Journal *of the* American College *of* Dentists

Lessons Learned

Fall 2009
Volume 76
Number 3

Journal *of the* American College *of* Dentists

A publication advancing excellence, ethics, professionalism, and leadership in dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD.

Postmaster–Send address changes to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

The 2009 subscription rate for members of the American College of Dentists is $30, and is included in the annual membership dues. The 2009 subscription rate for non-members in the United States, Canada, and Mexico is $40. All other countries are $60. Foreign optional airmail service is an additional $10. Single-copy orders are $10.

All claims for undelivered/not received issues must be made within 90 days. If claim is made after this time period, it will not be honored.

For bibliographic references, the *Journal* is abbreviated J Am Col Dent and should be followed by the year, volume, number and page. The reference for this issue is: J Am Col Dent 2009; 76(3): 1-52.

Member Publication
AADE
American Association of Dental Editors

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.

Objectives of the American College of Dentists

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.

Correspondence relating to the *Journal* should be addressed to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

Business office of the *Journal of the American College of Dentists:*
Tel. (301) 977-3223
Fax. (301) 977-3330

Lessons Learned

Manuscript

Issues in Dental Ethics

Departments

Cover photograph: Otto Bismarck is supposed to have said,
"It is wisdom to learn from mistakes, especially the mistakes of others."

From the Editor

E-mail

My point is simply this: if people do not have much to say, giving them a powerful means for doing so is a mistake. E-mail is more about the connection than the content.

E-mail is an ornery acquaintance. I can do a lot of things with it that I could never have managed before; in fact I did not even know a few years ago that it would be worthwhile doing those things. And people I do not know at all have figured out how to do things to me everyday that I find annoying. The number of words and images exchanged in the world has exploded. But I have not been able to find on e-mail's cousin, the Web, any references to studies showing that communication has improved.

I have no doubt that e-mail will shortly go the way of the "Selectric" typewriter. We will drop it long before we figure out whether it is useful because something better will come along. The smart money is on voice and visuals. And readers of this journal heard it first in a paper by Sysco Systems president John Chambers which we published in 2004 (check it out at the College Web site).

My point is simply this: if people do not have much to say, giving them a powerful means for doing so is a mistake. E-mail is more about the connection than the content.

I smile when I hear colleagues "outbid" each other in "complaining" how many e-mail messages they have to clear out on a daily basis. They are addicted to looking at the screen or their Personal Whatever in hopes of getting lucky with an invitation to speak at a prestigious meeting; or glowing praise for a journal article; or one's spouse or lover just saying "I was thinking of you." Generally, those who expect these messages are disappointed because the number of people who use e-mail this way is much smaller than the number who wish it were. Most e-mails are either useless intrusions or requests that add to the length of the To Do List. They are losing numbers in the lottery.

There are three distinctive features of e-mail, compared with a handwritten note with postage attached: speed, asynchrony, and cost. There are some good things to say about each feature and some real gripes.

E-mail has dramatically cut the time it takes to pass a message, especially internationally. I can consult a colleague in England more quickly than I can get the answer from anyone in the building where I work. It is a quick delivery system, but the content still has to be good. I typically type a letter as a Word document and then up-load it as an attachment or what appears to be the body of an e-mail text. The delivery time is cut so dramatically that I can afford to spend more time on the content.

The problem with speed is that it tempts us to send incomplete or ill-thought-out messages. When I knew it would take eight days for a letter to get to England, I was careful to craft the message so that it told the whole story. It is surprising how many e-mail messages appear to be bits and pieces snatched out of context from ongoing conversations I was not part of but was merely expeditiously cc'ed.

But worse is the impression that it is okay to speed-read e-mail messages. What appears to be written in haste cannot expect to receive more than a cursory scan. I am so tired of incomplete responses (read till one sees something that can be done, postpone doing it, quit) that I have taken to stating in the first sentence how many points there are in the message and each action I am hoping for. This procedure does not work, and I will explain why below.

Asynchrony means that an activity does not have to be performed by two people at the same time. The advantage is obvious to veterans of the phone-tag wars and to those with friends in different time zones. Have you ever noticed the big bunch of spam that comes in from Russia on Sunday night?

I much prefer the richness and etiquette of phone or face-to-face conversation. People cannot hide. The eighteenth-century arbiter of taste and regal prig, Lord Chesterfield, famously advised gentlemen that if topics arose in conversation they found inconvenient, the best policy would be to appear not to hear. With the asynchrony of e-mail, this is a practice no longer limited to gentlemen. We are all bombarded with uninvited messages, some of them appear to require a major effort to reply. Why not just cherry-pick the winning lottery tickets and let the rest go unanswered? Or why not, instead, read the e-mail message twice to understand what is required, open one's appointment book (or the electronic equivalent) to make a note to handle the matter or decide that it cannot be done, and then reply immediately: "Thank you for your inquiry about... expect to get back to you by..." or "This looks like something that is beyond me, you might try...?" Whenever you receive a response to any request you have made, a "thank you" should follow immediately.

Manuscripts submitted to this journal have always been sent to six reviewers. A year ago, the process was changed in a single aspect: exactly the same material is now distributed via e-mail instead of through the regular post. The result has been a drop from a consistent average of 4.5 reviews returned by the deadline to barely 2.0. It matters which door the messenger enters by.

Cost also matters. And since cost is generally taken to be an indication of value, e-mail has cheapened communication. If we are to believe Carl Sandberg's biography, Lincoln regularly met with mothers who had walked from Kentucky to plead for their sons or with church members who had taken the train from Chicago to discuss emancipation. I am still waiting after five months for a reply to an e-mail request to a representative in Congress on a question about this journal. But I suppose he is a gentleman.

Cost also matters. And since cost is generally taken to be an indication of value, e-mail has cheapened communication.

The Fantasy of the Triple Threat in Academic Dentistry

Sreenivas Koka, DDS, MS, PhD, FACD

Abstract

One of the fond hopes of academic administrators is to assemble a faculty with a core of triple threats: individuals who excel in teaching, research, and patient care. This report describes the quest of one faculty member to achieve this T3 status. Gradually it has become clear that excelling in any of these areas is more than a full-time commitment in itself. Although each experience contributes to the skill set of a professional, a realistic view of excellence means concentrating one's efforts.

Academic dentistry continually tinkers with the notion of the perfect academician, specifically the notion of "the triple threat," or dare I create an acronym: T3. The T3 is a person who is an outstandingly successful researcher, an educator without equal, and a clinician with exemplary talent. In science fiction *Star Wars* terms, I would say that it is akin to becoming a Jedi Knight. As I finished my dental school training at the University of Michigan and embarked on a residency in prosthodontics at the same institution, little did I know that I would soon be sucked up by the lure of becoming a T3. Indeed, the encouragement I received to pursue such a path as I finished my residency was matched only by my drive to strive for it.

By the summer of 1991, I had completed the requirements for the master of science degree in prosthodontics. The first of three (so far) major career decisions needed to be made. Would I follow in my father's footsteps and commit to a life as a private dental practitioner or would I pursue a career in academic dentistry? My heart chose the latter and received the necessary support from my head, which assured me that to follow anything but the heart was foolish. To that end, I was fortunate to have very successful mentors at the University of Michigan who impressed upon me the concept of the triple threat as a most worthwhile career path.

I was duly inspired by the thought of being a T3 and embarked on the next phase of information gathering to learn what it would take to become one. The advice and perspective I received would become the foundation for the rest of my career, and I have nothing but gratitude for those who took the time in their busy schedules to sit down with me, learn about me as an individual, and then offer guidance that was insightful and personal. At the end of the day, my current perspective leads me to conclude that I might have done things differently, and I will elaborate on this later. I also am well aware that my life has been enriched beyond words by the advice those mentors shared with me then and many continuing friendships with them to whom I still turn today, much like a Jedi Knight might seek Yoda's counsel.

The culmination of the information-gathering phase led me to conclude that the probability of T3 success would rise if I accumulated a certain set of credentials. The research facet demanded PhD training; the education facet would require course-director experience in lecture halls, pre-clinic laboratories, and student clinics; and a high level of patient care would undoubtedly ensue as a result of board certification in prosthodontics. Furthermore, I was

Dr. Koka is Professor and Chair, Department of Dental Specialties at the Mayo Clinic; koka.sreenivas@mayo.edu.

advised that to be the quintessential T3, I should aspire to be a board-certified prosthodontist with PhD training who was independently funded by NIH and who directed a course or multiple courses in the dental school curriculum. This should be no problem for a Jedi Knight, right?

So the journey began. The second major career decision was how to go about getting the credentials and training. The University of Nebraska Medical Center College of Dentistry (UNMC COD) offered me a faculty position in the Division of Prosthodontics, and I was fortunate to be permitted to pursue PhD training on a part-time basis. I received a great piece of good fortune when Professor Rick Reinhardt agreed to be my PhD advisor. Although Rick's professional achievements are numerous, it is his profound humility that sets him apart from everyone else. During the first seven years after joining the UNMC COD faculty in 1992, I pursued basic science PhD training in oral biology, gladly received some significant teaching responsibilities as course director and instructor, ultimately becoming the section director for prosthodontics, and prepared for the American Board of Prosthodontics certifying examination. By the summer of 1999, I could write DDS, MS, PhD after my name and list diplomate of the American Board of Prosthodontics as one of my credentials.

