop format that includes active research, reading, and discussion of ethical dilemmas. Such interactions typically require students to examine and defend their ethical belief systems while also exposing them to the ethical perspectives of their peers. Role playing has also been identified as an effective method for teaching ethics and professionalism (Shefrin, 1978). Fox and colleagues (1995) reported that an interdisciplinary approach that used lectures and panel presentations in conjunction with small-group seminars was rated as excellent by the majority of medical students (75%). It was suggested that this can provide students and practitioners with valuable insight into ethical decision making as well as important exposure to the multidisciplinary team process. Jett (2000) suggested that the majority of students will benefit from an interactive, case-based format that examines ethical dilemmas while emphasizing faculty-student dialogue and introspection. But Bertolami (2004) cautions that the present method of teaching ethics in dental schools is inadequate: "Students take the ethics courses offered and pass the tests given, but no one's behavior is changed."

One of the most difficult aspects of ethics education is the measurement of curriculum outcomes, especially as there is no generally accepted tool to measure outcomes of ethical training in dental schools. Berke (2001) suggests that we as educators have no simple means of determining the role that motivation and underlying values play in influencing students' ethical behavior. Clinical evaluations and ratings of student-patient interactions must often serve as the measure of professionalism and ethical behavior for dental students.

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Mastery of the ADA Code of Conduct does make the big ethical decisions easier to recognize and makes it easier to identify acceptable professional responses. The concern is the small number of students, residents, or dentists who have this knowledge base and nevertheless still fail to practice ethical dentistry. Sharp and colleagues (2005) reported on ethical dilemmas as perceived by fourth-year dental students at the University of Iowa. Students' main ethical concerns included: (a) patients' lack of resources, (b) conflict among clinicians (regarding proposed treatment plans), and (c) practices or policies they felt to be inconsistent with standards of care. In such cases, "the system" makes it difficult for students to do the right thing. Some issues traditionally included in ethics curricula, such as observed breaches of confidentiality, mistakes, and breaking bad news, were rarely addressed in the students' written reports.

Koerber and others (2004) reported on the views of students, administrators, and faculty members concerning methods of enhancing ethical behavior. The students' essays in this series of papers supported the difference between teaching about ethics and changing behavior (as discussed by Bertolami) and recognized the pressures to cheat in dental school. If we assume Bertolami is correct in stating that the dental schools are failing in regard to ethics education, this leaves the postgraduate programs with an even greater responsibility.

Teaching Ethics in Postdoctoral Programs

Approximately 8% of GPR and AEGD program directors found attitudes on professionalism to be a critical issue for incoming residents (Atchison & Cheffetz, 2002). Their attitude was characterized as "what's in it for me." The marketing environment has affected ethics and has led to an increase in cheating. According to Masella (2007), "American society, including higher education, glorifies a market mentality centered on expansion and profit."

As the program director of a postdoctoral program in general dentistry, I have experienced several incidents of unprofessional academic behavior, including cheating. In our postdoctoral program, tests and examinations are frequently used as one of the measures of competence. There have been incidents in which our residents have been discovered cheating, although not to the extent expected considering the report published by Andrews and others (2007), who found that 75% of dental students admitted to cheating on tests and examinations at some level.

When residents were asked during interviews why they cheated they said they wanted to assist a friend and they questioned the relevance of a written examination as a tool to evaluate competency in a postdoctoral program. The first response could be interpreted as

There is no shortage of demonstrated approaches to enhancing ethics curricula in dental schools.

showing that our concept of team-building (the importance of teamwork) and compassion for a colleague is successfully implemented in our program. Obviously it is difficult to determine the authenticity of this rationalization. When discussing the issue of cheating with all of our residents, it was clear that most of them agreed with the residents who were caught and felt that most likely the cheating was more widespread. Many of them did not have a clear understanding that what they were doing was wrong. These incidents have caused us to critically review and revise how we teach ethics in our program.

Many of them did not have a clear understanding that what they were doing was wrong.

Our Curriculum

Considering the recent literature and suggestions by several authors that ethics should be more integrated into the academic and clinical curricula from the start of the programs, we will have an increased focus on ethics throughout the clinical and didactic portions of our program. We will especially emphasize ethics during the orientation to ensure a sound foundation. We will build on that foundation in workshops and small-group discussions. Additional lectures by invited speakers (as suggested by residents) will be offered throughout the year. Ethics will also be included in many of the traditional courses. Ethics and professionalism will have a more prominent role in clinical teaching by enhancing the faculty's training and by including ethics and professionalism as part of the clinical evaluations of the residents. The anchor concepts for our curriculum will be the five principles in the American Dental Association Code of Conduct and the aspirational values of the American College of Dentists.

In the didactic program, residents will be asked to present situations where ethics is a concern in the practice of dentistry, and case presentations could be considered an opportunity for clinical application of ethics as the dentists' biases (and possible financial benefits) can strongly influence the way treatment plans are developed and presented to the patient. The residents will be asked to review each treatment plan from an ethical standpoint, using the academic guidelines from ADA and the American College of Dentists. Annually, one of our weekly literature review sessions will be a review of the literature regarding ethics and professionalism. The residents are responsible for selecting and reviewing these articles. An overview of the ethical principles at our institution will be included in the handout for each didactic course, to remind residents that these principles need to be followed in all academic areas.

Speakers presenting different ethics topics will be invited to present to our residents four times per year. Residents will be involved in selecting the topics as well as the speakers for these lectures. Annually, at the close of the academic year, the American College of Dentists will present a seminar on ethics and professional conduct. In these seminars the residents should demonstrate a clear understanding of the ethical principles and concepts that have been discussed during the program. All faculty members will be encouraged to participate in these seminars. The guidelines and content of policies and seminars will be reviewed in faculty meetings to encourage their application on the clinical floor. It may be a challenge to train faculty members, but we will provide the entire faculty with an "Ethics Manual" to serve as a guide.

Outcome Evaluation

As the literature indicates (Berke, 2001; Jett, 2000), it is difficult to measure the success of ethics programs. We propose,

as part of our assessment approach, to consider ethics and professionalism as separate competencies. Reaching a level of "competent" in both areas would be a requirement for program completion. Faculty members will evaluate the residents according to their level of understanding and how well they practice ethical principles in the clinical environment. In addition residents will be required to perform a self-evaluation. We will also request that our alumni, in the annual outcome assessment survey, evaluate the impact our ethics curriculum had on the way they practice dentistry. Residents will be evaluated each quarter, and when faculty members have a concern regarding a resident's progress toward competency, individualized educational plans will be created to assist such residents.

In the outcome surveys completed by alumni one, three, five, and ten years post graduation, a question will be included regarding the impact our ethics and professionalism curriculum has had on graduates' professional careers and the way they practice dentistry. The results of the ethic curriculum will be reviewed annually and discussed by the entire faculty, and appropriate changes to the curriculum will be made.

In conclusion, we are aware of the difficulty in addressing ethics and professionalism in a postdoctoral dental curriculum and in objectively measuring the impact it will have on the residents' practice of dentistry. The literature indicates that although we may not reach all of the residents, by integrating the ethic curriculum from the start to the completion of the program, through lectures, workshops, group discussions, and clinical experiences, we will affect a large group of the residents. The curriculum has to be a dynamic process, allowing the residents to have a significant input in determining what format the subject of ethics is taught. ■

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We will especially emphasize ethics during the orientation to ensure a sound foundation.

Pointing the Profession in the Right Direction

Positive Ethical Movements among Dental Students and Education

Brooke Loftis, DDS

Abstract

The American Student Dental Association has a substantial stake in the future of the dental profession. ASDA is taking a proactive role in addressing recently publicized cases of academic dishonesty and other ethical problems. Some of these initiatives and a sampling of the positive efforts in dental schools to build sound ethical climates are reviewed.

Sometimes in life we find ourselves headed in the wrong direction. When this happens, it is our decision to redirect and get back on the right path. And it helps immensely to know that there are professional colleagues and organizations supporting our doing the right thing.

Reports of recent ethical issues in dental schools and in the dental profession have focused our attention and raised challenging questions. We could let this divide and damage the profession, or we could take it as an opportunity to become stronger by addressing the issues. I favor the positive approach, and I feel that the overwhelming majority of dental students share this view.

ASDA's Role in Ethics

Being a leader in the American Student Dental Association has given me the unique experience of working with students and schools nationwide. ASDA is the largest student-run dental organization, with nearly 17,000 dental student members. The ASDA House of Delegates has equal representation for each of the 56 United States dental schools. This association is the beginning for many students in organized dentistry, and I know that ASDA has played a significant role in shaping my professional identity. ASDA gives students an active voice in discussing issues that concern dental students and the dental profession. It is one of the most valuable experiences I had during dental school.

Through leadership in ASDA, students begin to develop a sense of ownership within dentistry. Part of ASDA's mission is to protect and advance student rights and the dental profession. Many leaders within ASDA have the opportunity to represent students to various organizations within the dental community. One such opportunity is the American Dental Association's House of Delegates. ASDA has five voting seats in the ADA House of Delegates and is involved in framing ADA policy. The voice and representation that students have is an honor, and many ASDA leaders have had the chance to represent students across the nation on issues that were brought before the ADA House of Delegates. ASDA students are making decisions based on many of the ethical principles that were instilled in them from early childhood. But beyond that, these students are making decisions based on their learning in dental school and what they believe is best for the future of dentistry. ASDA members in both the ASDA House of Delegates and the ADA House of Delegates learn to focus on what is ethically right for the public and the profession and to understand the importance of leaving personal gain behind. This lesson is

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invaluable in a selfless profession in which patients are and should be the number one priority.

I would like to share with you three resolutions the American Student Dental Association adopted this year regarding the improvement of ethical behavior among dental students. The fact that these resolutions were brought to the ASDA House of Delegates proves the interest students have in protecting and advancing ethics among dental students.

The first resolution addressed changing our membership application to include "Members shall voluntarily abide by the ASDA Student Code of Ethics." This resolution also sent the ASDA Student Code of Ethics to our Council on Membership for review and revision, and the council's deliberations will be presented at our next house meeting. Currently, the ASDA Student Code of Ethics aligns with the ADA Code of Professional Conduct, but it could be more focused on ethical behavior during the didactic years. The ASDA hopes to revise the Student Code of Ethics to address behavior more specific to dental school and expectations as a dental student. Students would be able to use this Code of Ethics to ensure their behavior is acceptable. Through collaboration with the ADA, the American Dental Education Association, and the American College of Dentists, ASDA hopes to develop a mutually accepted Student Code of Ethics or Honor Code that can be employed nationwide.

The second resolution charged ASDA to investigate the feasibility of a pre-specialty peer review system among dental students at every school. At the present time, there is no standardized mechanism in place that holds students accountable for their actions and ethical decisions by peers. Many students feel that peer review councils would be effective in encouraging increased ethical behavior toward patients and peers in dental school. If a peer review system were in place, students would be able to assess candidates applying for specialties and postgraduate positions. ASDA's Council on Professional Issues is currently working on this issue.

The last resolution recommended that ASDA formulate a letter to dental schools with recommendations on forming a committee on ethics consisting of students, faculty, and administration. ASDA members believe there is not an open forum at schools to address ethical issues and concerns. ASDA hopes that students would be able to increase communication among students and with administration regarding ethical behavior in the dental school setting. This committee would encourage open discussion of ethical issues and promote professionalism within each school.

ASDA publishes an ethics section in its quarterly journal, *Mouth*. These ethical dilemmas typically address clinic situations that might arise and how students should handle them in an ethical manner. Additionally, the Spring 2008 issue of *Mouth* was dedicated entirely to

Students who do behave ethically and responsibly want to see repercussions and consequences applied when unethical students are identified.