Following on, I was given wonderful latitude by UNMC COD to continue my education with a postdoctoral research fellowship in signal transduction at UNMC's Eppley Cancer Center, which I thoroughly enjoyed from 1999 to the end of 2001. The credentials were now successfully in place. Little did I know that gathering them (albeit the result of dedication and hard work) was the easy part. If nothing else, the credentials brought with them a series of professional opportunities—let's call them open doors—certainly a nice problem to have. The hard part was deciding which door to go through and when to go through it. Hence, the third major career decision which brought me to the Mayo Clinic five years ago.

My current position at the Mayo Clinic is founded upon clinical patient care. My calendar from Monday through Friday involves 30-35 hours, and sometimes more, of patient care activity. In addition, I am fortunate to be able to teach residents in prosthodontics, orthodontics, and periodontics as well as maintain a focused research initiative in oral systemic links associated with osteoporosis.

I have found the time spent treating patients to be consummately fulfilling. The sense of gratification to make a difference in a person's life through the practice of prosthodontics still leaves me with a sense of wonder. However, the vagaries of human nature are such that I have come to understand, and more importantly to accept, that taking care of patients as a clinical healthcare provider cannot be accomplished to the necessary level of focused excellence unless one is

Even though funding is one benchmark of peer recognition, it seems to me that the funding has become, to many investigators, more important than the science.

truly committed to it. That commitment is represented by many variables, but one of the most important ones is time. Simply put, in my opinion, one cannot excel as a clinician by practicing for one or two days a week. Based upon my experiences in part-time practice, I believe that a part-time practitioner is unable to meet the challenge of truly providing the best possible care to his or her patients. I should also point out that many of the clinicians whom I admire are not board-certified. Board- certification is certainly a worthy aspiration, brings tremendous personal satisfaction upon completion, and does indeed help one learn and understand the principles and concepts vital to providing quality care. However, on its own, it is not a guarantee of clinical excellence.

My experiences as a PhD student, a postdoctoral research fellow, a young junior investigator seeking grant funding, a mid-career investigator seeking grant funding, a member of numerous journal review boards, and a reviewer of grants submitted to the National Institutes of Health have all shaped my view of a research-focused career, especially as it relates to the lure of T3 status. At UNMC and at most universities, the attraction to extramural funding—whether it be from industry, foundation, or government body—is strong. At the end of the day, however, even though funding is one benchmark of peer recognition, it seems to me that the funding has become, to many investigators, more important than the science, i.e., the benefit actually realized from the funding. This is an unfortunate consequence of choosing an inappropriate benchmark, funding, to define success or failure of an academic career. Of additional concern is the fact that the highly competitive nature of grant review necessarily leads reviewers, me included, to be more supportive of applications from investigators with strong publication records and strong preliminary data. In a similar manner to my comments about the time that needs to be invested if one seeks to be an outstanding clinician, it is extremely challenging for an investigator who is not focused full time on research activities to be competitive for the very funding that is the lifeline of a productive research career. When one considers that many "full-time" researchers spend evenings and weekends at work as well, how can an individual who is spending anything less than all of his or her time on research activities be expected to remain competitive? One form of dissenting argument to my belief is that the principal investigator should form a research team of co-investigators, research technicians, graduate students, and others to act as the collaborative dynamo underpinning research productivity. This argument, however, holds credence only for those who already have established their credibility to some degree. For a junior investigator emerging from a PhD program or postdoctoral research fellowship, the early years are daunting and many leave the research arena for other career paths.

The educational aspect of a T3's life is the one that seems to be least respected at many, but not all, universities, since research funding and clinical productivity bring in cold, hard cash. At these institutions, educators feel that their craft is not considered as important as the other two parts of the academic triad, and circumstances surrounding promotion and tenure bear this out. Such a scenario weakens the academic environment, since being an effective educator is as worthy a goal as being an effective researcher or clinician. Indeed, a special skill set is needed to educate well. I have been very fortunate to receive teaching awards from dental students. Many faculty colleagues were congratulatory, whereas a few were critical and opined that these awards were nothing more than popularity contests. The question of why someone was popular was never asked, however, the unsaid assumption being that the "easy" teachers got the awards. Needless to say, I do not consider myself an "easy" mark. Indeed, if only dental students were so easily influenced! There is plenty of research from educational circles that demonstrates that there is little correlation between a student's perception of whether a teacher is "easy" or "hard" versus whether they are "good" or "poor" as an effective teacher. To my amusement, one of the teaching award critics went on to receive such an award. The award was most deserved, as this individual is a gifted teacher, and I hope its receipt has had a mollifying effect.

Beyond the issue of respect, however, lies a greater problem for the aspiring T3. Once again, the issue of time comes into play. The time necessary for preparing lectures, teaching in laboratory sessions or clinical sessions, grading, writing examinations, and directing courses is enormous. It is intimidating enough without the added challenge of trying to keep one's educational materials current in this era of rapidly growing

volumes of new information and evolving technologies and techniques. Yet time for reading and assimilating and deciding on evidence-based course content and competency-based delivery is vital. Clearly, being an effective educator at the course director level is a full-time job.

Looking back, I believe that to be a triple threat is a foolish aspiration because for everyone but the rare human being it is unattainable. Each single aspect of the academic triad demands a focus of thought, effort, and time that excludes the other two aspects from the thought, effort, and time they need if excellence is the goal. Furthermore, the need to address administrative duties serves to prematurely invoke the law of diminishing returns. If mediocrity in some of the aspects of the academic triad is the goal, however, then the game has a different set of rules. But who aspires to mediocrity? Why bother playing that game?

In his recent book *Outliers*, Malcolm Gladwell suggests that those that are the best are not necessarily the most gifted. In fact, Gladwell makes a compelling argument that practice and repetition can supersede talent and suggests that 10,000 hours of practice is necessary. Let's not quibble: 10,000 hours is a lot of hours! I use this number merely to make the point that true excellence for most humans is an extension of practice and repetition that requires time.

The T3 will never have enough time to excel at research, education, *and* clinical practice. I certainly bit on the T3 bait back in the early 1990s, but now I am comfortable with the realization that for me, no matter how talented I am or how hard I work, I cannot successfully blend the demands of excellence in research, education, and clinical practice. That is not to say I regret my education and research-intensive experiences. I feel very fortunate to have enjoyed those experiences and do not regret them at all. Without those experiences, I would have very different perspectives and indeed I depend on all of them daily. However, I readily admit that if I were to do it again, I would do it differently. For example, I wish I had pursued PhD-level training in a field with direct clinical interaction, such as epidemiology, health care policy or translational research, linking basic science findings to clinical applicability. This type of combination of clinician-PhD scientist training would have far better enhanced a career as a clinician-scholar in contrast to the little true synergy that resulted from the combination of my basic science training and clinical training.

It has been a few years since I accepted that it makes sense to spend my time doing what I cherish most; and that's making a difference in the lives of my patients. In fact, this acceptance has been liberating and I find the atmosphere at Mayo Clinic, where the needs of the patient come first and life as a clinician-scholar is promoted and celebrated, to be an almost Utopian experience for my personality. For me, there is no greater gift or privilege in committing myself to life as a T1 clinician, and I recommend it highly. ■

Indeed, a special skill set is needed to educate well. Being an effective educator at the course director level is a full-time job.

A Dear Teacher

Steven A. Gold, DDS., FACD

Abstract

We learn much of our professional expectations from colleagues, especially those we admire. This report describes one dentist's disappointment in extending the same professional relationship to an associate that he had experienced when he first associated. In the absence of a written employment agreement, the new associate set up practice a few minutes away, stealing staff and patients. The silver lining has been greater office efficiency and a richer relationship with patients and staff.

In the practice of dentistry, experience is desirable stuff. We are seen in a better light if we have it. Patients generally feel more comfortable with a dentist who has "experience" because in their minds, that translates into a smaller chance mistakes will be made. And mistakes are costly to all involved. Ironically, it is those very "mistakes" which constitute "experience," and it is out of that experience that we learn and grow. In my youth, when I screwed up, my grandfather often reminded me of this more simply and bluntly, borrowing loosely from Benjamin Franklin, "Experience is a dear teacher, but fools learn no other way." And so armed with his warm and comforting words, I undertake the challenge of relaying my biggest mistake of practice in the hopes that readers of this *Journal* might also learn and grow from it.

To understand the origins of my mistake, I must first give a brief accounting of the events in my career that led to it. Soon after graduation and passing the state board exam, I was fortunate enough to become an associate in the office of one of my professors. The owner-dentist and I knew each other well and had very compatible personalities. His practice values matched mine and he gave me a great deal of freedom within the practice to schedule patients according to my speed and to use materials and techniques as I was taught in dental school. For the most part, it was what every new dentist wants in a practice associate position.

One thing he did not offer was a written employment agreement. In fact, I knew of no other recent graduates who were offered a written agreement either. We were warned in dental school not to work without one, and yet it seemed as though in the real world, they simply were not used, so I did not insist on one. Nevertheless, the next two years of practice were happy ones. On the eve of my two-year anniversary in the practice, however, I received an unfortunate phone call. My employer informed me that he had just been diagnosed with cancer and would be out for several weeks to undergo surgery. To everyone's surprise and sadness, he never made it back. He rapidly deteriorated and passed away less than two months later. His final request of me was that I take over the practice and continue the care he provided for his patients for so many years. Though I felt I was not really ready to become a practice owner, I did as he asked of me, and completed the purchase of his practice in October 1996.

In the relative chaos that ensued, I was able to establish a few goals: keep the patients in the practice; keep the existing staff; make as few changes as

Dr. Gold practices in Santa Monica, California, and is on the editorial board of this journal; sgold_90266@yahoo.com.

possible; keep the production up; and hire an associate. After all, the practice was supporting, and was supported by, two doctors. Because none had existed previously, and because my time was being diverted by no fewer than ten more urgent matters at any given moment, I made no effort at developing written employment agreements with anyone. The truth is, I had virtually no real understanding of my responsibilities as an employer or any other aspects of being a practice owner. At three years out of dental school, I felt I had only just begun my journey of learning and mastering basic clinical skills. In the dental hierarchy of needs, one must tend to the clinical needs of the patients first and foremost. Minding the rest of the practice took a back seat, and it would end up costing me dearly.

My new associate was a recent graduate from my school, whom I knew well, and who was familiar with the practice. In many ways, I was simply happy to have another warm body with a DDS degree to lean on in these trying times. The fact that he was a good clinician and a good communicator and was cool under pressure quickly made him invaluable to me. In return, I afforded him the same desirable practice arrangement that I had enjoyed as an associate. It was a way for me to pay forward the kind and decent way I was treated by my late mentor. Together we stabilized the practice and began to thrive. As the months grew into years, I expressed my desire to have my associate become a partner and buy into the practice. I saw this as a win-win opportunity for both of us; but after careful consideration, he told me he could not make the financial commitment at this time. He would simply be unable to afford the payment on financing a practice purchase.

Needless to say, I was surprised when later that year, on the last work day before the holidays, my associate informed me that he would be leaving and that he had bought a practice from a retiring dentist. My immediate reaction was happiness for him. "That's great. We'll miss you here, but it sounds like a great opportunity for you. Where is the practice?" I asked. "Well, it's...I don't remember." As soon as those words were uttered, I realized my life was about to take a dramatic turn for the worse. Over the next 24 hours, the truth unfolded. He bought a practice about five minutes away from mine. One of the hygienists remaining from my mentor's practice resigned on the same day my associate did. Although she did not disclose her plans, it turns out that she was going to work in his practice. Furthermore, the two of them had colluded to download patients' addresses and proceeded to send a letter announcing the location of his new practice, making sure to mention that their hygienist would be there to help provide their care, just as she had for the last 25 years. He broke off all communication with me. Yet even as it was happening before me, it was hard for me to believe that someone close to me would do something so hurtful.

The truth is, I had virtually no real understanding of my responsibilities as an employer or any other aspects of being a practice owner.

Yet even as it was happening before me, it was hard for me to believe that someone close to me would do something so hurtful.

Naturally there was immediate fallout from this event: I lost hundreds of patients, possibly half of all active patients in my practice. Some patients who had previously seemed so close and happy left with completely unexplained anger towards me. (I lost many hours of sleep wondering what was told to those patients to have turned them so vehemently against me.) The practice production dropped by $20,000 per month or more for the first few months. I lost two additional staff members to my former associate, including the front office manager who took with her 20 years of experience and patient relations. I struggled with feelings of betrayal, and at the same time, my own guilt and anger for having left myself so vulnerable to the stealing of my practice. I explored legal options to recoup my losses but decided against them, one of the reasons being that there was no employment agreement to define what my associate could or could not do with regard to patients he had treated upon his leaving the practice. Other reasons were the high legal fees required, the cost in time away from work, the risk in not winning or being countersued or having my own motives and reputation questioned and scrutinized, and finally the emotional drain of using too much negative energy in litigation.

But there was another side to the fallout from this event, the silver lining which kept my spirits up and kept me moving forward when I most needed it: I became more efficient in my clinical dentistry and a better practice manager. Production came back up to, and even surpassed, its previous level while the overhead plummeted due to my smaller staff size; thus profitability actually increased. Every employee from that day forward—whether they turned into long-term staff or were simply hired for a day of temporary help—had a written employment agreement. I became closer to my staff. I got more involved, without micromanaging, by taking an increased interest in them and providing needed guidance. Now my trust in new employees is harder to earn, but once developed, it is more meaningful and has led to greater accomplishments by our team. And there is a much more vigilant eye to guard against violations of that trust. My wife, a hygienist, joined my practice and together we were able to grow the practice in an honorable and enjoyable way, while we also were able to grow closer to each other in so many ways.

The effects rippled beyond the walls of my practice, as well. I spent many hours reflecting on ethical and professional conduct and attitudes. Some in our profession do not think twice about doing things that others would never even consider. I would have never dreamed of doing anything like that to my mentor and employer—furthering my own career at the expense of his. In some ways it was a sad realization that our noble profession is rife with dentists who place their own well-being above that of others, whether it be colleagues or their patients, and who subordinate higher and loftier values to personal greed. My glimpse of these realities became a personal calling for me to educate myself about and champion ethical and professional ideals.

The experience of mistakes or an episode of poor judgment is seldom pleasant. It often exacts a high toll emotionally, physically, and financially. Accepting that it is inevitable is growth in itself, but if we can move beyond merely accepting it to learning from it as well, then we will have more than offset that toll. When we learn, we have the potential to change our behavior for the better, which is the highest form of growth, for it benefits not only the individual but all those he or she touches. In that light, experience really is the dearest of teachers. ■

Don't Miss That Opportunity

By Richard V. Tucker DDS, FACD

Abstract

How do you tell recent graduates who are full of emerging success that they don't know it all? Of course you don't tell them. You have to show them, and the best ones to do that are respected, caring colleagues. The study club format is uniquely designed to accomplish that, and it is a mistake for anyone to pass up the opportunity to join one.

That famous question, "How do you know what you don't know if you don't know," applies to our mindset almost every day. Upon graduation from dental school in 1946, it is a vivid memory of mine that a classmate and I had a discussion that we would be in our peak of knowledge and expertise as dentists in ten years. Would you say more than a little naïve? We just didn't know.

So I applied this lack of understanding and, though I had a very busy post-war practice, I passed by many opportunities to learn until in my seventeenth year after graduation,when an older colleague and good friend took me under his wing and insisted that I participate in a study club. At that time there were only two study clubs in the area, both gold foil, and he was the mentor of the Vancouver Ferrier Gold Foil Study Club which was 60 miles from my office. When I became a member of this group my eyes were opened wide. I not only learned about good margins, but how a good preparation is done with some amount of perfection, all with a view to what can be accomplished with direction, time, and patience.

I soon learned that I had missed a great opportunity by not having joined this group much sooner, preferably 17 years earlier, when I was a new graduate. Now after 45 years as a member, I realize how it has affected my life in many ways. Without a study club affiliation, I would certainly not be doing the quality of dentistry we all would like. I would have missed associating with all of the study club members who are now my closest friends. All who were members of that gold foil study club at the time I joined have died long ago, but they each remain in my memory, and I believe every one of them influenced my life.

Discipline is an attribute that is a part of the study club philosophy. Attendance at the meeting each month is an obligation. For example, after 11 years' membership and never having missed a meeting, my wife, Elaine, and I took a vacation to Mexico. Upon my return there was a letter from the secretary, a very close friend, who relayed the message that members of our study club try to arrange holidays at times that do not interfere with study club attendance.

Since those early days of study clubs when the primary interest was gold foil work, other types of study clubs have been organized. In particular, many practitioners wished to learn our techniques in gold castings. Membership is usually limited to 12 members and as interest has grown; when there are no vacancies, potential members must start a new group. Consequently, our organization has grown to 67 study clubs

Dr. Tucker sails his boat, the *Line Angle,* on Puget Sound and is the 2005 winner of the Gies Award from the College.

When I became a member of this group my eyes were opened wide.

throughout the United States, Canada, and Europe. The members are very dedicated and have a desire to provide a special quality of dentistry for their patients.

Each study club sets its own rules, with helpful guidelines, but in a very democratic manner. They decide the best place to meet (usually a dental school, clinic, or large dental office), the hours for the operations and dinner, as well as the dates for the meetings. The mentor for each group is chosen by the members themselves with perhaps some advice from the parent organization or other members.

One aspect of our study club program that makes it possible is that many members have belonged to one of the study clubs for 25, 30, or more years, operating each month and critiqued at each session. This provides a cadre of potential mentors that are capable and knowledgeable about all procedures. They are also dedicated to the cause of this type of dentistry. It is traditional that honorariums for the mentor are kept quite low in the cause of keeping the study club dues minimal. The dues usually include payment for the mentor, rent of clinic facilities, and a dinner which is usually held the evening after the clinical operations and critiques.

There is a little philosophy in clinical study clubs that, "we learn from doing it, not from talking about it"; however there is plenty of talk describing merits and shortcomings of each operation. A typical mentor's report would perhaps mention "the marginal ridge was not full and rounded, the lingual embrasures are overcontoured, or a lingual spillway is missing; the casting is underexpanded so the margins are not good, the gingival bevel is not precise, or a marginal ridge is higher than the adjacent tooth." In spite of any mentor's report, the finished operations are usually excellent and the finished castings are beautiful. The satisfaction of doing this special kind of dentistry is what causes the members to make the effort, as there are no direct monetary rewards. The patients do not even know that dentists take a day away from their offices every month only to learn to better serve them.

A special respect is developed among members of a study club, because all in the group know what an unselfish effort is made to accomplish this kind of dentistry. One observation sometimes made is that members of the study clubs often have only one thing in common. Some are old, some are young, some are golfers, some are mountain climbers, some are quite academic, and some enjoy a concert; but they all have a love for dentistry and want to serve their patients.