Many students feel that peer review councils would be effective in encouraging increased ethical behavior toward patients and peers in dental school.

the subject of ethics. We feel that the more exposure students get to ethical standards and situations the better for the entire profession.

Ethics in the Schools

I want to share with you just a few examples of students and schools that are taking a proactive role in developing strong ethical dentists for the future of this profession. These are examples of the many schools and students making a difference in the ethical arena. We have chosen to be a part of a great profession, and many of us want to protect the integrity and image that we hold dear.

All dental schools report having ethics classes or in-depth exposure to the ADA Code of Professional Conduct. This should be an integral part of the dental school curriculum. Although the ADA Code of Professional Conduct does not specifically address unethical behavior in school, it is a great foundation for the expectations of being a dental professional.

I believe that by the time a student enters dental school at the average age of 24, the ethical core values and moral principles have been in place for years. It is hoped that students have not reached that level of academic success through unethical behavior. But schools are given a huge responsibility to take action if an unethical situation arises. In recent years, threats of litigation upon the consequence of expulsion due to unethical behavior have led schools to be timid in applying the correct and appropriate repercussions. Threats of this kind cannot continue to lead our educational and professional process down the wrong path. Students who do behave ethically and responsibly want to see repercussions and consequences applied when unethical students are identified. I believe there is an unspoken reward to ethical behavior that enables a person to feel morally healthy. But when students see other students behaving unethically with no punishment applied, it becomes harder and harder to struggle to maintain an ethically sound mentality. Based on a poll of the American Student Dental Association members, it is clear to me that students believe the majority of the reported cases go unpunished or are punished with mild consequences. Students believe this must change.

Although much of the publicity is centered upon negative ethical behavior from dental students, the majority of students base their decisions on the highest ethical standards, and there are schools that are taking action to promote positive ethics.

One model of ethical education within the dental school curriculum I have found quite impressive is at New York University College of Dentistry. They have approximately 50 didactic hours devoted to ethical courses throughout the four years of their dental education.

Dr. Fred More is the course director, and he has done an excellent job in preparing dental students for ethical situations that might arise while in dental school or as a dental professional. He challenges students to prepare for any unknown circumstances and decisions they will face during their lifetime. Cases are used to teach students the importance of decision making and how different decisions result in different outcomes. Dr. More encourages students to remember that there are always two sides to every story and that one must consider both when making ethical decisions. Dr. More uses cases that are relevant to current ethical issues within dental schools. Each year there are new cases as different ethical infractions occur.

Another great example is the dual degree DMD/Master in Bioethics that the University of Pennsylvania offers to students entering dental school. Typically, two to four dental students per class enroll and complete certain classes to obtain both degrees. The program gives students an exposure to the full range of topics and issues in contemporary bioethics. ASDA District 3 Trustee Lindsay Pfeffer will complete the program this year and finds the classes "very educational and inspirational."

Dr. Jos Welie, ethics professor from Creighton University, was ASDA's keynote speaker at its 2007 Annual Session. Dr. Welie encouraged students to take a proactive role and stand up for ethics. He called many of the white-coat or "Welcome to the Profession" ceremonies "ethical drive-bys," stating that students do not take a one-time reciting of an Oath or Honor Code of Ethics seriously. He challenged students to approach their administrations to provide meaningful experiences for students.

Another example of a proactive role is the University of Mississippi School of Dentistry, where students publicly sign the school's honor code, witnessed by peers, family, and faculty, and it continues to be displayed for the extent of each student's educational career. This helps to increase student awareness and education in ethics and helps to solidify the expectations of dental students throughout their academic and professional careers.

Other examples of curriculum change that are addressing the ethical issues are schools that are using the comprehensive patient care clinical model. Some have eliminated "requirements" documented by numbers of procedures in the expectation that this will encourage students to treat the whole patient and not the procedure.

I am sure there are many other schools around the nation taking a proactive role, and I hope that they will continue in their efforts to promote positive ethical behavior among students.

Students Are Ready to Contribute

These examples of positive ethical movements are only the beginning in turning the wheels down the right path. We cannot try to point the blame at any one institution or organization, but we must continue to take a proactive role in resolving this ethical crisis before it is too late. So instead of always pointing the finger at the bad, let us remember to pat the good on the back.

A critical part of organized dentistry is to become involved and ensure that it will continue to be led by ethically sound dentists. The importance of positive ethical role models for students and young dentists is exceptional. If you have not had the opportunity to mentor a young dentist, I encourage you to make it a top priority. The future of dentistry is bright and you can become an integral part in promoting positive ethics in dentistry. ■

Dental Students Persuade the Michigan Dental Association to Strengthen Its Codes of Ethics

Do Actions Speak Louder than Words?

Marilyn S. Lantz, DMD, PhD, MSD, FACD

Abstract

This is a case study of how four different groups viewed proposed language in professional ethics codes regarding personal relationships with patients. The ADA Council on Ethics, Bylaws, and Judicial Affairs; the House of Delegates of the Michigan State Dental Association; and first-year students at the University of Michigan School of Dentistry favored a strongly worded statement in their codes, while the House of Delegates of the ADA passed a statement that was more "advisory" in nature. Support material concerning the statement on personal relationships is presented as an ethics case, and suggestions are presented regarding the ethical principles underlying positions on the issue.

At a time when the American Dental Association is focusing much attention on addressing the issue of academic integrity in the nation's dental schools, it is a pleasure to share a "positive ethics" story about dental students. The story begins after the 2002 annual meeting of the ADA House of Delegates. At that meeting, the house overwhelmingly rejected a resolution to add a specific Code of Professional Conduct addressing sexual misconduct by dentists to its Principles of Ethics and Code of Professional Conduct. The specific Code of Professional Conduct rejected was recommended to the house by the ADA Council on Ethics, Bylaws, and Judicial Affairs (CEBJA). It read:

> 2G. PERSONAL RELATIONSHIPS WITH PATIENTS. It is unethical for a dentist to engage in a dating, romantic, or sexual relationship with a current patient of record. This prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

In its stead, the house passed a resolution to include the following statement as a Code of Professional Conduct:

> 2G. PERSONAL RELATIONSHIPS WITH PATIENTS. A dentist should avoid an interpersonal relationship that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient.

In a report to the Michigan Dental Association on the 2002 ADA annual session, the speaker of the MDA House of Delegates, also a delegate to the 2002 ADA house, characterized this resolution as the most controversial before that year's House of Delegates. He described the resolution that was passed as a "rather watered-down" version of the resolution originally proposed by CEBJA (Secord, 2002). I also participated in the 2002 ADA House of Delegates as an alternate delegate. I contributed to the discussion and debate around these resolutions in our district caucuses, at the reference committee hearing, and on the floor of house. I was surprised by the intensity of the debate and the outcome.

I direct a course in ethics and professionalism for first-year dental students and I am always looking for teaching material that makes ethical dilemmas facing the profession "real" for dental students. I wondered how first-year students would respond to these resolutions and which one they would support. To find out, I decided to use this issue as a dilemma-resolution scenario for the course final examination. In constructing the scenario, I used information available to the delegates and I tried to capture the essence of the arguments for and against the resolutions that I heard proposed. The scenario is presented on page 25. In large part, the

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background material is abstracted from a report prepared by CEBJA in support of the resolution it proposed to the 2002 House of Delegates. Students studied the ADA's Principles of Ethics and Code of Professional Conduct as part of the first-year course, but the topic of dentist sexual misconduct was not considered during the course. For clarity, CEBJA's proposal for Code 2G was called 2H in this scenario because the substitute 2G had already been added to the ADA Code.

Student Response

In contrast to the position taken by the 2002 ADA House of Delegates, the students overwhelmingly supported adding proposed Code 2H to the ADA Code. Of 107 students who took the examination, 80 favored including Code 2H in the ADA Code, 23 concluded that Code 2G as it currently stands is a sufficient expression of the profession's position on sexual misconduct, and four students were undecided. It occurred to me that one explanation for the discrepancy between the position taken by the students on this issue versus the position taken by the delegates to the 2002 house might be that the students encountered this dilemma as part of a (graded) final examination and were therefore looking for the "right" answer. If that were the case, it would be an interesting finding in its own right. I think, however, that this is unlikely. This dilemma was also presented to senior dental students over a two-year period where they considered it as part of an ungraded professional development sequence, as individuals and in small groups where there was a degree of anonymity. The results were the same. By a wide margin, the fourth-year students voted to include 2H in the ADA Code. Moreover, when I was reading the first-year students essays, I was struck by the quality of the arguments that many of our profession's newest members made in favor of the dental profession adopting 2H.

Michigan Dental Association Response

In early 2004, the Committee on Peer Review/Ethics of the Michigan Dental Association considered whether it should develop a resolution for the MDA House of Delegates to address sexual misconduct by dentists. I made copies of the essays written by the first-year students (with all identifiers removed) available for review by committee members so that they could gain some insight about how the students viewed this dilemma. At the conclusion of its deliberations, the committee decided to submit the following resolution for consideration by the 2004 MDA House of Delegates to expand on Code 2G:

> Resolved, that at a minimum, a dentist's ethical duties include terminating the dentist-patient relationship before initiating a sexual relationship or sexual contact with a patient. Be it further resolved that this prohibition does not apply if a

A large body of evidence suggests that much of what health professions students learn about what it means to be a professional is taught in the "hidden" or "informal" curriculum of health professions education programs.

> sexual relationship existed prior to the initiation of the dentist-patient relationship. And be it further resolved that this prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

During the discussion and debate of this resolution on the floor of the 2004 MDA House, a second-year dental student from the University of Michigan (Dr. Erin Kloostra, Class of 2006), serving as a student delegate to the house, rose and spoke on behalf of her classmates. She spoke passionately about the students' desire to have our Codes of Conduct be more than "adequate," for dentistry not to be the only major profession that leaves this type of behavior open to individual interpretation, and for clearly articulated rules and guidelines that we can all follow. She said that she and other students cared about this issue because dentistry is the profession into which she hoped to graduate (Mastey, 2004). Her remarks were applauded by over 200 members and observers of the MDA House of Delegates. After much discussion, the resolution was passed, and Code 2G was amended in the combined MDA and ADA Codes of Ethics.

Students often "model" the professional behaviors of individuals they admire or wish to emulate, including peers, faculty members, and dentists from the community with whom they interact.

Reflecting on the Story

It is encouraging that dental students were able to play a role in strengthening the MDA Code of Ethics. After reading the first-year student essays, I formed some impressions about how our dental students viewed this dilemma. In general, students in favor of adding Code 2H to the ADA Code supported their position by raising issues about dentists' professional obligations to protect the public's welfare, to not abuse the special relationship of trust with patients and the public, and related issues. In other words, these students gave reasons to support their point of view that were, in general, "other" directed, focused on their commitment to their future patients and society. In contrast, students who believed that Code 2G, as written, is a sufficient statement of the profession's position on sexual misconduct, tended to support their point of view with reasons that were more "self" directed, such as, that it may be awkward or embarrassing for a dentist to refer a patient to a colleague under these conditions, or that it could be inconvenient or extremely difficult or burdensome to comply with Code 2H if a dentist is practicing in a remote area and has no colleagues practicing nearby.

As I reflected on discussions I heard during the 2002 ADA House of Delegates, the same general themes emerged. There may be many reasons, beyond those considered here, for the 2002 ADA House of Delegate's rejection of CEBJA's resolution to address sexual misconduct by dentists. If dentist self-interest played a major role in that outcome, it would be cause for concern.

A large body of evidence suggests that much of what health professions students learn about what it means to be a professional is taught in the "hidden" or "informal" curriculum of health professions education programs (Stern, 1998). Unlike the formal curriculum, which is described in our course syllabi, the hidden curriculum is often unarticulated and it "runs" at all times in parallel with the formal curriculum. Our students learn a whole curriculum of values and ethics just by observing the choices and

actions of "teachers" in their environment. Students often "model" the professional behaviors of individuals they admire or wish to emulate, including peers, faculty members, and dentists from the community with whom they interact. They also learn lessons about what it means to be a professional by observing the decisions and actions of the dental profession itself. Arguably, this hidden curriculum of values is a much more powerful influence on student learning in ethics and professionalism than what is taught in this discipline in the dental school's formal curriculum.

Perhaps the American College of Dentists could encourage the ADA to take a broad view and make some recommendations to enhance its Principles of Ethics and Code of Professional Conduct as it develops recommendations to enhance academic integrity at U.S. dental schools. Such actions may speak much more powerfully to dental students about what it means to be a professional than any recommendations for action or policy statements the ADA develops to enhance student's academic integrity. ■

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Scenario: An Ethical Dilemma for the Profession

Beginning in the late 1990s, the ADA Council on Ethics, Bylaws, and Judicial Affairs conducted a three-year comprehensive study on whether dentist sexual misconduct should be addressed in the ADA Principles of Ethics and Code of Professional Conduct (ADA Code). CEBJA concluded that the subject should be addressed in the ADA Code and recommended that specific language be added to amend the code, as follows:

> 2H. PERSONAL RELATIONSHIPS WITH PATIENTS. It is unethical for a dentist to engage in a dating, romantic or sexual relationship with a current patient of record. This prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

The reasons for this recommendation are cited below.

First, CEBJA argued that the dentist-patient relationship is characterized as "fiduciary." In a fiduciary relationship, one party places trust and confidence in another party, who accepts and encourages that trust in an undertaking. The more powerful party is held to a higher standard that requires him or her to act only in the best interest of the other. Professionals, unlike lay persons, are in a unique position of power by virtue of their professional status.

Second, in the course of their study, CEBJA reviewed the codes of ethics of other professions to assess their positions on sexual relationships between professionals and patients or clients.

There is a long-standing consensus within the medical profession that sexual contact between physicians and patients is unethical. In 1989, the AMA adopted an ethical rule that is unequivocal. Its Code of Ethics states that:

> Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being.
>
> If a physician has reason to believe that the non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

The American Osteopathic Association's ethical principle is similarly unequivocal in its Code of Ethics:

> It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.

The American Chiropractic Association published an addendum to its Code of Ethics which reads as follows:

> *Sexual Intimacies with a Patient*
> The ACA Ethics Committee ("Committee") has received numerous requests for clarification relative to the ethical implications of sexual intimacies between a doctor of chiropractic and a patient he or she is treating. The advisory opinion is intended to resolve any misunderstanding and to state that it is the opinion of the Committee that sexual intimacies with a patient is unprofessional and unethical based on the existing ethical provisions in the ACA Code of Ethics: A(6), A(7), A(10) and C(2).

(continued on next page.)

Scenario: An Ethical Dilemma for the Profession (continued.)

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct provides:

> *Sexual Intimacies with Current Patients or Clients*
> Psychologists do not engage in sexual intimacies with current patients or clients.
>
> *Therapy with Former Sexual Partners*
> Psychologists do not accept as therapy patients or clients persons with whom they have engaged in sexual intimacies.
>
> *Sexual Intimacies with Former Therapy Patients*
> Psychologists do not engage in sexual intimacies with a former therapy patient or client for at least two years after cessation or termination of professional services.

The APA's code also provides expectations for psychologists who wish to engage in an intimate relationship with a former patient after two years. The APA, however, has a draft of a new code for member comment that proposes a perpetuity rule that would prohibit relationships no matter how much time has elapsed since the last client visit.

Though lawyers are not health care providers, the legal profession has similar professional stature and accountability to the public. The American Bar Association's Model Rules of Professional Conduct also prohibit client-lawyer sexual relationships:

> A lawyer shall not have sexual relationships with a client unless a consensual sexual relationship existed between them when the client-lawyer relationship commenced.

Two states, Massachusetts and California, have already disciplined dentists for engaging in sexual relationships with patients. The reasoning applied in these cases is consistent with ethical views published in the dental literature on this subject. In discussing the appropriate boundaries between dentists and patients, ethicists point out that sexual contact between dentists and patients is unethical, legally perilous, may be cause for professional discipline, and can be viewed by the public as an outrageous transgression. They suggest that dentists who find themselves romantically attracted to patients should either avoid initiating a more intimate relationship or refer the patient to another dentist.

CEBJA recognized that "professional standards in this area are evolving and believes that it is vital to dentistry's ability to manage critical issues that it continue to be perceived by the public as a highly ethical profession." They stated that "silence on a subject with the potential for such egregious consequences is a void which must be filled." CEBJA suggested that if a dentist wishes to enter into a personal relationship with a patient of record that the dentist terminate the professional relationship and refer the patient to another practitioner. Therefore, CEBJA recommends amending the ADA Principles of Ethics and Code of Professional Conduct, by adding the following:

> 2H. PERSONAL RELATIONSHIPS WITH PATIENTS. It is unethical for a dentist to engage in a dating, romantic or sexual relationship with a current patient of record. This prohibition does not apply to relationships between a dentist and his or her spouse or equivalent domestic partner.

You are a practicing dentist and a member of your state's delegation to the ADA House of Delegates. You have recently been elected an officer of your state dental society and you will soon assume a leadership role in organized dentistry in your state. At the annual session of the ADA House of Delegates you and the other delegates will be asked to vote on a resolution to amend the ADA Principles of Ethics and Code of Professional Conduct, by adding Code 2H.

As your delegation discusses this issue, it becomes clear that two very different points of view are emerging. Some members voice the concerns that the proposed Code 2H would place unreasonable restrictions on dentist's freedom of choice and would violate a dentist's personal privacy. They are concerned that it would be awkward and/or difficult to refer a patient to another practitioner under these circumstances. This group also expresses the opinion that the proposed Code 2H insults dentists who dated and subsequently married individuals who were, at the time, patients of record and now it is being implied that they behaved unethically in these relationships. In this group's opinion, Code 2G, which is already part of the ADA Code, is broad enough to deal with this issue and no additional codes are necessary.

In contrast, a number of delegation members agree with CEBJA and strongly support adoption of proposed Code 2H as written. They reject the idea of using Code 2G as the profession's "statement" about sexual misconduct because it is extremely vague, subject to many interpretations, and fails to adequately address the issue of sexual misconduct by dentists. This group believes that dentistry should stand on a par with other professions by making a strong statement about not exploiting the public's trust in the profession in this particular way.

As an emerging leader of organized dentistry in your state, you are asked to make a recommendation to the delegation about whether or not it should support addition of proposed Code 2H to the ADA Principles of Ethics and Code of Professional Conduct. What will you recommend? Is Code 2G a sufficient statement of the profession's position on sexual misconduct or does the profession need to add proposed Code 2H to its Code?

Please use the space provided on the next page to write a principled argument to support your position on this issue. Your response should contain at least three distinct justifications for your recommendation.

Positive Ethics and Dental Students

Sigmund H. Abelson, DDS, FACD

Abstract

Recent negative publicity has drawn attention away from recognizing and celebrating the ways today's dental students differ in a positive fashion from previous generations of dental students who may have suffered the same ethical lapses we are hearing about now. Dental students are more diverse than their predecessors and learn to develop a sense of integrity that encompasses more toleration of alternative cultures. They are group-oriented, which expresses itself in sharing responsibility for their colleagues, both in educational settings and in their practices. With guidance from senior dentists and organized dentistry, they will contribute inclusiveness and group responsibility and thus strengthen the profession.

The literature is replete with articles about the decline in ethics among dental students and in professional schools. Many examples are given that focus on cheating on examinations and other negative occurrences. While these events reflect poorly on our dental students and our profession, I submit that these breaches of ethical behavior are not representative of the overall behavior of the students. In fact, while newsworthy and troublesome and requiring response, these ethical concerns represent a very small percentage of our student population.

The dental student of today has been exposed to a very diverse world, representing gender and a wide variety of cultures and ethnicities compared to the dental student population of 20 to 30 years ago. The students have become acculturated to this new society and are, therefore, much more tolerant and understanding than their predecessors. What this exposure to a diverse student world has resulted in is a dental student that has greater appreciation for the different ethical behaviors of various cultures and ethnicities. What is considered ethical and acceptable in one culture may not be so in a different culture. Understanding and accepting this has resulted in most students being more tolerant and accepting of others, including those new populations representing the patient bases many practitioners are now serving.

Students must learn to communicate in and forge new communities of value. Students can do this because they base their values on a common core of integrity that transcends cultural differences. If one truly has integrity than he or she will exhibit the character traits expected of a healthcare professional.

The dental students today do exhibit integrity. It is seen in the way they care for their patients, offering truly comprehensive oral health care. Much of the credit for instilling integrity in our students goes to the faculty who act as true professional role models. The students not only learn clinical skills and didactic knowledge from the faculty, but they also learn character. That is why it is essential that faculty members be positive professional role models for students.

Students inherently want to do the right thing. It is the faculty's obligation and that of senior dentists in associateships and practitioners who serve as role models to ensure that students maintain and enhance this value. When students see that those they admire are truly living these values, they will not only adopt these values and concepts, but they will enhance them.

Dental students themselves have taken the lead in promoting ethical values among their colleagues. They have formed student ethics clubs to discuss ethical

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issues which are proactive measures to enhance the understanding, concepts, and ultimate value of ethical behavior.

Dental students have also formed study clubs and asked faculty members to assist them in developing their practice management skills. There has been an emphasis on understanding the various models of oral healthcare delivery. It is important for students to understand how different models of healthcare delivery such as fee for service, PPOs, HMOs, capitation plans, and contracted service agreements work. With this knowledge they can make economic decisions on how they will conduct their professional practices while not sacrificing their core ethical values. This initiative of the students is very impressive and speaks well for their desire to use their professional skills, understand the economics of private or group practice, and maintain their integrity and values in delivering their services.

One force for positive ethical behavior that is exhibited by dental students is related to the way students learn today. The pedagogy that is used now in dental schools focuses on student-centered learning. This may be problem-based learning, case-based learning, or other modalities where the student is an active participant in the learning. This type of learning contributes to ethical behaviors because it places emphasis on learning as a team. The student learns that each member of the learning team is dependent on the others. The team dynamics help promote both responsible behavior and a greater understanding of how to learn from each others' strengths.

When students understand that they are valued members of a team and that there are standards, accountability, and expectations for the team, behavior that would be considered unethical or lacking in integrity will not be attempted because it will not be tolerated by the group. Group dynamics are an important factor in developing character traits and ethical values among students and practitioners.

Students carry over early learned behavior to their clinical experience where they work in group practice settings. Again, there is a group dynamic. Unethical behavior by a member of the group reflects on the entire group of students and if that were to occur, the group actively works to see that this behavior stops.

Another important factor that influences and assists in developing ethical values and behaviors is the role of organized dentistry and professional organizations such as the American College of Dentists in promoting these values. By attending programs such as ethics conferences and sessions devoted to professionalism, which organized dentistry sponsors at the local, state, and national level, students learn the importance of developing these positive character traits and understanding what it means to be a professional.