All of the foregoing discussion is only to remind us that sometimes opportunity only knocks once, but my life has been completely changed by the persistence of one man, Dr. George Ellesperman. Another person might not be so fortunate. Dr. Ellsperman also sponsored me for fellowship in the College more than 40 years ago.

To further the philosophy of study clubs and benefit from the experience described above we might discuss how this could be applied to other fields in the practice of dentistry. It is interesting to note that having talked to colleagues in the medical profession, there are no such organizations. Some friends have lamented that none exist and what a great thing if there were study clubs in medicine. It could be a great learning experience for dentists interested in implant dentistry, periodontal care, ceramics, esthetic dentistry, or perhaps there could be composite study clubs. In any case the group would presumably foster perfection and refinement in the restoration of the teeth and the same could be applied for any particular interest in our profession.

The study club format has been successful for many years, and the numbers are still growing. It is a very special type of continuing education that probably deserves some consideration by many more of us.

From my own experience, I would advise, "Don't close the door too quickly." If someone has suggestions or is willing to share knowledge, take advantage of it. It took me too long to learn this. ■

Teeth Don't Have Emotions, People Do: Teeth are Easy

Dr. David R. Neumeister, DDS, FACD

Abstract

Dentists naturally tend to think in terms of order and control. But the mistake is looking for them in technical speed, new materials, and chair time. What needs to be managed to bring meaning to practice is the interpersonal relations, especially those involved in building a team. This article describes how one dentist came to this realization, how he incorporated the best advice from around the country, and made these skills an integral part of the office and what this has meant for the practice.

When I started a dental practice, I had dreams of helping anyone and everyone who came in the door. I imagined that I would be successful in life if I was available whenever a need arose and I maintained a perpetual journey for more technical knowledge. I knew happiness would include gaining more speed with providing services. That, however, would come quickly and then I would get the loans paid down a bit and be able to buy a home. I followed that model, pretty successfully, with speed and confidence building, for a few years as I tried to get my dental practice under control.

But the daily office experience never quite stabilized, either on the technical side or the staffing side. Dental materials changed faster than I could read the inserts, and new techniques that I had not been taught in dental school left me wondering how I could possibly keep up. Overriding all this was the turmoil caused by the loss of an experienced dental assistant and the arrival of a new hygienist who would not help with improving her own schedule when there was free time in her day. The realization came slowly to me, and it was sometimes a painful and anguishing process, that I might never get control of the best material to use, the appropriate patient care technique, or the office personnel hiring and training that would support a happy dental office. Maybe constant white water was just going to be normal for me. Or maybe white water was what everyone experienced. Was it me or was it built into dentistry? I lived this daily tension for about a decade into my practice life. In a way my whole practice was a mistake simply because I did not understand it.

Some days it felt like the only thing I really enjoyed about dentistry was that I could always look forward to the weekend. Then it happened. "The biggest single determinant of success in your dental practice is the quality of relationship you have with your staff." Avrum King said that. I heard the words and tried to imagine a "quality relationship." My sense of personal mastery was never the same. Just like a license to drive an automobile changes your definition of independence, I was forever a different person.

I can vividly remember the room, where I was sitting, and King's presence that afternoon. The room was very large, I was sitting on the center aisle, and I missed the next few minutes of his presentation. I did not hear what he said for what seemed like a long time. My head was simultaneously full of excitement and fear. There was excitement because the success of my life dream was not all about me, my head, and my hands. Despite the ten years of short spurts and prolonged plateaus I had experienced thus far, the success of my life dream was still possible. There was

Dr. Neumeister continues to build his team in Brattleboro, Vermont; neum1@sover.net.

the excitement of new-found hope. There was also the fear that I was now in the middle of my third decade of life and I had no training in building quality relationships with people.

I was the typical dental introvert who spent most of my time struggling in that very narrow space between perfect and wrong. How do you have quality relationships with myriad staff members who come with their own skills, biases, and agendas? Could it be that my real success was dependent on something so obscure that I had never even read a book about it? I had never been interested in reading a book about relationships. I was not even sure what quality relationships in the work place would look like. That was fear.

Again I read the words I had quickly scribbled on my note paper: "The biggest single determinant of success in your dental practice is the quality of relationships you have with your staff." I think I have this right. Happiness in dentistry is not all about what I do. Not all work faster, take more continuing education, and hire good people. As I emotionally returned to Avrum King's lecture and heard about discretionary services and values that drive people to action I was trapped in the thought that my success was not about me, it was about we. My success as a dentist was not based on technical knowledge, which was what I spent many years achieving. My success was about emotional awareness and the relationship within my staff. I was stuck on that.

That afternoon I began a journey that has made me a better person. I painstakingly grew into a better husband, father, son, community member, and happier person. Dentistry has forced me to be a more complete person and I love everything about it. Do not get the idea that I am complete or have been inducted into the Emotional Hall of Fame. I am a long way from finished with this, but at least I got over the need to control every outcome and I came to enjoy the challenges of the journey.

Later, I went with the whole office and heard Bob Frazer from Austin, Texas, at a two-day retreat and learned about behavioral styles. The words "team building" were used together in a way that had new meaning. The next time he came to New England I went with everyone in my office for another two days and invited his office manager to come to my office and spend a couple days watching us interact.

I searched out Jim Pride and attended some of his early courses. Verbal skills went from being a strange word combination to something we practiced at staff meetings. We started having regular meetings. They became longer and longer because we had so much to learn, so much to accomplish. Staff meetings at lunch time evolved into quarterly whole-afternoon meetings and then half-day every month meetings. We now hold our meetings on a rotating basis in each team member's home. That growth took years to evolve, but it happened because we all came to realize that more time in increasingly relaxed environments leads to a deeper level of trust and support within the office.

We started rotating leadership of each meeting so that each person could be moderator in a pattern we agreed to in advance. We asked some of Jim Pride's consultants to come to our office every two years to observe our patterns of behavior and establish some new, shared outcomes for success. Each person and each area of the office established their own particular standards of excellence. We posted the newly chosen outcomes on the staff lounge wall and checked the list every month to celebrate progress.

I struggled with the mental gymnastics of identifying personal goals, family goals, and practice goals. I learned how much fun it is to watch others learn and grow in confidence. We stopped using the word "staff" and renamed what we did "team activities." If it was not good for everyone it was not good for anyone. The person answering the phone is just as critical to patient happiness as the person who walks with them to the dental chair and thanks each person for coming. The individual who answers questions when the dentist is out of the room is no less essential to building trust than the hygienist who takes the x-rays or explains why food always collects between those molars. The dentist becomes the one to facilitate all the points of contact and set the standard for quality and thoroughness. The dentist assures the focus is on patient health, the correct diagnosis and appropriate treatment and supports the learning and growth of each team member.

I spent almost as much time building the skills and talents of the team as I spent taking technical education courses about advancements in materials and diagnoses. I spent as much time in lecture rooms with the lights on as I did with the lights off. I got used to pairing off and doing exercises with other attendees. Very slowly I became comfortable sharing my feelings and exposing my inner thoughts to strangers and friends in a dental course.

The need for technical excellence for the entire team did not diminish through the years. The difference was that we realized that quality dentistry, although critical to practice success, was not the same as daily peace and joy. The drive home at night was most gratifying, not because we found a better bonding agent or discovered a new use for digital photographs. We smiled because we

helped some special friends become healthier and we had many teammates to thank for another success.

A strange thing happened. It became evident that as we continually grew technically and behaviorally within the office, we had greater impact on our patients. They could sense the energy and trust in the office. They began to want more health. They asked for more information. They sent their friends too. The patients were happier and the team felt more satisfaction. We smiled more and, magically, I did not have to struggle each day to hold the office together. It almost managed itself. Each person took responsibility for his or her area of expertise and we celebrated the gifts each person brought to our success.

After a long conversation one evening, Burt Press clarified for me that I had developed a process for practicing group behavioral skill building each week through something I called Unique Person Time. We set aside 30 minutes each week, right after lunch, for group brainstorming to help a specific patient make better health choices. When a patient continued to refuse to see a specialist for necessary care we asked a team member to present some history and we then shared questions and suggestions that we could use at the patient's next visit to improve behavior. We had patients every week who were delaying important care, who refused necessary x-rays, or who needed to improve daily home care to be assured of health in the future. We devoted the weekly time because we needed more frequency to grow skills of listening, curiosity, and empathy. Twenty years of these team sessions has resulted in increasingly thoughtful patient behavior and a very intuitively sensitive team that can better support our patients and each other. The weekly Unique Person Time grew out of a necessity to make behavioral skills more reflexive for each person and a need to support new team members as they learned and practiced the process of building trust and growing long-term friendships.

There were other steps in my search for quality relationships. I learned from SRI Gallup in Lincoln, Nebraska, how to interview and hire for talent so we could ensure an easier learning curve for each new person to join our office. I spent many weeks at the L. D. Pankey Institute in Key Biscayne, Florida, where I found a compassionate faculty, connecting excellent treatment skills with behavior skills. Mary Osborne spent some two-day sessions helping us understand active listening and curiosity in a way that magically opened new windows on relationship building.