Using the definition of integrity as "how one would behave when no one is looking," we can feel comfortable with this generation of students. When the instructor is no longer looking at their work, we can be confident that they will exercise correct judgment and ethical values in making their treatment planning decisions.

This is extremely important in this era, when dental students graduate with, in many cases, $300,000 of debt. When they enter private practice, they will be pressured, sometimes by the examples of dentists in the community, to make decisions that can be influenced by the economic situation. By instilling ethical and moral values in them when they are students, this will be part of their core values when they are practicing healthcare professionals facing difficult decisions. Ethical core values will assist in guiding those decisions.

Dental students are the future of the profession. The dental students of today, having had exposure and interaction with diverse cultures and ethnicities, and benefiting from innovative pedagogies that enhance team and personal responsibility, will be true healthcare professionals of the future, grounded in ethical values, and will practice and live their lives with integrity.

Not only are the dental schools realizing the importance and value of having students well-grounded in ethical behavior, but the students themselves understand the importance of developing ethical values and the rewards of living a life of integrity. ■

When a student understands that he or she is a valued member of a team and that there are standards, accountability, and expectations for the team, behavior that would be considered unethical or lacking in integrity will not be attempted because it will not be tolerated by the group.

Issues in Dental Ethics

American Society for Dental Ethics

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Violation of Trust

Ethical and Legal Considerations in a Case of Research Fraud

Sigrid I. Kvaal, BDS, Dr Odont

Abstract

In 2006 a researcher at the main hospital in Norway admitted that he had forged data in a study published in the medical journal *The Lancet* that was co-authored by 13 others from both Europe and America. The researcher, dually qualified in dentistry and medicine, immediately admitted fabricating the results. A Commission of Enquiry reported that most of his publications were fabricated or manipulated and that he was alone in the fraud. As a result, the researcher lost his authorization to practice medicine and dentistry. His action has shaken the trustworthiness of science and the trust for the scientific community, both in the institutions that support the research and in the review process in science publications.

Following this revelation, the management of scientific fraud has been widely discussed, including concerns about the dual role of a Commission of Enquiry as both investigator and judge, and also the legal rights of fraudulent scientists. Other issues concern the responsibilities of supervisors and institutions in the guidance of candidates in research procedures and ethics. In addition, commentaries have appeared in national newspapers as well as in medical and dental scientific journals. Various issues have been discussed, including the fact that editors and referees in scientific publications rarely have the opportunity to check raw data, which emphasizes the need for data confirmation by independent groups. These reflections have been fruitful for the community, although it will not, nor can it, prevent fraud in the future.

A press release on January 16, 2006 from the Rikshospitalet-Radiumhospitalet Medical Center in Norway stated that a hospital scientist had fabricated data in cancer research. He had written, together with 13 co-authors from both Europe and America, an article that was published in the prestigious scientific medical journal *The Lancet* in October 2005 (Sudbø et al, 2005). The article, which was based on the author's doctoral dissertation research, reported that non-steroidal anti-inflammatory drugs (NSAID) might reduce the risk of oral cancers but increase the risk of cardiac problems.

The division director of the newly established national health register discovered that the study's data were claimed to have been received from a drug registry before it was actually operational. She warned other colleagues and health institutions about this discrepancy. When a search was made in the raw data, it was obvious that all 908 patients had been invented. A couple of years earlier the American National Cancer Institute had awarded a $10 million research grant to a prestigious international research group, and a

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substantial amount of that sum had been allocated to a clinical study at the Radiumhospital in Norway. The fraud, with its international involvement, was picked up by news agencies and became a worldwide research scandal.

The lead researcher, who was also employed as a consultant at the hospital, was dually qualified in odontology and medicine and had obtained a doctorate in medicine in 2001 at the University of Oslo, Norway. He had 38 publications listed in *PubMed*. It soon became clear that it was not only *The Lancet* article that was based on fraud, for he admitted a partial manipulation of data in earlier articles in the *Journal of Clinical Oncology* and *The New England Journal of Medicine*. In addition, several other of his publications were suspected of containing fictional or incorrect data. Both *The Lancet* and *The New England Journal of Medicine* have issued expressions of concern (Curfman et al, 2006; Horton, 2006).

A Commission of Enquiry was appointed in the middle of January 2006. Although the researcher had confessed to inventing and manipulating the data in three publications that derived from his doctoral thesis, the commission concentrated on the research work which made up most of his doctoral thesis and the articles that resulted from it. The investigation turned out to be more extensive than first anticipated, and at the end of June 2006 the Commission published a 144-page report. This report is the major source of background material for this article and is available in English at www.rikshospitalet.no/portal/page/portal/no/forsiden/globale/oss/article_doc?p_doc=411236&p_dim_id=44887. (Although this paper contains only references in English, much of the source material is available in Norwegian, and scholars who are interested may contact the author.)

Thirty-eight articles were reviewed and almost 60 co-authors in five different countries were contacted by the commission in its investigation. In the initial phase, the co-authors were asked to make a written statement of their involvement and answer questions. All the co-authors responded to the initial contact, which demonstrated their willingness to co-operate and may indicate that they did not have anything to hide. Some of the co-authors were also called for one or more interviews with the commission, during which they were questioned on their statements and asked to clarify inconsistencies. In addition to these statements, the commission obtained copies of correspondence and documentation from co-workers and compared these with the published results.

The commission found that most of the published research was based on manipulated or incorrect data, and they recommended that 13 of the articles be withdrawn. As early as 2001, an article in *The New England Journal of Medicine* contained examples of manipulations such as double registration of patients and fictitious interviews. In addition, various other inconsistencies were noted. For example, patients who already had been diagnosed with cancer were included in a study of patients with a risk of developing cancer. Altogether, 69 out of 141 patients should have been excluded for various reasons. The results presented in the article were therefore not representative.

An article in the *Journal of Clinical Oncology* from 2005 contained inconsistencies and incorrect registration of data, and the commission also questioned whether the patient material presented in the paper existed at all. *The Lancet* article from 2005 was based on 454 fictitious patients and an equal number of controls, and was thus founded entirely on fabricated material.

The report concluded that the researcher had acted independently in manipulating the data. This he could do because he had full control over the material and all communication. There was no evidence that any of the co-workers were involved in the fraud. None of the co-authors were given opportunity to check the results, and, when they made enquiries, they were given different explanations. In one of the articles it was stated that the diagnosis of the material was checked by one of three oral pathologists, but it did not specify who. When questions were raised, inquirers were given the impression that it had been done by one of the other two, which as it turned out, was not the case. This was an example of collective and cumulative mistakes.

As a consequence of a recommendation from the commission, the University of Oslo retracted the researcher's doctoral degree. The Norwegian Board of Health Supervision has also withdrawn his authorization to practice as a medical doctor and dentist.

This paper looks at some ethical issues related to the report of the Commission of Enquiry. Some ethical aspects related to co-workers, co-authors, and institutions to which they belong will also be discussed. Included are some reflections on the process of peer review in scientific journals and on the responsibility of editors, both in scientific publications and in the national press.

Ethical Considerations

Fraud in science may be defined as the intention to deceive, in contrast to error or carelessness. It includes fabrication, falsification, and plagiarism. The term dishonesty may be used to separate all

forms of misconduct from carelessness and honest mistakes (Franzen et al, 2007).

Determination of Fraud

The Commission of Enquiry that was appointed in this case was headed by a highly respected non-Norwegian professor of epidemiology at the Karolinska University Hospital in Stockholm. The other four members were from the Faculty of Law and the Faculty of Medicine at the University of Bergen, from the Institute of Public Health, and from the Research Council of Norway. The secretary, a law graduate, was from the Department of Public Health and General Practice at the University in Trondheim, Norway. All members represented institutions not connected to the Radiumhospital or the University of Oslo, and nobody has questioned the impartiality of the commission.

The task of the Commission of Enquiry was to conduct an independent investigation in accordance with the detailed terms of reference. As explained in its paper, the commission has applied "a standard of evidence entailing a qualified preponderance of probability as a condition for accepting a particular fact as grounds for the report."

One of the differences between a court of law and a commission of enquiry is that in the latter case, the same group of people performs the investigation, presents findings, draws a conclusion, and in most cases gives recommendations for action in such a way that it acts both as the investigator and judge. The conclusion has no official judicial status, but such a commission's recommendations have serious and wide-reaching implications. The hearings are private, and although the defendant and some of the co-authors in this case were given drafts that included the opportunity to challenge their findings, the commission's findings are regarded as facts with no opportunity to appeal. It is essential that such a commission has members that can understand both scientific and legal implications of the case. In addition, members must be independent and preferably from outside the institution, since administrators at research institutions and universities often do not have such expertise and may not appear to be impartial. Furthermore, some universities are reluctant to initiate investigation in alleged fraud cases because they may fear that a guilty verdict will stain their reputation (Brumfield, 2007). Such concerns are magnified when, as in this case, the researcher has legal representation.

Supervisory Responsibility

Another ethical concern in this case pertains to the responsibility of the supervisor of a doctoral thesis to guide and advise the candidate. A doctoral thesis must be original and independent research, and it is the supervisor's responsibility to ensure that quality assurance control of the work is performed. However, the candidate might easily get a feeling of distrust if the supervisor repeats all the tests in order to verify the candidate's data entries. Some candidates work more independently than others, and in this case there was no reason to question whether anything untoward had been done when the researcher said that he had done it. Another responsibility of a supervisor is to help with the applications to the various legal and ethical committees. In Norway there are several examples—including this case—of compromised follow-up.

The working relationship between a supervisor and a PhD candidate is now more formalized than it was 15 years ago. The present regulations for the degree of Philosophiae Doctor (PhD) state that supervisors and PhD candidates must maintain regular contact and that

The Lancet article from 2005 was based on 454 fictitious patients and an equal number of controls, and was thus founded entirely on fabricated material.

the supervisor is responsible for ensuring that the PhD candidate participates regularly in an active research group. Both parties have to sign ethical regulations. The examples set by senior researchers and department heads who show positive leadership appear to be important in fostering good ethical conduct (Giles, 2007).

Responsibilities of Authorship

Co-authors' and institutions' responsibilities have been widely discussed in the medical community and in the press. The International Committee of Medical Journal Editors, Uniform Requirement (Vancouver Regulations) states that the authorship credit should be based on "substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content; and final approval of the version to be published." Authors must meet all requirements. These requirements are available at www.icmje.org.

The requirements state quite clearly that co-authors should contribute substantially to the article. Even so, the requirement that all co-authors should be involved in all three processes has been criticized for its strictness (Kwok, 2005). Current research is often so specialized that there are few others who can do the job. However, all authors have to take part in discussions, critical reviews, and the granting of final approval of the manuscript.

In addition, the granting of authorship requires justification. Collection of data alone no longer is considered as meeting that requirement. Along a different line, in at least one of the articles investigated in the fraud case, the suppliers of research material were co-authors. According to the Vancouver instructions, they should only have been included in the acknowledgments.

The tradition of gift authorship was once an accepted procedure, but no longer meets the requirements of the International Committee of Medical Journal Editors. An example is that in some countries there has been a tradition that the head of department is always included as an author. Such traditions also exist in some departments in Norway, but not in the fraud case presented here.

Issues in the Editorial Process

The editors of scientific journals have authority over the editorial content as well as the quality and scientific relevance for their readers. They seek advice from referees, but they make the final decision themselves, which means that they have the responsibility to see that what they publish is of the required quality and scientific standard. However, each country has its own national regulations and medical systems, and it is unreasonable that overseas editors will know about them.