What a journey it has been, over 25 years and still learning new ways to help. The epiphany began one day in a large conference room. The search has led me all over the country and it has expanded my comfort level with family members, friends, teammates, and strangers. I am a better person because, after my formal education was over, I recognized the necessity for informal learning, constant challenges, and learning from mistakes; and I developed an openness to seeing opportunity in every life activity. I found there could be order in a dental practice without strict control. I lost my need for perfection every moment and I discovered a peace that comes from continuous improvement over time and involving everyone on the team. Each person felt personal responsibility for daily achievement and I was able to lead the celebrations. Being comfortable with honoring the feelings and wisdom of each person released startlingly high levels of energy and enhanced the calm from personal peace. ■

I was the typical dental introvert who spent most of my time struggling in that very narrow space between perfect and wrong

The Value of Unlearning Hubris

Michael Rethman, DDS, MS, FACD

Abstract

Sometimes the most important lessons are what we learn to stop doing; the most valuable patient may be the one that is never presented to one's colleagues. This story recounts what a young periodontist learned, in preparing for boards, about how unproven and overly aggressive treatment need to be tempered with common sense and fundamental concern for the patient.

While thinking over this assignment to share a mistake and what I had learned from it, I looked back at my career as a clinical dentist, organizational volunteer, Army officer, scientist, and science manager and found plenty of experiences from which to select. But most are arcane and not relevant to clinical dentists. So, I chose to relate an example of how hubris derived from past successes was interlaced with personal needs and led to poor clinical judgment.

In 1983, I was assigned to a 12-chair Army clinic in New Jersey. Having recently finished my residency training in periodontics at the U.S. Army Institute of Dental Research (at Walter Reed), I was in a hurry to get my American Board of Periodontology certification so I could compete for reassignment to a research job in Washington, DC.

Until then, my clinical training as a general practitioner and periodontal resident had been exceptionally—if not uniquely—broad and deep. While in dental school, my extracurricular hobby was working in the oral pathology department "grossing" incoming specimens and reading-out the histopathological slides (as a prelude to having them read-out officially by qualified oral pathologists). Because I had a longer service commitment than my colleagues, while serving as a newly-minted Army dentist from 1975-1980, my Army supervisors made me a "favorite son" when it came to training opportunities. Indeed, during the years I was assigned to Fort Campbell, Kentucky, I benefited from one-on-one, full-time, four-month clinical rotations with bona fide specialists in periodontics, endodontics, pediatric dentistry, and removable and fixed prosthodontics, as well as hospital oral surgery. Later, I oversaw the outpatient oral surgery service and the endodontic service in a 28-chair clinic, eventually removing hundreds of impacted third molars and completing over 1,500 root canals. Later as a periodontal resident in the early 1980s, I earned the highest grades in my class of 13 residents (training in periodontics, endodontics, and oral pathology). I also collaborated with investigators at the National Institute of Dental Research (now NIDCR) and went on to win the American Academy of Periodontology's prestigious Balint Orban research competition—the first-ever military winner. Indeed, the only critical counseling I heard during my entire residency was the suggestion (accompanying congratulations on my academic and clinical performance) "not to come across as so arrogant."

I should have paid more attention to this good counsel.

In the mid-1980s, the American Board of Periodontology (ABP) required board candidates to pass a difficult written

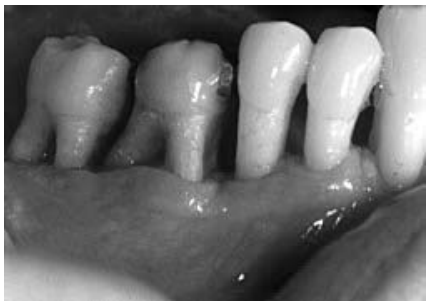
Dr. Rethman is a Past-president of the American Academy of Periodontology and practices in Kaneohe, Hawaii; rethman@hotmail.com

examination; submit three meticulously documented and "completed" cases—each with a one-year-minimum follow up—in which moderate to severe periodontitis had been diagnosed and treatment planned and completed; and appear in Dallas to present two of the three cases to board examiners during two 90-minute oral examinations. Unlike today, the cases had to have been started after graduating from one's residency. The logistics of these requirements made it extremely rare for a candidate to pass his or her board exams in fewer than four years following residency. Most periodontists needed five or more years. Cocky me was determined to do it in three.

Finding the Right Cases

At my post-residency assignment to Fort Monmouth, New Jersey, most periodontitis cases referred to me evidenced mild to moderate periodontitis. Moderate to severe cases in which patients still had most of their teeth were uncommon. So, in light of my haste to undertake my board exam, I focused attention on several very severe periodontitis cases as potential board patients. Thus began the sequence illustrating how hubris, inexperience, and lack of insight drove poor decisions that caused a patient more harm than good.

The first photograph depicts the mandibular right posterior sextant in an otherwise healthy, 67-year-old male patient ("Mr. X") who had quit smoking a few years before. At the time this photo was made, Mr. X had already undergone repetitive nonsurgical care provided by my dental hygienist. Mr. X's gingivae had shrunk noticeably and appeared healthier than before. Negligible mobility was present in the molar teeth, Class I facial-lingual mobility was seen in the premolars. Repeated plaque staining revealed a patient performing diligent self-care. At the time of this photo, bleeding on probing remained present in the generalized deep periodontal pockets, but it was clear the patient was faring much better than when he had first appeared. (Note that tooth roots appear stained because the patient was using a European concentration of 0.2% chlorhexidine rinse every day—prior to approval of a 0.12% version by the FDA.) At the time of this photo, Mr. X had been diligent about his self-care, was comfortable, and had no functional limitations or esthetic complaints.

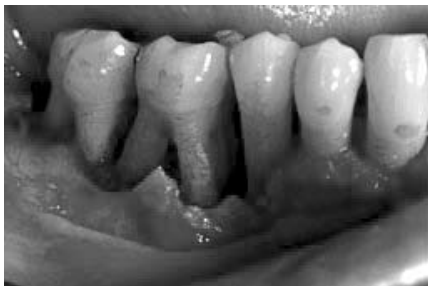


Unfortunately, rather than simple maintenance and observation of this 67-year-old patient over time, my needs interfered with good judgment. I acted as if I had blinders on. My lack of common sense was in part because: (a) it was reliably rumored that nonsurgical cases would not be accepted by the ABP

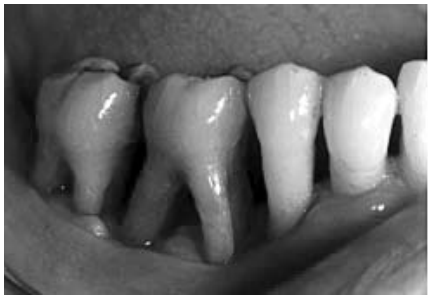
Thus began the sequence illustrating how hubris, inexperience and lack of insight drove poor decisions that caused a patient more harm than good.

examiners; (b) there was little formalized risk assessment routinely performed in that era, often resulting in the elderly receiving much the same therapies as much younger patients; and (c) an overriding goal of much periodontal therapy at that time was to reduce probing pocket depths to shallow dimensions that could be more easily maintained free of infection. So, I foolishly decided to perform periodontal pocket reduction surgery on Mr. X.

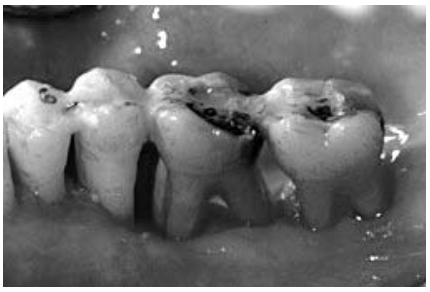
The second photograph reveals the appearance of alveolar bone with tissue flaps reflected. After limited bony recontouring and scaling and root planning, the flaps were sutured closed and the patient's wounds healed uneventfully.



In the next photograph it can be seen how the sextant appeared several months later. Self-care remained good. Probing depths were decreased. However, the teeth were now mobile enough to be bothersome.



The final photograph shows a lingual view that depicts a temporary splint that was later replaced by a sturdier device.



Consistent with the then newly published literature on the topic, tooth mobility decreased in the following months. However, all these teeth remained more mobile than they were initially, confirming observations from a (Reinhardt et al) manuscript published about that time suggesting that a bony support threshold that exists around every tooth violated by either progressive periodontitis or other means results in disproportionate and persistent increases in tooth mobility. (Within a year, this patient relocated to Florida and was lost to further follow-up.)

Lessons Learned

Among most periodontists three decades ago, pocket reduction surgery reigned supreme. Crude regenerative therapies were new and minimal science-based literature existed to support their use. Furthermore, little had been published regarding periodontal risk assessment and long-term management strategies based on patients' ages. Nevertheless, despite the lack of research available at that time regarding how best to manage such cases, I failed to think through my treatment plan and see it from my patient's perspective. Indeed, even without good literature support regarding secondary tooth mobility, it should have been obvious to me, as a former car mechanic and apprentice electrician accustomed to working with structural materials, that if I removed too much attachment apparatus I would cross a threshold when symptomatically mobility might become a permanent feature. A consideration of obvious mechanical principles should have alerted me to this possibility—if I had been thinking about my patient instead of me.

I also learned, and I tout this observation to anyone who will listen, that periodontists, as well as others performing involved periodontal treatment, need better technologies that can improve nonsurgical outcomes. Numerous devices and medicament delivery systems such as subgingival irrigants and medicament trays have been introduced over the intervening years and some are still sold, but none have been properly validated in clinical studies. (Several years ago a promising periodontal endoscope was introduced and although the original company failed, this technique has numerous advocates who have built successful, patient-centered periodontal practices around periodontal endoscopy. More and more research is suggesting that a periodontal endoscopic approach works well and helps many patients avoid periodontal surgery. Happily, a second-generation periodontal endoscope is under development.)