Another issue is the duty of the editors to retract already published articles where it turns out that the research is based on false and incorrect data. Equally, the co-authors should check their references to ensure that retracted articles are not included (Sox & Drummond, 2006). (One exception might be that the retracted paper contains detailed description of methods unavailable elsewhere.) Then comments and retractions should be included (Odell, 2007).

The responsibility of referees in scientific journals is considerable, but also limited. They can comment on the scientific content and presentation. They should check that the relevant statistical methods are applied, but they have to trust the authors' statement on how the raw material was collected and entered into the analyses. Articles must present new discoveries or methods to the scientific community to reach the high-ranking medical journals. This fraud case, as well as several others, shows how important it is that all new discoveries are confirmed by other independent groups before they can be accepted in the scientific community.

Other Ethical Issues

Plagiarism has long been a difficult issue for editors and the scientific community to deal with. In today's world, the risk of plagiarism is significantly increased by access to the Internet and is not easy to demonstrate unless the entire work is copied. Plagiarism was not an issue in the current case.

Another issue pertains to the education of researchers. All research institutions—hospitals, universities, or national organizations—together with the supervisors and co-worker have the responsibility to educate the fresh researcher in the ethical principles of research. This not only implies attending courses but also the daily application of principles by supervisors and senior researchers who inevitably must be regarded as role models. It is also important that the institutional recommendations for the conduct of research be known and followed by all researchers. In addition, a procedure for making complaints should be available and known by all.

Commercialism in science and publications may also encourage misconduct. For example, some scientific journals are dependent on "revealing" discoveries in order to sell their product. Research groups are dependent on

grants that are awarded to innovative groups who produce many publications in journals with a high impact factor. Such competition may lead to rushed results rather than well-controlled studies.

Response from the Scientific Community and the Public

A book describing a case of whistleblowing in medical research was published in Norway shortly before this research fraud was discovered. The *Journal of the Norwegian Medical Association* received letters to the editor related to the content of the book and to ethics in research in general; misconduct reported earlier in this paper was a case in question.

The first issue of the *Norwegian Dental Journal* in 2006 contained an editorial on ethics in research which was in print before the fraud case described in this paper was made public, and the journal closed the year with another editorial summing up what had happened during the year. Both the aforementioned journals published separate expressions of concern related to a single article that was published in both journals. Based on the statements in the commission's report in the current case, the article has been retracted without the researcher's consent. In addition, all the co-authors have taken the initiative to write to the two journals and to ask for retraction of the relevant articles.

The research fraud described in this paper was also a popular topic in the national press in Norway. The researcher was regarded as guilty from the start, and since he had admitted fraud, this assumption was to some extent correct. The co-authors, on the other hand, were found neither responsible nor negligent by the commission. They were, however, heavily criticized in the press before the commission's report was published. It was repeatedly maintained that there was no way they could be co-authors and not know of the fraud. A letter to the editor from a medical professor published by a national paper led to a complaint to the Ethics Council of the Norwegian Medical Association. The council considered it "important, timely, and commendable" that the responsibilities of the research institutions with regard to publications are discussed in public, but in this case "unnecessary condemnatory phrases had been used to characterize co-authors."

There are many stories of how whistleblowers have been treated badly by the research community and institutions. This case was different. The division director of the national register, who first alerted colleagues to the fact that the cancer research may contain irregularities, has today more fame than she feels she deserves. She maintains that she is no hero but did what she felt was her duty as a newly appointed administrator. This duty is to notify the appropriate authorities when irregularities are discovered in research, provided that the irregularities are based on well-founded facts.

Implications and Reverberations

As mentioned previously, the researcher was found guilty of fraud, lost his job, his PhD, and his authorization to practice both as a physician and dentist. In addition, his scientific work is regarded as invalid. More than that, his fraudulent scientific work could have serious consequences for patients and is not in conformity with good medical or dental practice. Based on these arguments there was no other choice but to withdraw his authorization to practice. Furthermore, his doctoral thesis contained so many errors in the data that it should not have qualified for a degree. Each of these decisions is well founded, and when such fraud is uncovered it must have

The researcher was found guilty of fraud, lost his job, his PhD, and his authorization to practice both as a physician and dentist.

The examples set by senior researchers and department heads who show positive leadership appear to be important in the fostering of good ethical conduct.

serious consequences. It is a truly serious and tragic end for a good clinician and a highly intelligent scientist.

When the fraud was made public, a PhD candidate from the Faculty of Dentistry had just submitted her thesis. Some of her research had been based on material received from the fraudulent researcher. Her thesis had to be withdrawn and she had to start again from scratch.

Anxious telephone calls have been received from patients who wondered what was going on. Fortunately, even though some patients had been allocated to the research program, none of them had been included. Therefore these anxious callers could be reassured. This program is now discontinued.

The commission had recommended that institutions and universities strengthen their controls to prevent fraud. On June 1, 2007 a new act on ethics and integrity in research was introduced in Norway. This act reinforces the previous regulations and makes them more formalized. The preparation work for this act was started before the fraud presented here was discovered, but this case reinforced the need for ethical approval and complaint procedures in research. Both national and regional ethical committees will be established, and prior approval has to be obtained if the research involves human subjects. The National Committees for Research Ethics in Norway were established as independent institutions as long ago as 1990. Having been initially disbanded, the new act has called for the reinstatement of such national and regional committees.

The Faculty of Medicine, University of Oslo, already has a Web site with good information regarding ethical issues which is both relevant for undergraduates as well as established researchers, and both the Faculty of Medicine and the Faculty of Odontology now cooperate on education regarding research ethics and procedures.

Several questions remain unanswered, among them the fraudulent researcher's motives for acting as he did and choosing to violate the trust given to him by his supervisor, his co-workers, and his research institution. It is quite clear that the article in *The Lancet* was written with the intention of deceiving, and in some of the other publications there is certainly a strong suspicion of intent to defraud. His earlier work could at best be attributed to ignorance. One can only speculate on the reason why he chose this course of action. It has been shown that some researchers constantly try to prove themselves by publishing papers or behaving unethically if they think managers are treating them unfairly (Giles, 2007). Whether this is a possibility here is unknown.

Science published in July 2006 an article entitled "Fake data, but could the idea still be right" (Couzin, 2006). It states that three groups are trying to follow up the researcher's initial work on DNA abnormalities in cells as a prognostic factor. An article from March 2007 shows that the diagnostic technique using DNA abnormality to predict the development of cancer can have predictive value in oral verrucous leukoplakia, but the background material in this article is very small (Klanrit et al, 2007). It has also been shown that the abnormal DNA in cells from lesions on other sites than the oral cavity can be used to predict the outcome of treatment.

It is possible that the researcher's main conclusion was correct. However, the evidence so far has not been as convincing as his research maintains—not a surprising observation since he had deliberately improved the results. Regarding NSAID in cancer prevention, that is still an open question (Rainsford, 2007).

One other issue that evolved from this case should be noted. In June 2007 the researcher was granted restricted authorization and allowed to practice dentistry under supervision in a community dental clinic. This action has provoked questions about whether lower ethical standards are required to practice dentistry than medicine.

Conclusion

Scientific journals make public the results of research work done all over the world. The scientific community has always relied on trust from co-workers and institutions, and that what is submitted for publication is factually correct, but someone will always try to manipulate the truth and betray that trust. When serious fraud comes to light, other minor irregularities are also discovered. Errors, however, are made all the time. They may be unintentional by excluding outlying data, not including patients where data is missing, incorrect statistical handling, etc. (Franzen et al, 2007). Such minor acts of misconduct are much more common and potentially more damaging to the scientific progress and are rarely discovered (Giles, 2007). Preventive measures cannot stop those whose intention it is to commit misconduct. Good record keeping, robust and positive mentoring, and experiments which are run properly rather than rushed are important factors so that professionals and the public can trust biomedical science. New revelations in scientific research are rarely valid before they have been replicated by independent groups. This case is an example of fallibility in many aspects, including the education and training of researchers, the peer review process of journals, and the self-regulation of scientific professionals. ■

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Large Ethics

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Abstract

This essay presents an alternative to the traditional view that ethics means judging individual behavior against standards of right and wrong. Instead, ethics is understood as creating ethical communities through the promises we make to each other. The "aim" of ethics is to demonstrate in our own behavior a credible willingness to work to create a mutually better world. The "game" of ethics then becomes searching for strategies that overlap with others' strategies so that we are all better for intending to act on a basis of reciprocal trust. This is a difficult process because we have partial, simultaneous, shifting, and inconsistent views of the world. But despite the reality that we each "frame" ethics in personal terms, it is still possible to create sufficient common understanding to prosper together. Large ethics does not make it a prerequisite for moral behavior that everyone adheres to a universally agreed set of ethical principles; all that is necessary is sufficient overlap in commitment to searching for better alternatives.

Long ago in Greece, so long ago in fact, that history and mythology are indistinguishable, Sisyphus was king of Corinth. He chanced to observe a form like a magnificent eagle carrying a maiden to an island. The girl was Aegina, daughter of the river god Asopus. When the river god asked for Sisyphus' help, the king explained what he had seen by way of doing a good turn. Big mistake! The eagle was Zeus, who never took kindly to anyone interfering with his dalliances. Sisyphus was condemned in Hades to forever push a large boulder up a hill, only to have it roll back to the bottom each time.

That is an apt metaphor for the history of ethics over the past 3000 years. Each new generation wants to try its hand at showing how things ought to be done, all to the displeasure of the fatigued older generation that complains "You're going about it the wrong way; just wait and see." We really have not made much progress on this task of improving mankind's basic ethical nature. (A different metaphor is appropriate for science. The boulder does not roll back down on scientists nearly as much; but there is always another and higher hill when the top of each ridge is reached.)

Here is the real tragedy of the story: we are not even certain Sisyphus was on the right hill. Literally, we may have made so little progress in trying to make people be good by getting them to do things our way precisely because that is not the proper business of ethics. Like the pot of gold at the end of the rainbow, we might go on searching endlessly just because we do not have the big picture right.

In a companion piece to this essay, entitled "Small Ethics," which appeared in the Spring 2007 issue of this journal, I argued that big ethical issues are rare and difficult to hold in focus long enough to get consistent solutions. Most of us engage in routine minor ethical lapses that can be understood as opportunism —intentionally acting as if agreements had been renegotiated in one's favor in order to see what is really permissible. The analysis of small ethics makes it clear how impractical it would be to sharpen our ethics detectors or expect to curb wholesale opportunism. We are in need of approaches to ethics that manage damaging ethical behavior without killing off those who engage in it.

By watching others work on landmark theoretical issues instead of our own small ethical lapses, we have been able to maintain the comfortable fiction that there is a grand ethical system. We would prefer to see this as concerning good guys and bad guys, rules and punishment. Good ethical theories should not leave us wondering where we stand and should issue warrants in case we want to nail those caught trespassing. There are many good ethical theories built on high principles, but

they are aspirational and none of their proponents believe that most of us are consistently moral in that sense. Most of us only have momentary glimpses of this grand scheme, and those who have spent their careers peering through the fog of specific good and bad behavior keep sending back conflicting sketches for the grand plan.

The purpose of this essay is to explore a general theory of ethics that works for all of us all the time. It would have to account for the fact that we have our ups and downs; but we are all players, and in the end we should know in a general way which behavior is more to be desired and how to promote it, even if we cannot achieve perfectly consistent results. It is necessary to see if big ethics can be saved from ridicule just as small ethics was. Is it possible to have a general ethical system that we are proud to endorse despite its holes and dead ends?