But the most important lesson I learned was that no matter how "good" a clinician I thought I was, carelessness and lack of insight on my part could seriously hurt another human being. Until this case, nothing I had done in my dental career had turned out so poorly that it could not be mitigated. So I learned from this case that the patient's needs must always come first. Indeed, my arrogance and tunnel vision had finally blown up in my face. Even though I passed my boards, the most valuable patient I prepared was one I never presented. Ever since that time, I've endeavored to always put patients' needs first and foremost. In fact, I tirelessly preach this mindset—which is why I appreciate this opportunity to share this story with the readers of the *Journal of the American College of Dentists.* ■

Making Mistakes… An Honorable Pursuit

Phillip Bonner, DDS, FACD

Abstract

People who make mistakes are more interesting than those who seem not to, and they have much more to teach us. In that spirit, the author shares what he learned from his own missteps in suing a client who reneged on the judgment against him by declaring bankruptcy, by developing a business model that was expropriated, and by believing what a journal author said about copyright ownership.

George Bernard Shaw said that, "A life spent making mistakes is not only more honorable but more useful than a life spent doing nothing." Doing nothing may be risk-free and very safe, but it certainly adds nothing to society or to the growth and development of an individual... not to mention, it is extremely boring. I would venture to say that one learns more from making mistakes than from easily accomplishing a task in an error-free manner. If this is true, then not only have I accumulated a fair amount of knowledge during my life's journey, but if Shaw is to be believed, then a good part of my life might be considered "honorable and useful."

Making mistakes is a universal human trait, but getting people to admit and talk about them is not as common. This is unfortunate, because there is much to learn from mistakes. Indeed, I would much rather hear about someone else's mistake and learn from it than to make the mistake myself. Alas, there have been many instances when either no one was willing to share their mistakes with me, or even worse, I was not listening. So, in the spirit of passing along potentially valuable knowledge, I will share three mistakes I have made that will, I hope, help others avoid similar ones. Selecting only three was perhaps the biggest challenge, but after all, there are space limitations.

Before I launch into an analysis of the three mistakes, it will be helpful to define the context in which they occurred. My career path in dentistry took an abrupt turn after a number of years in private practice. My college major prior to dental school had been English literature, and my love of journalism and communications, plus an entrepreneurial spirit, led me into a series of endeavors outside dental practice. These included owning an advertising and public relations agency, owning an international dental trade show company, and serving as a dental editor. It is within the contexts of these endeavors that the three mistakes I will discuss took place. I hope the lessons I learned will be useful to others in any field they undertake.

Mistake #1: A Costly Matter of Principle

When I owned an advertising agency, my staff and I worked with many clients, both large and small. As a rule, the large corporate clients were reliable and knew how to play by the rules of business, including the rules pertaining to intellec-

Dr. Bonner is an editor and entrepreneur who lives in Big Canoe, Georgia; phillipbonner@hotmail.com.

tual property rights. However, it was one of our smaller clients (an individual) who taught me a costly but valuable lesson.

This client was conducting a series of seminars and hired our agency to develop the marketing materials to be used on a nationwide basis, including the development of a logo for all materials. Our graphic artists worked hard to develop an original logo, attractive brochure prototypes, and other graphic materials (e.g., forms of intellectual property), which the client really liked. Unfortunately, he didn't want to pay for them. But that did not stop him from duplicating all of our prototypes and using them in his national marketing program. Since he had not paid for our work, I felt we had sound legal grounds in terms of him violating intellectual property rights. I was irate that he would take advantage of us in this fashion. I consulted my attorney, and as a matter of principle I decided to file a lawsuit against the former client.

The amount of time the entire legal process took was staggering, and it definitely interfered with my own work and that of my staff, not to mention encroaching on my personal time. After months of legal maneuvers, depositions, and accumulating reams of data, the case went to court in a jury trial. When the jury announced its verdict, the former client was found guilty. Not only was he liable for what he owed us and our legal fees, but the jury awarded us damages in excess of that amount. We had won a great victory, both legally and as a matter of principle. A happy end of story, right?

Wrong. The client, who was from out of state, returned home and immediately filed for bankruptcy. As it turned out, he owed money to a lot of other individuals and businesses, including the Internal Revenue Service, which was first in line to go after any assets. We never received a penny, and to add insult to injury, my company was of course left with all of our legal bills, which were substantial.

Lesson learned: acting as a matter of principle can be honorable, but that does not mean it is the smart thing to do. Sometimes it is better to swallow your pride and accept the fact that not everyone is going to treat you the way you think they should. As the old saying goes, I won the battle but lost the war. However, I do believe there is a silver lining in every cloud, and in this case, the experience I gained from this mistake possibly saved me from an even bigger one later.

Mistake #2: Swimming with the Sharks

Many years ago a certain nation was making giant strides toward becoming a big player in the global economy (I won't mention the country's name in the interest of international relations and global harmony). The country's dental profession was growing with the rest of its economy, and when I was approached by an individual with considerable experience dealing with that country, I saw a great business opportunity. He wanted to establish a company that would organize, manage, and own a dental trade show with an accompanying scientific symposium to be held annually in that country, which I will label the "host country." Although a few companies had attempted to hold dental shows there in past years, none had ultimately been successful, and all had been discontinued. My partner and I felt that due to dramatic changes both politically and economically, the time was right for someone to try again.

Following months of due diligence and organization, including fact-finding trips to the host country, we developed the infrastructure for a large annual dental trade show and symposium, then marketed it globally. To make a very long story very short, we held the first show and it was a huge success. Dental manufacturers from 22 countries exhibited at the show, and the scientific symposium was co-sponsored by four major dental schools, two in the United States and two in the host country. More than 7,000 dentists attended, most from the host country, which was remarkable considering that this represented a significant percentage of its entire dentist population. Flush with success, we held the second show the following year and it, too, was a big hit. My partner and I envisioned an ongoing annual event that not only would generate substantial income but would make a genuine contribution to dental education and international professional relations, and we began planning for the third show to be held the following year.

Then an event occurred that changed everything. An agency within the host country's government decided that a show this successful should be owned and operated by entities within that country rather than by entrepreneurial foreigners. Using the exact same name as our show, they developed marketing materials, used our contact list of exhibitors and academic institutions (which of course was available in our own show literature), and proceeded to

announce that they were sponsoring next year's show. The exhibitors and attendees assumed that the show was the same as before, so they signed up (of course, they sent their checks to the new "owners"). The third show was once again a success (as was the show in subsequent years), but we were left out in the cold.

What could we do? We could take a legal approach, but that would involve international courts, and we would be doing battle with an economic colossus compared to our own resources. After much deliberation, my partner and I decided to lick our wounds and move on to other endeavors (remember my lesson from mistake #1?).

Lesson learned: if you swim with the sharks, particularly in unfamiliar waters, be prepared to be eaten. We made a mistake by launching a business endeavor in a foreign country that did not do business the way we did, and we had done so even though we knew there was a possibility that something like this might occur. We had thought the reward was worth the risk. Was it? In this case, I believe it was. The experiences I gained and the international friends I made (yes, there were many wonderful people in that country) were ample reward, in spite of the outcome. But, as the late actor Dudley Moore said in the movie *Arthur*, "I may be crazy, but I'm not stupid." After that time I kept my business dealings closer to home, in more familiar waters.

Mistake #3: Protecting Personal Accountability

In my career as a dental editor, I have had many responsibilities, including assuring that authors do not violate copyright law, which would reflect poorly on the publication I edited as well as the authors themselves, not to mention the legal ramifications. One tool that I and my staff developed in this regard was a copyright form that each author was required to sign. This form specified, among other things, that by signing it the author warranted that he or she had not published the article or any materials associated with it in another publication, that the manuscript was original and written by the author, that the author had the right to assign the manuscript to our publication, etc. The rationale for this form was that if the author signed it, thus agreeing to its terms, we could move forward with confidence that there were no copyright violations (i.e., that we were not publishing something that had been published before in another publication or plagiarized). As editor, I was accountable for all editorial content, and I wanted to make sure that authors understood their own accountability.

One day I received an article that was interesting and worthy of publication, and we moved forward with our usual production procedures, including obtaining the author's signature on our standard copyright form, as noted above. We published the article, and a few months later we received notice from another publication that the clinical photos in our article were identical to ones it had published the previous year (by the same author). Even though the author had written both articles, he had also signed that publication's copyright form, which transferred copyright (i.e., ownership) of those photos to them. (Note: This is confusing to many authors, but the law is the law. Authors should make sure they understand basic copyright law to avoid such problems.) The

Lesson learned: acting as a matter of principle can be honorable, but that does not mean it is the smart thing to do.

Lesson learned: if you are accountable for a given result, take every step possible to ensure that the result you require is achieved. Protect your own accountability; do not assume someone else will protect it.

other publication could have taken legal action against ours for publishing photos they owned, but when we informed them that the author had signed our copyright form (and we provided them with a copy), thus warranting that he owned and had the right to assign the photos to us, they turned their attention to the author instead. The good news here is that they decided not to pursue legal action against the author after he apologized profusely and claimed (probably truthfully) that he thought he had the right to publish his own photos again. I would bet that is the last time he made that mistake.

For my part, the mistake had been to assume that because the author signed our copyright form, all was well. As editor, I was still accountable for the content of my publication, no matter what someone else did or did not do. It became clear that a copyright form alone, even though it did in this case prevent any legal action against us, should be augmented by some other method for ensuring (in the best way possible) that the results for which I was accountable were achieved. After that incident we instituted a painstaking process for checking every article that was submitted to make sure that it had not been published before or that it did not contain plagiarized material from a previously published article. (The Internet, with its massive databases of published literature, was essential for this process to be feasible.) Instituting this process has enabled us to detect several instances of copyright violations by authors well in advance of the publishing deadline.

Lesson learned: if you are accountable for a given result, take every step possible to ensure that the result you require is achieved. Protect your own accountability; do not assume someone else will protect it.

Conclusion

An unknown scribe once wrote, "I've only met four perfect people in my life and I didn't like any of them." It's true: people who make mistakes are much more interesting and likeable than those who are perfect (or claim to be). Mistakes may be painful, humiliating, or costly, but rarely do they fail to teach us lessons, if we are open to learning them. I hope that by sharing just a few of my mistakes and the lessons I learned from them, I have imparted information that will be beneficial to you on your life's journey. ■

Low-Income and Minority Patient Satisfaction with Visits to Emergency Departments and Physician Offices for Dental Problems

Leonard A. Cohen, DDS, MPH, MS; Shelly L. Harris, MPH; Arthur J. Bonito, PhD; Richard J. Manski, DDS, PhD, MBA; Mark D. Macek, DDS, DrPH; Robert R. Edwards, PhD; Niharika Khanna, MD; Keith O. Plowden, PhD

Abstract

Objectives: Individuals lacking access to dentists may use hospital emergency departments (EDs) or physicians (MDs) for the management of their dental problems. This study examined visits by minority and low-income individuals to physicians and hospital emergency departments for the treatment of dental problems with the goal of exploring the nature of treatment provided and patient satisfaction with the care received. **Methods:** Eight focus group sessions were conducted with 53 participants drawn from low-income White, Black, and Hispanic adults who had experienced a dental problem and who had sought MD/ED care at least once during the previous 12 months. **Results:** Toothache pain or more generalized jaw/face pain was the most frequent oral problem resulting in MD/ED visits. Pain severity was the principle reason for seeking care from MDs/EDs, with financial barriers most often mentioned as the reason for not seeking care from dentists. Expectations of MD/ED visits were generally consistent with care received; most participants limited their expectations to the provision of antibiotics or pain medication. Nearly all of the participants thought they would eventually need to see a dentist for resolution of their dental problem. **Conclusions:** Poor/minority individuals seek relief from oral pain through MDs/EDs while recognizing that such care is not definitive.

Although we have a sound understanding of who uses dental services, our knowledge of the pain relief-seeking strategies used by the poor and minorities that lack a usual source of dental care is limited. There is a well-established association between toothache pain and the use of dental services. However, it is clear that not all individuals suffering from toothache pain or other dental problems seek relief from dentists (Riley et al, 1999; Riley, Gilbert, & Heft, 2005; Gilbert et al, 2003). In addition, many individuals who experience dental problems might use self-care/home remedies (Gilbert et al, 2000; Cohen et al, 2009) or recover without receiving dental treatment (Duncan et al, 2003). Individuals lacking access to dentists also may use hospital emergency departments (EDs) (Burt & Schappert, 2004; Cohen & Manski, 2006; Cohen et al, 2008) or physicians (MDs) (Burt & Schappert, 2004; Cohen & Manski, 2006; Cohen et al, 2008; Woodwell & Cherry, 2002; Cohen & Cotton, 2006; Lockhart et al, 2000) for the management of their dental problems. Some individuals may use these sites as an interim measure until such time that professional dental care is obtained.

Poor/minority individuals most often lack access to dentists (U.S. Department of Health and Human Services, 2000). In addition, these groups often face both a heavier burden of oral disease (U.S. Department of Health and Human Services, 2000; Green et al, 2003) as well as financial and other barriers to dental services (U.S. Department of Health and Human Services, 2000; Manski, Moeller, & Mass, 2001; National Center for Health Statistics, 2003). Although visits to MDs/EDs for the treatment of dental problems are well documented, the nature of treatment provided is not well understood (U.S. Department of Health and Human Services, 2000). Only a few studies have described the services provided in EDs (Burt & McCaig, 2001; Lewis, Lynch, & Johnson, 2003) or patient satisfaction with those services. Similarly, with few exceptions (Lockhart et al, 2000) little data exist that describe the treatments provided by MDs, its effectiveness, or with rare exceptions (Cohen & Cotton, 2006), patient satisfaction. Many individuals with dental problems who lack access to dentists will continue to seek care from MDs/EDs. This issue will grow in importance with an aging and increasingly diverse population, since these groups face significant financial obstacles to obtaining dental services (U.S. Department of Health and Human Services, 2000; Anderson, 2005).

Drs. Cohen, Macek, and Manski are in the Department of Health Promotion and Policy in the Dental School; Drs. Edwards and Khanna are in the School of Medicine; Dr. Plowden is in the School of Nursing; all at the University of Maryland, Baltimore. Dr. Bonito is at the Research Triangle Institute in North Carolina. Direct correspondence to Dr. Cohen at lacohen@umaryland.edu.

This research was supported by Grant Number 5R01DE017685-02 from the National Institute of Dental and Craniofacial Research.

Table 1: Sociodemographic Background of Focus Group Participants (n=53)

	Number	%
Age		
21-25	2	3.8
25-34	12	22.6
35-44	14	26.4
45-54	16	30.2
55-64	5	9.4
65 and over	4	7.5
Gender		
Male	12	22.6
Female	41	77.4
Race/Ethnicity		
White	13	24.5
Black	24	45.3
Hispanic	16	30.2
Highest Grade		
1-5	3	5.7
6-8	2	3.8
9-11	9	17.0
12	15	28.3
Some college or technical school	11	20.8
College graduate	13	24.5
Marital Status		
Married	21	39.6
Separated	5	9.4
Divorced	9	17.0
Widowed	4	7.5
Never Married	14	26.4
Income		
$5,000 or less	15	28.3
$5,001-$10,000	12	22.6
$10,001-$15,000	10	18.9
$15,001-$20,000	2	3.8
$20,001-$30,000	5	9.4
$30,001 or more	2	3.8
Don't know	5	9.4
No response	2	3.8

Total percentages do not always equal 100% due to rounding.

The purpose of this study was to gain a better understanding of this under-explored pattern of non-dentist health professional care. The findings from this study will aid in the development of low-income/minority population specific data that may be used in the development of quantitative studies leading to a more comprehensive understanding of the use of EDs and MDs for dental problems and ultimately to improvements in the care provided.

Methods

Focus group interviews were used to gather qualitative data pertaining to factors influencing the participants' decision to seek treatment for dental problems from MDs/EDs, as well as their treatment expectations and satisfaction with care received. Focus groups are particularly helpful in understanding the language used by a group around a particular issue and in identifying and clarifying important aspects of a particular experience (Meadows, Verdi, & Crabtree, 2003; Trotter & Schensul, 2000).

Eight focus group sessions were held across Maryland; two in Baltimore (one in a Black and one in a Hispanic neighborhood), two in the Washington, DC, area (one in a Black and one in a Hispanic neighborhood), two in western Maryland (both in White neighborhoods), and two in eastern Maryland (one in a Black and one in a White neighborhood). Focus groups were held during both the day and early evening to maximize participant availability and in locations near the communities in which participants resided.

Participants were drawn from low-income non-Hispanic White, non-Hispanic Black, and Hispanic adults over the age of 20 who had experienced a dental problem and who had sought MD/ED care at least once during the previous 12 months. There were a total of 53 participants (see Table 1). In addition to seeking recruits through the University of Maryland Statewide Health Network, the investigators also used secondary recruitment strategies via message boards and screening at health advocacy organizations, local community organizations, places of worship, and local health departments.

Project staff used a screener to guide the recruitment process and conducted telephone conference calls with organizations that agreed to assist with recruitment. Potential participants were given a toll-free number to call. When they called, a member of the research team explained the purpose of the focus group again, answered questions, and conducted the screening interview. For those who met the screening criteria, we described the focus group, provided the time and location of the group, and told potential participants that they would receive $40 to cover their time and any incidental expenses involved in participating. Each focus group included both men and women of varying ages, but was homogeneous in terms of race.

An experienced moderator and a co-moderator who took notes conducted the groups. Focus group sessions were audiotaped to aid in the subsequent analysis and ensure that the actual language and word choice of the participants were captured. The moderators debriefed after each group. Multiracial/ethnic focus group staff were matched to the race/ethnicity of the groups to reduce initial barriers to communication and contribute to building rapport. The same moderator and co-moderator conducted all Black focus groups. Similarly, the same moderator and co-moderator conducted all Hispanic groups. The same moderator and co-moderator conducted two of the White focus groups, but there was a change in the moderator for the third group due to a change in staff. Hispanic focus group sessions were

conducted in Spanish. Moderators used a focus group guide to direct the discussion. This structured interview guide included questions in complete, conversational sentences, prepared in appropriate sequence for the facilitator to follow. Group meetings generally lasted 90-120 minutes. At the completion of each meeting, participants were asked to complete a short, written questionnaire covering sociodemographic, general health status, and health service utilization variables.

After each meeting, the moderators prepared a two- to three-page summary of the discussion using the broad categories from the interview protocol as structure. Information from the moderators notes as well as the audio recordings of the groups were used in preparing the summaries. After the eight focus group meetings, the recordings were transcribed and the transcriptions were analyzed using QSR's NVivo (QSR, 2002), a qualitative data analysis software program, in order to sort the text data into the broad categories from the interview protocol. We then conducted additional analyses to identify recurring themes within each coding category and to summarize the findings.