Ethical Aims

Ethics is often thought of as something like geometry. It is a theoretical discipline with a practical analogue, often called moral behavior. If we understand that triangles are bisected rectangles we can calculate the amount of paint needed to cover the side of a shed that has a sloping roofline. Some people seem to "see" it and other do not, but we can teach courses that might help. Although the rules of Euclidian geometry combine this common sense insight and pure theory, we may be vaguely aware that there are alternative systems, each theoretically defensible, where what is self-evident is not really true.

I remember Mrs. Ferry explaining all of this to me in high school. I also remember the contortions she went through to convince us that the lines we used to draw our triangles were only representations and were entirely too fat. The ideal line in geometry is so thin that it only fills the space left between the theoretical and the practical worlds. I have always thought of that as an impractically small space. It certainly has the potential for letting a few things ooze over from one side of the line to where they do not belong.

Perhaps Mrs. Ferry understood in some fundamental sense what has been wrong with our approaches to ethics. The line that theory draws in our ethical space is too thin to effectively sort the good from the bad behavior in anything like a consistent fashion. Arguments over the placement of such lines have engaged some of the best minds over the centuries—mostly in controversy.

The essay on small ethics made a case for having no "line" at all, at least no line that was continuous and that entirely delineated the entire ethical domain. Rather, there are substantial barriers, some of which significantly deter ethical lapses. But these barriers are porous, there are large gaps in places, and the barriers move from time to time. As realistic as this picture might be, it is horrifying to ethicists. This is "ethical relativism": barriers are supposed

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Twenty-five hundred years of tromping around in the field has not produced much agreement on where the ethical landmarks are.

to stay where we agreed to put them. Otherwise there would be some uncertainty over whether individuals were acting ethically, and punishing people would become an untidy business.

I think I have experience on my side in describing ethics in such terms. Twenty-five hundred years of tromping around in the field has not produced much agreement on where the ethical landmarks are. Ethical people sometimes disappoint. (A few years ago some students complained to me in an ethics class that I was teaching that somebody had stolen the assigned readings from the library.) Punishment has failed to deliver on its promise—witness the cartoon with the hangman placing a noose over the condemned man's head and intoning, "I hope this teaches you a lesson." And ethics is becoming such a messy business we are happy to let others do it, and I fully expect to see it soon on that television show, "America's Dirtiest Jobs."

But I know I do not have theory on my side. If I were so smart, I should be able to think up a new rule that clearly identifies which of us are good, in distinction from those others. The rule would be easily taught and recognizable. And it could be enforced unambiguously to the benefit of society. (Wait; do I hear the sound of several smirks from a few who believe there are such rules? No, that was just the sound of a few people changing their minds.)

Not every question that can be asked has an answer. For example, "Is it hotter in Florida or during the summer?" First, we need to get the question right. If all we mean by ethics is general approaches for enhancing behavior that promotes social good, we may not need rules at all. All that is required is some understanding of how individual behavior contributes to or detracts from social well-being.

Promises to the Community

Consider this paradigmatic story. Every year at the community fair the villagers drank from a large common barrel of wine. It had been agreed that citizens contribute several bottles of their own wine to the community store. Some villagers were generous to a fault, bringing many bottles of fine wine; others were opportunistic, being stingy or even pouring in water. Some years the common draught was pale in color.

Traditional ethical analyses proceed by drawing some line based on principles or community agreement. Those who fail to measure up are labeled unethical. Although few villages would go to the trouble of deputizing wine police, we can predict with great confidence that there would be moralizing and hand-wringing sufficient to compensate for the certain failure of the system. Incidentally, all those above the line would be lumped into the same category, "ethical," regardless of how much or what quality of wine they contributed.

This approach to morality seems to bid fair for taking all the joy out of the village fair. It is certainly calculated to promote some pretty slick ways of getting around the system. The problem is that traditional thinking views this situation as one where ethics must be judged from the outside—objectively, as it were. There might be an ethics equation: $MB < S = R$ (moral behavior that falls on the wrong side of the standard is reprehensible). How can we know, the argument goes, whether something is ethical unless somebody judges it to be so? There is behavior and there is an evaluation of whether that behavior is good or bad—two separate activities. Lots of room for

the parts to disarticulate: certainly enough room to crowd a handful of lawyers or one ethicist into the gap.

The trick to removing the gap between actions and their evaluation, between ethical theory and moral behavior, is to realize that many kinds of behavior are defining as well as being objects of evaluation. When a football referee declares that the ball crossed the plane of the goal line and is a touchdown, various judgments can be made about the call based on partisan perspectives, but the act of making the call creates the touchdown. When state boards grant licenses they both create and certify dentists. When the adoption papers are signed, the parents make themselves responsible for the child. When the dentist diagnoses periodontal disease, he or she becomes liable for malpractice. Ethical behavior is precisely those actions that are intended to place the actor in an ethical position with respect to the community of reference. Those who bring rich wine are saying, "I intend to live in a community where the wine is plentiful and of good quality." Those who water it down say "I don't mind living in a community where the wine is thin and I personally have no need to avoid the possible stigma of being caught contributing less than others." Ethical behavior expresses a view of the kind of world one wishes to live in.

Ethical judgments are about whether behavior is right or wrong; they are not actual moral behavior. We cannot "judge" ourselves or others into better people. But we may be able to "behave" ourselves to higher ethical levels. And—this is the critical point—by taking ethical positions we may be able to affect the entire tone of the community. We certainly alter our relationship with communities by the behavior we exhibit in those communities. Consider the following: "We are out looking for the guy now, and when we find the fool who decided that Christmas should be at such a busy time of year, we will force him to change it." This is an extreme example of a self-referential statement. An individual cannot say "I respect these rules I am breaking." It also sounds strange for people to say, as they seem to be doing with increasing frequency, "I am not guilty because if I were I would have to be punished" or "We agree to pay the fine appropriate to the crime, but we admit no wrongdoing."

It is sometimes mistakenly asserted that Immanuel Kant's categorical imperative—"So act that you could will your behavior as a universal" is an example of the "Golden Rule": "Do as you would be done by." On this reading, heavy drinkers, introverts, racists, and social do-gooders are entitled to ethical protection for advancing their causes. What Kant really had in mind was behavior that is presumed self-evident as a precondition for building community. Three of the four examples in his *Critique of Practical Reason* concern themselves with promises and explanations in terms of self-contradictory language. I believe Kant was trying to say that it is unethical to attempt to create a relationship, a community, where you would not be willing to live. (His fourth example concerns lazy natives in the South Pacific, and that just makes no sense unless you recall Kant's religious right upbringing.)

If Aung San Suu Kyi says there is an opposition movement in Burma, there is one. If no one says there is, there is none. If minorities decline to vote or participate in local government because it is "undemocratic," it certainly becomes more so. The first reason students give to justify cheating in higher education is that "others are doing it." That is probably why people cheat on their income taxes and exceed the speed limit as well. The self-reflective, performance language nature of ethics means that individuals help define by their actions the groups that provide the context against which the ethical tone of their actions are interpreted.

Self-Referential Performance Language

The position I would like to explore is that ethical behavior—actions and language that can be accepted as promises on which others can safely proceed with their lives—is intended to bring about a community one wishes to live in. Promises create community; they allow others to act on their own parts assuming that their conceptions of community (provided there is significant overlap) will be functional. The assumption of and valuing of community-creating behavior is a precondition for living in community. In this sense, ethics is not so much right or wrong as self-confirming or self-contradictory. Cheating, lying, coercion, and hurting others are unethical because they damage community—regardless of what ethicists might have to say about them.

Certainly we need to hold the possibility that individuals can act ethically in ways that have no impact whatsoever on the lives of anyone else. But I believe it may be easier to demonstrate that individuals cannot be considered ethical in a meaningful sense unless they are part of community. It is easy to bring to mind situations were the same behavior is ethical in one community and unethical in another: bribery, fee splitting, nepotism. Alistair

Ethical behavior—actions and language that can be accepted as promises on which others can safely proceed—is intended to bring about a community one wishes to live in.

MacIntyre and John Seely Brown both develop the view that ethics is meaningless outside of community. One might consider, as an example, the case of Alexander Selkirk, who was, by his own choice, left alone on one of the San Fernando Islands four hundred miles west of Chile in about 1690. He was eventually rescued and told his tale to Daniel Defoe, hence the story of Robinson Caruso. But the question no one seems to be able to answer is whether Selkirk was ethical while he was alone on San Fernando? (The executive assistant named Friday was an invention of Defoe.) Actually, the most satisfactory response is probably "who cares?"

The self-referential performance perspective on ethics suggests a slightly different definition for the normative principle of veracity–which is usually taken to mean telling the truth in some objective fashion. If ethics is understood as creating community in which it is prudent for members of the community to proceed as if their interests were aligned, any communication, including silently letting others make assumptions consistent with these assumptions of aligned self-interests, exhibits veracity. This definition helps us wiggle out of the problems over "little white lies" and self-serving rationalizations. Motives do not matter if they have the wrong effect, and the admonition against "false and misleading" advertising collapses into a single consideration: only the "misleading" part matters. We should worry about communication that causes others to do things that are not really in their best interests.

Ethical Games

Alistair MacIntyre uses the example of a game of checkers to show that ethics is meaningful only in the context of community. He claims that it is impossible to play by the rules of checkers and at the same time cheat. Cheating arises when the rules are broken for the sake of winning. The cheater is no longer a checker player; he or she is serving some other, presumably undisclosed and devious motive other than playing checkers well. By analogy, dentists who materially mislead patients during informed consent, who upgrade insurance claims, and who practice so close to the standard of care that mishaps are expected are all no longer professional. They are not poor dentists; they have stepped outside the community of dental practice. What makes their "crime" so heinous is that they continue to hold themselves out as belonging to the profession while they are operating outside it. Unethical practitioners claim the advantages of being a professional while simultaneously damaging the credit the public extends to all professionals. Unethical behavior means cheating in the game of building community.

What, then, is a game? Even though there are rules and chance involved, solitaire and playing with drugs are not games in the strict sense. More is required than structured moves and uncertainty. Games are social, they take place in community, and under the right circumstances they build community. Good golfers want to play with other good golfers.

There are three essential requirements for games: (a) a payoff matrix for distribution of gain and loss that is agreed in advance; (b) certain actions are allowed, others forbidden, and some are optional; and (c) the outcome depends on the interaction between players' moves. The payoffs need not be identical across

players, as in a fox hunt. Sometimes chance is introduced as in bridge, or it may be absent as in chess. Finally, some games are zero-sum—meaning that the total of the winnings exactly matches the total of the losses, as in poker. There are also games that are played under conditions of scarcity (negative-sum), such as the rituals in prisons or prisoner-of-war camps, or perhaps in our welfare system. Most real games, however, involve munificence. There is a net common benefit, and the real issue is deciding how to divide the bonus fairly. The game of monopoly is a good model of what is known as a positive-sum game. The longer the game is played, the more resources are at stake since every player who passes "Go" adds $200 to the pot. Presumably, an evening's entertainment can be enjoyed playing Monopoly and every player ends by having more money than he or she started with. Game theorists have worked out the implications of games of munificence (positive-sum) and games of scarcity (negative-sum) to the point where it is almost certain that a different kind of ethics attaches to each.

Dental practice is a game. Each practitioner attempts to advance his or her self-interests. These include, but are certainly not limited to, economic considerations; reputation, mastery of new skills, service, and curiosity are also desirable outcomes. Patients similarly have goals, as do staff, insurance companies, professional colleagues, and even the government as a representative of the community at large. What the practitioner is capable of achieving depends on the motivated actions of others, just as the practitioner's actions help shape the community. There is also general agreement regarding which actions are acceptable. Some of these are defined by law, such as having a license to practice and paying incurred debts. Some are professional in nature, such as policy regarding patient abandonment and acting as the patient's advocate. Many are locally negotiated and explicit, such as a cancellation fee. Some are subconscious and idiosyncratic like the amount of informality or the extent of technological sophistication employed.

In this game, all parties assume that the others will follow the agreed rules (even if they would have preferred other rules more to their advantage) and that they have a better chance of achieving their self-interests in such a situation than they would under other arrangements (this is the best game in town). If actions are taken outside the rules or if the possibility of achieving important self-interested outcomes is altered, surprise is registered, protests are entered, negotiations for corrections are attempted, and perhaps the game is quit. But as long as the three necessary conditions for a well-ordered game are maintained, continued play can be expected to lead to increased satisfaction for all players, or at least to satisfaction for some and neutral results for all others. Long-term patients, staff, and commercial and professional relationships are preferred because less time is lost establishing mutual expectations, because increased trust permits greater freedom and flexibility in negotiating ambiguous actions, and because dentistry is a positive-sum game, practitioners, patients, and others benefit more the longer they are mutually engaged. Well-played games build the community, which is a precondition for their being played.

Unethical practice consists of activities that damage the community (the agreed conditions for well-ordered games). If a dentist allows the patient to believe that a new bridge will last a lifetime, the dentist is acting unethically because the patient plans and acts in ways that will be to his or her detriment and professional colleagues will suffer from unrealistic expectations circulating in the public. The unethical behavior is not the misrepresentation; it consists of allowing the patient to form expectations about dentistry that are unrealistic and damaging. If the dentist shades disclosure with the intent to get patients to agree to a new (to the dentist who has just spent $20,000 in CE programs) and experimental procedure so the dentist can get good photos for his or her own CE program or recoup the expense of training and new equipment, the dentist is unethical because the rules of the game have changed without the patient (the other player) being notified. The community they have been building is subject to being pulled apart. If the dentist exaggerates an aspect of treatment alternatives to steer patient choice, he or she is guilty of an ethical breach against autonomy—all players in games must have the opportunity to withdraw. If the office manager makes a few personal copies on the office equipment and then tells the dentists, offering to make restitution, this would not be considered an example of unethical behavior. It might actually strengthen community in the office by making the rules regarding private use of community resources clearer.

Opportunism, as developed in the first essay, can now be placed more clearly in the context of ethics. It is

behavior that probes the bounds of acceptable game playing. It would be futile to attempt to categorize all of its various flavors by predetermined rules; instead we look to the effect it has on community to decide what must be done about it.

The terms "game" and "ethics" do not naturally go together. There is some baggage tied to games that has nothing to do with the three formal conditions stated above. Some think of games only in terms of winner and losers, or worse, they fail to distinguish between "competition," where the goal is to win, and "aggression," where the goal is to destroy others. It is sometimes said that something is "only a game." This means that the interactions among people is artificial and do not count. If the outcomes are unsatisfactory, we all return to the position ex ante. Sometimes, as in "love was only a game for her," the goals and rules for "her" differ materially from the goals and rules for the series of "hims." In these latter two cases, there is a game within a game. If we agree to play poker for match sticks we are negotiating about the game of an evening's entertainment which will consist of a game of cards (properly with lots of commentary and helpful hints about the play where the only ethical danger is bad manners). For the game within a game of love, the risk of unethical behavior is substantial because there is an attempt to deceive regarding future mutual expectations. Finally, there is the pejorative use of game in the sense of "gaming the system." Smart, rich folks game the income tax system by following the rules to the letter of the law without honoring its intent. That is outrageous opportunism.

Multiple, Poorly-Defined Games

So far we have considered the case of well-defined games where all players understand and use the same rules and the case of unethical games, where one party attempts to deceive the other regarding which game is being played. Now we take up the much more common situation where players engage in similar or complementary but different games at the same time and in the same place. Surprisingly, most of us pull it off quite handily.

I will tell the story of one such situation involving an attempt to play a formal game with more than 100 people. The game is known as "the prisoner's dilemma," and as typically played, individuals or groups are asked to choose among two alternatives: cooperating with the person running the game to the detriment of a potential partner or cooperating with a potential partner to the detriment of the outside party. What makes this a game is that the potential partner is offered the same choices and communication between potential partners is constrained. In the munificent version of the game, the outcomes are rigged so that if both potential partners cooperate with each other, they both win; if either defects, he or she wins big but the potential partner suffers. This is a game of trust. It is a stock exercise in MBA programs and has been used at the ACD LeaderSkills programs. The point of the game is transparent: ethics wins. (In my teaching, I have used the exercise many times and find it singularly ineffective. I have seen repeat players, following clear demonstration of the advantages of trust, readily revert to defection.)

In the very large exercise I recently participated in, it required about ten minutes to lay out the rules because the game had some complex variations. Only a few minutes into the rule giving, the leader had lost the attention of many groups: they were already discussing strategy. And that was before the objectives of the game were presented (which included both ensuring that one's own needs were met and that the interests of the entire group should be maximized—clearly signaling that both could be done together—munificence). The play of the game was chaotic. Some groups flagrantly violated the given rules; others were sneaky; some redefined the goal as engaging in clever little ruses; some struggled along in frustration; and many simply used the time to chat about personal matters. Each played its own game, but only one group completed the exercise according to the given rules. During the debriefing, each group defended what it had done, even though there was no consistency in the activities.

This is a situation where multiple, poorly-defined games were being played at the same time in the same space. The leader of the exercise may have had a rule book and two objectives, but an observer who was screened from that information would be unlikely to have been able to reconstruct it based on observing the apparent intentions of participants. The written post-meeting feedback confirmed the impression that no sense of community was built in that exercise.

The goal in the companion essay on opportunism was to develop an approach to ethical lapses that preserves the agent intact while addressing immoral behavior. The goal in the present essay is to develop an approach to ethics that remains valid even when it is confessedly incomplete and inconsistent.

Types of Unethical Behavior

What requires explanation is why ethical behavior does not always occur, even when ethical behavior is defined positively as building community that is mutually beneficial. An apparently obvious situation that is ethically neutral is where individuals have so little in common regarding shared rules or mutually reinforcing goals that there is virtually no likelihood of useful interaction. A dentist is usually disinterested in potential patients in other states or insurance programs that offer unattractive terms. These would be "a-ethical" situations—there is no realistic prospect of damaging each other through mutual efforts to advance common interests.

The second situation involves intentionally unethical behavior. Cheating, lying, shoddy work, breach of contract, and the like share a common feature that one party offers to play one game but substitutes a different one to the detriment of other parties. Intentionally unethical behavior creates false expectations about mutual future behavior in the community. This is the world of frauds, quacks, charlatans, and con artists. It includes taking unfair advantage, plagiarism, false statements, and any other misrepresentation. It damages the person who plays the honest game and is thus deceived. It also damages the community generally that supports such honest games. It is the abuse or misappropriation of a community good (reputation and trust) for personal means.

Opportunism is near-unethical behavior. It is exploration of the boundaries of games. Opportunism has the potential for damaging community if others in the game do not respond by clarifying and reinforcing the rules. This is the situation dental education finds itself in currently. Students are probing, but it is unclear that the academic community is responding by means of useful discussion about what the rules should be. The practicing community is struggling in a similar fashion over the opportunism exhibited through commercialism.

There is another category of "unethical" behavior that potentially opens a useful understanding of what it means to be ethical. Ethical differences exist among people who have overall motives for cooperating in building better communities. Sometimes this takes the form of errors. Those who study them generally distinguish between "slips" and "mistakes." A slip is an unintended action that will be disavowed if detected or will be corrected immediately if self-detected. HIPPA violations, billing errors, and statements that might impugn another's integrity are of this sort. A mistake is an intentional action that was taken based on partial information or misinformation and only comes to light when the consequences are revealed. In the famous movie, The Oxbow Incident, a lynch mob purposefully hangs a man, only to find later that they made a mistake. Due diligence and reasonable prudence are expected to reduce the chances of ethical mistakes (and one may be criminally liable for negligence in these regards, but only if a bad outcome occurs), but the hind-sight quality of this kind of ethical reasoning is obvious. Also in this category are the various cases of ethical waffling. Indecision and inconsistency bother attempts to tidy up ethics.

Ethical Frames

A common feature of these examples of unethical behavior can be expressed as "framing." Perhaps we can assume that no individual is intentionally unethical:

Unethical practitioners claim the advantages of a professional while simultaneously damaging the credit the public extends to all professionals.

Adding to this realistic confusion is the fact that individuals, as ethical actors, play more than one game simultaneously.

different individuals simply define the issue differently and respond accordingly. That would certainly appear to be true for slips and mistakes. The behavior was correct, given the prevailing interpretation of the situation on the ground at the moment. Indecision and inconsistency are plausible examples of partial frames or ones that go in and out of focus. Perhaps even opportunism is an effort to discover which frames apply in various situations. But what of downright deception and intentionally unethical behavior? At least it must be agreed that the deceived party has one frame for the situation and the deceiving party has a different frame that includes the "con frame" as a sub-element.

Ethical frames are actors' understanding of their own and others self-interests and the rules of ethical games. They are always incomplete. This follows from the rule of "bounded rationality" proposed by Herbert Simon. This Nobel Prize winner in economics developed the idea half a century ago that humans are intentionally rational but practically limited in this regard. We have too little mental capacity and too little time to gather all the relevant facts and evaluate all alternative outcomes in even the simplest practical situations. We fall back on habits of action that have worked in the past and only seriously analyze issues, and then only for limited periods of time, if we encounter unexpected situations or are artificially required to do so, as in classroom situations for example. We always work from incomplete frames of situations that provide our basic understanding by highlighting limited salient features.

There is a considerable body of research arguing that criminal behavior is substantially explained on the basis of small frames. Sociopathic behavior has a common foundation in individuals' inability to see their immediate actions in the larger contexts either of the norms of society or their own long-range self-interests.

Finally, it must be noted that frames can be expected to change over time. As one gets deeper into a situation, new evidence is uncovered, better understanding is achieved regarding other's interests, relevant rules and expectations are uncovered. This happens at the individual level, causing the appearance of a person changing his or her mind. It also happens in the larger history of human ideas. Plato understood justice as every element of society or human nature being in its correct place and being ruled by reason. In the seventeenth century justice meant adherence to agreed rules. Today, a view popularized by John Rawls is justice-as-fairness, or, even beyond that, to some notion of entitlement.

The perspective of evolving frames helps clarify an issue in complex ethical situations. Ex ante and ex post analyses of unfolding ethical issues may differ—and may both be correct. An instructor announces a firm deadline for a class project, with grade penalties for late work. Many students miss the deadline, and on investigation, it is discovered that a project of great weight was due at the same time in another course. The instructor relaxes the rules and accepts late projects with no penalty. This is greeted with appreciation by the students who were late and derision by those who worked hard to get the project in on time (and may even have received a poor grade because of low quality due to being rushed). The ex ante ethical position and the ex post position support alternative ethical views; both create different definitions of community.

Ethical situations involving mercy should be analyzed along such lines.

Ethical frames may exhibit a different kind of inconsistency, one of a logical nature. This is known as the transitivity problem, and it can be illustrated as follows. A is better than B, B is better than C, and C is preferred to A. King David, in the "Book of Samuel" encountered a problem of this sort. He placed his lust for Bathsheba above his respect for her husband's life and so placed him in a battle where he would be killed. He viewed himself as an enlightened ruler who punished unethical behavior. But when Nathan confronted him with the logical chain leading to the conclusion that he should punish himself, King David waffled big time.

Transitivity is at the heart of one of the central problems in healthcare economics. Kenneth Arrow proved an impossibility theorem regarding the fair allocation of health resources. We begin with five reasonable assumptions: (a) there are at least three good alternative applications for our resources; (b) preferences for one alternative are not dependent on other available choices; (c) society has real preferences; (d) these preferences are intransitive; and (e) all involved must agree. It turns out that it is impossible, under these assumptions to determine the optimal allocation of resources. The big problem is that preferences are unstable.

The transitivity problem is not soluble in ethics, certainly not by means of specifying rules. We are back to the problem of the imaginary line that divides the ethical from the unethical realms. Not only is it thin; there are large gaps where systems are silent or where individuals are not paying attention. The segments of lines move from time to time, or at least they appear to move based on shifting backgrounds. And with the transitivity problem we must be prepared to deal with ethical space in more than two dimensions. All ethical decisions cannot be placed unambiguously on a single continuum.

It may not be so easy now to put the moral genie back in the ethical bottle. It is fine to say, as we apparently have agreed to do, that intransitivity makes thing messy and that is why we have so many papers and hire so many lobbyists. But there is something deeper working in this frame. For purposes of ethical analysis, does it make sense to say that the individual is the appropriate unit of analysis? We are dealing with an entity (human nature) that is well-known for its shifting form, for its inconsistency across contexts, and for purposefully seeking new identities through participation in different groups. And what of groups themselves? Are not the AARP, the Oregon State University, and the clique that hangs out near the Coke machine by the gym ethical entities, capable of all the ethical and unethical actions that apply to individuals?

Adding to this realistic confusion is the fact that individuals, as ethical actors, play more than one game simultaneously. From the perspective of an officer in a state or component dental society, the ethical problems of a quack colleague take on one cast; if the dentist is a member of a peer review committee, the same problem can appear differently. As a colleague, and perhaps as a partner in the group practice, the identical situation has now become complex indeed.

Recognizing the possibility of multiple frames, each potentially valid and overlapping or interacting in some situations, may be a necessary requirement for a realistic understanding of moral behavior. But it is unlikely that this possibility will simplify matters any. The practice in modern bioethics is to use highly restrictive frames to focus on "pure form" issues of the MB < S = R type, where MB is a specific level or type of moral behavior, S is the applicable ethical standard, and R is the judgment of reprehensibility if the behavior fails to meet the standard. This conceptualization, this framing of the ethical problem, simply says that the behavior which does not come up to standard is reprehensible. Those who place these equations in play, as in teaching or discussion among practitioners, are often caught by the "yabuts." Exceptions seem to emerge from hiding; alternative framings show up; hypothetical extenuating circumstances come to hand. One way to dodge the yabuts is to restrict the conditions or allow multiple framing: MB* < S = R,* MB' < S = R', or MB" < S = R", etc. (very rarely altering S). Often, ethical avoidance is a search for frames that allow one to be absolved of responsibility for undesirable behavior without having to take inconvenient action. "Ya, but..." is the door to ethical relativism.

True ethical discourse is a search for overlapping frames that preserve or create new and more robust communities where apparently conflicting moral equations can be reconciled. This involves us in multiple simultaneous equations. In some cases the honest solution to such sets remains indeterminate and in some the solution involves simultaneous solutions based on acceptance of shared equations and constants. This may provide a mathematical model for both game-theoretic views of moral behavior and for the sometimes elusive aim of ethics as building community

through joint ethical action. As a replacement for the inadequate metaphor that ethics involves judging which side of the line a person is on, I suggest a richer picture, one involving multiple overlapping frames that define an ethical space. This is the zone in which those in the ethical community are free to act on the promises of mutually harmonious pursuit of personal interests. The goal of ethics is to build robust ethical spaces and to make them as large and inclusive as possible.

This approach to big ethics is sometimes described as "discursive ethics." The essential features of this view are that those affected by community norms should have an opportunity to participate in discussing and framing them, as well as a responsibility for both living and enforcing them if failure to do so would undermine the community. Such discussion may take the form of conversations, writing, or other displays. It is not the arguments or rational content of this communication that matters, but the underlying promise that others in the community can count on not being damaged by acting on the implied promises justified by the actions and declarations of others in the community. Very often, such promises are nothing more than announcing that one is a member and acting consistently with the expectations of the community. That is certainly the sense in which professionals promise to be ethical.

There is a further element in discursive approaches to community building beyond mutual promise-making. Occasionally, a frame emerges in discourse that has portability; it appears to work well across discussions. When that happens, the frame undergoes a conversion from background to object and even to the status of agent. These are called discursive objects or documents. An example is the "Belmont Report" that began as the consensus of 11 ethicists about treating participants in experiments with regard for their person, beneficence, and justice. The report has assumed it own identity over the past quarter century to the point where it anchors the deliberations of Institutional Review Boards that must approve all research project in the medical and psychological sciences (if the sponsoring agency eceives federal funding for any of its research). The Belmont Report "sits" as a participant in all IRB meetings.

Harmonizing Aims, Games, and Frames

It may appear at this point that the partial, simultaneous, shifting, and inconsistent frames through which ethical situations are understood offer more of an excuse for confusion than a way forward. It is certainly true that the descriptive nature of frames and games accounts for the difficulties and confusions that attend ethical problems. But ironically, the same approach is normatively powerful and supports useful statements with the word "ought" in them. It is naive to assume that the only two positions are ethical universalism (the fantasy that we can create rules that covers all situations for everyone) and relativism (the expedient position that no rules are possible because anyone can justify his or her own views). The middle ground is ethical pluralism. There are two requirements for this view: First, there must be sufficient overlap among frames to support good faith efforts to engage in meaningful ethical games to build community. The overlap need not be complete; it only needs to be extensive enough to engage the process. The second requirement is a discursive promise to engage others in clarifying ethical space in fashions that are self-justifying ways to establish preconditions for ethical effort.

This might be the correct point to visit Kant again. He made a second attempt to explain himself on ethical matters by saying that we should never treat humanity as merely a means to our own ends. This has been popularly interpreted to mean individuals have rights that should not be abridged by casting those individuals as instruments to some other, even larger purpose. The problem here is that the term *Menshcheit* in German is a mass noun, roughly equivalent to "mankind." Thus, Kant seems to be saying that we should not act so as to damage community.

Actions intended to be ethical always flow from frames, our necessarily limited understanding of the problem as presented. Much of ethical conflict can be traced to divergent frames. Good ethics education would consist of two parts: (a) widening frames to include the salient features common to our professional communities and (b) acquiring skills in negotiating when frames are recognized as incomplete or divergent: resolution of ethical conflict as metagames.

It has been observed for years that children in the ages of four to six engage in parallel play. They build, vocalize, and emote in small groups that have the appearance of shared purpose. On closer inspection, each child is in a parallel world that interacts sufficiently to allow others to play their own games. That is "protoliberalism." Naturally, we as adults do much better. We can manage partial incompleteness and inconsistency because full consistency is not required in many cases. For example, Gödel has proven that the system of real numbers (1s, 2s, etc.) cannot be simultaneously complete and consistent. Heisenberg has demonstrated that we cannot simultaneously know a particle's location and direction of travel. Arrow showed that there is no system for allocating welfare resources that is both consistent and commonly agreed at the same time. In none of these cases is simultaneous consistency and completeness a prerequisite for engaging in collaborative effort. Practically, there is enough overlap for us to mutually benefit through cooperation. The only fundamental assumption is willingness to engage in the self-referential activity of building ethical communities. And when we discover that there is insufficient overlap to ensure prima facie confidence in mutually proceeding as if there were agreement, we can engage in discussion to determine whether the necessary degree of overlap can be created. If not, we can agree to part ways without coercing a continuing relationship against some party's wills.

In this sense, the ethical theory developed here remains valid even while the ethical rules on which other theories are based change. Discursive ethics is grounded in a self-referential process that both creates community and at the same time uses community to give meaning to ethical acts. Some degree of inconsistency and incompleteness is built into the system, along with means for working out such divergent frames and games. Other ethical theories to this point have been built on rules that must either be regarded as poorly understood and implemented or as wrong because they are different from other systems. By contrast, redeeming the promise of creating ethical communities works well even when it does not work perfectly.

It would be difficult to prove that human nature has been genetically modified to make it more ethical since Sisyphus started pushing his rock. But we have reduced much of the traffic in slavery; we care about what happens in parts of the world where there are drought and natural disasters; pressure is brought to bear on tyrannical rulers; prisoners have rights; and we try to eradicate diseases on a global scale. All of this would come as a surprise to our colleagues a few thousand years ago. If it is problematic whether individuals are made of better stuff, there is a good case to be made that we are learning how to push the rock together and that we have made some progress in raising the collective standard. ■

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Recommended Reading

Summaries are available for the three recommended readings with asterisks. Each is about eight pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in 15 minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on big ethics; a donation of $50 would bring summaries for all the 2008 leadership topics.

Gauthier, David (1986).
Morals by Agreement.*
Oxford, England: Oxford University Press. ISBN 0-19-824992-6; 367 pages; about $20.

Moral action is analyzed in game-theory terms. It is assumed that perfectly rational and fully knowledgeable individuals recognize that cooperation offers better prospects than does the state of nature where it is "every man for himself." An economic model is first considered where each participant selects the strategy that ensures a maximal return based on the assumption that others will attempt to minimize what is available. This can be improved upon by agreeing in advance to some principle for fairly sharing the common surplus in society. Gauthier's libertarian views show through at times.

Habermas, Jürgen (1984).
The Theory of Communicative Action. Volume One: Reason and the Rationalization of Society.*
T. McCarthy (Trans). Boston, MA: Beacon Press. ISBN 0-8070-1507-5; 465 pages; about $20.

In the German tradition of scholarship, Habermas combines philosophy and a little psychology with political theory; he is not concerned with the individual in the moment, but with nations over centuries. In this, the first of two volumes, he lays out his view of communicative action—individuals agreeing to commit to a common course of action—and the emergence of Western culture through governing society by tradition, through market and legal individual self-interest resulting from the Enlightenment, to today's search for a new basis of shared meaning (through communicative action).

James, William (2007/1907).
Pragmatism: A New Name for Some Old Ways of Thinking.
Sioux Falls, SD: NuVision.

A distinctively American approach to philosophy, Pragmatism holds that the complete meaning of ideas is captured by understanding what it means to use the idea in action. The bottom line in ethics for James would be to judge what I do and not what I am talking about.

Luce, R. Duncan, & Raiffa, Howard (1957)
Games and Decisions: Introduction and Critical Survey.
New York, NY: Dover.

The authors' primary topic can be viewed as the problem of individuals reaching decisions when they are in conflict with other individuals and when there is risk involved in the outcomes of their choices. Games are situations where individuals seek to maximize their utility by initiating strategy in the face of a generally known structure with uncertainty introduced by others' strategies or by unknown states of natures. The book describes games under increasingly complex sets of assumptions: zero-sum, non-cooperative, cooperative, n-person games with possibilities for coalition, and group decision making or the impossibility of a completely satisfactory welfare distribution.

Weick, Karl E. (1995).
Sensemaking in Organizations.*
Thousand Oaks, CA: Sage Publications. ISBN 0-8039-7177-x; 231 pages; cost unknown.

People construct rather than discover meaning. But there are patterns in this process. It begins when there is an interruption in experience. It is discursive, retrospective, and embedded in categories, a chopping of the continuous flow of experience, social, and driven by purpose rather than accuracy. It can be driven by beliefs or actions.

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