The research protocol was reviewed by the University of Maryland Baltimore Office for Research Studies and approved as exempt from full IRB review; however, a written informed consent was obtained from all participants at the beginning of each focus group session.

Results

Characteristics of Study Subjects. The sociodemographic background of participants is shown in Table 1. Among the 53 participants across the eight focus groups, 24 participants were Black, 13 were White, and 16 were Hispanic. The majority of participants were female (77.4%) and reported an annual income of $10,000 or less (50.9%). Information pertaining to the general health status and dental service utilization background of the participants which was collected at the completion of the focus groups appear in Table 2. Approximately one-half of the participants considered themselves to be in fair/poor overall health. The participants' assessments of their dental health were more negative with 80.8% considering it to be fair/poor. As expected, the majority of participants (76.5%) reported that they never visited the dentist or only visited when they had a dental problem. Participants were more likely to have reported making regular, non-symptomatic medical visits (60.4%). In general, the participants rated their pain as being very painful with 63.0% rating it as nine or ten on a ten-point scale. Participants were split between those who did and did not have any kind of health insurance. Among those with health insurance, the majority had medical assistance (58.6%); only 19.2% of the participants reported having dental insurance.

"I think they should have a flat-out dental ER, just a place where you can go for dentists—anything, emergency, low-income, no insurance—and still be able to get help, like any other health care."

Dental Problem Experience. Participants were asked to describe the type of dental problem that caused them to seek care from an MD/ED. Responses included (multiple responses possible): toothache pain (n=16); jaw/face pain (n=12); infections (n=9); abscesses (n=9); bleeding gums (n=5); trauma (n=4); burning mouth (n=3); loose teeth (n=7); broken teeth (n=6); as well as trouble with dentures, crowns, defective fillings, and assorted other problems (n=8). There was no dramatic difference associated with race/ethnicity.

Participants were asked the length of time between the first appearance of symptoms and seeking care. Responses ranged widely from many years (20-30 years) to mere hours (3-4 hours). "It don't take long because when I feel pain,

Table 2: General Health Status and Dental Service Utilization Background of Participants

		Black		Hispanic		White		Total	
		#	%	#	%	#	%	#	%
How would you rate your overall health?	Excellent/very good	5	21	1	6	3	23	9	17
	Good	6	25	4	25	7	54	17	32
	Fair/poor	13	54	11	69	3	23	27	51
How would you rate your dental health?	Excellent/very good	2	9	1	6	1	8	4	8
	Good	2	9	3	19	1	8	6	12
	Fair/poor	19	83	12	75	11	85	42	81
Which statement describes the way you make visits to a dentist?	I never go/only go when I have a dental problem	15	65	12	87	11	85	39	77
	I go occasionally even if there is no problem or regularly to have my teeth checked	8	35	2	13	2	15	12	24
How long ago was your last visit to a dentist?	1 year ago or less	17	71	10	63	8	62	35	66
	More than 1 year ago	7	29	6	38	5	39	18	34
Which statement describes the way you make visits to a medical doctor?	I never go/only go when I have a dental problem	5	21	9	56	7	54	21	40
	I go occasionally even if there is no problem or regularly for a physical exam	19	79	7	44	6	46	32	60
How long ago was your last visit to a doctor?	1 year ago or less	21	88	15	94	13	100	49	93
	More than 1 year ago	3	13	1	6	0	0	4	8
Do you currently have health insurance or medical assistance?	Yes	12	50	5	31	9	69	26	49
	No	12	50	11	69	4	31	27	51
If so, what type? includes multiple responses	Traditional	4	27	1	20	2	22	7	24
	Medical assistance	7	47	4	80	6	67	17	59
	Medicare	4	27	0	0	1	11	5	17
Do you currently have dental insurance?	Yes	4	17	3	19	3	25	10	19
	No	20	83	13	81	9	75	42	81
How would you rate the pain from your most recent dental problem? [0 = mild/10 = worst]	0 to 5	3	14	2	15	1	9	6	13
	6 to 8	4	18	4	31	3	27	11	24
	9 to 10	15	68	7	54	7	64	29	63

Cell counts not totaling 24 for Blacks, 16 for Hispanics, 13 for Whites, or 53 for the total are due to item non-respondents in the group. Percentages are based on the actual number of responding to each question. Total percentages do not always equal 100% due to rounding.

I go straight to the hospital. I might give it like three or four days." Some participants mentioned that their dental problems started when they were adolescents. "I think it all started about 24 years ago, in my late teens. When my mother took us to this quack dentist, instead of him giving us fillings, he gave us root canals. Every one of my siblings with root canals have crumbled. And it's been going on and on up through all my adult years." Most participants had experienced similar dental-related problems in the past.

Reasons for Seeking Care from MDs/EDs. Participants were asked why they visited an MD/ED for their dental problem rather than a dentist. Most often participants stated that they sought treatment from an MD/ED due to the severity of their pain. When questioned why they did not seek pain relief from a dentist, the most cited reason related to financial barriers. "My insurance won't cover it and I didn't have the cash to do it because I'm on a fixed income. I just couldn't afford to go to a dentist." "It's just affording a dentist...It's not like they can bill you and you can make payments or anything, they want money, they always want money upfront. I mean, it's not like a co-pay fee, they want a couple of hundred dollars." "We don't have any money and we don't have any way." "They have to decide if they want groceries or teeth pulled, what are you going to do?"

Some participants went to their MD for other concerns and were diagnosed with dental problems while they were there. "I went to my regular checkup and this time when I went I was complaining of weight loss. He said he's had more people that can't eat right because they can't chew their food. He said that's why I'm losing weight and that's when he referred me to a dentist." Other reasons for seeking care from MDs/EDs included: no available dentists (dentists not accepting appointments or a long time before an available appointment) and no dentists accepting payment plans. Some participants stated that the problem occurred after usual office hours. "It wasn't during business hours, nothing was open." Other participants mentioned a fear of dentists or past unpleasant dental experiences. "I'm terrified of dentists. For a long time when I had insurance, I was apprehensive about going because of the fear that was instilled upon me as a child because of this crazy dentist."

Most participants stated that they preferred to go to a dentist but didn't because of the factors mentioned above. "I'm sure everybody would rather go sit in a dentist's office and have the problem taken care of than sit in the emergency room, just for a temporary fix." "I would prefer to go to the dentist right away, but it may be insurance, it may be money, it may be getting off work, whatever reason, you can't go right away. So, if I have to go to a doctor, I'll go to get me over that hump until I can get to a dentist." Some participants explained how going to the ED was a waste of money for the government and, if dental care was provided instead, it would be cheaper overall. "It doesn't make sense. If you could get medical assistance for all of the emergency room visits, it would have been so much cheaper for them to just pay for your dental care. They're just wasting money and the problem's not getting taken care of, it's just getting numbed."

Expectations of Visit to MDs/EDs. Participants were asked about their expectations for care when they went to the MD/ED. Participants generally wanted any treatment that would relieve their pain. "Most people, if they don't have insurance, they usually go to the emergency room. When you go to the emergency room, somebody's going to be there to help you out and give you something for the pain." They expected the provider to "... actually look at their dental problem, for them to do x-rays, and for them to give them some kind of medicine such as an antibiotic or pain medicine." "I expect him to at least look at my mouth and I'm hoping that they will give me something, even if they only give me an antibiotic." "I went to the doctor recently and I was hoping that I could be given something until I could get to a dentist." "I wanted to get something for the pain. I wanted the pain to stop." Other participants stated that they expected the provider to pull their tooth or fix their fillings. "I expected them to pull it; I thought they was going to take it out." A few participants also expected the MD to refer them to a dentist.

Participants were asked if they thought a visit to the MD/ED would completely treat their dental problem; none thought that it would. "I've never known anyone to go the emergency room with a dental problem and it got taken care of right there." The majority of participants felt that they would eventually have to seek care from a dentist. "That's not their (physicians') area. It's not their field. When you go to a dentist, they were trained for teeth."

Diagnosis, Treatment, and Health Education/Promotion Received During MD/ED Visits. Participants were asked to describe their visit to the MD/ED. Most mentioned that the MD looked at their "problem" and provided them with a shot for pain or prescriptions for antibiotics and pain medicine. Several participants stated that often the ED would give them enough medicine to last until they could get to a pharmacist. "They ask you your symptoms and they take a look. Mostly every time, they give me an antibiotic for an infection. I do get a pain medicine and an antibiotic and then a follow-up for any type of dentistry I can afford. They say you need

"I was very dissatisfied because they didn't do anything. They gave me a weak antibiotic and a narcotic and sent me home. The problem is not solved. It's still there."

to follow-up with a dentist or we'll see you back here again for the same problem, and they do." Some participants received x-rays, blood tests, and temporary fillings. "They prepped me up, [I was] thinking they was going to pull my tooth but they didn't. They gave me antibiotics and took blood and x-rays. Then they say 'okay, we're referring you to [another institution] to have them pull your tooth.'" Some participants suggested having a dentist on staff at the ED. "I think they should have a flat-out dental ER, just a place where you can go for dentists—anything, emergency, low-income, no insurance—and still be able to get help, like any other health care."

The majority of participants stated that they received very little, if any, information about their dental problems. A few stated they received information about their treatment, the medications, and follow-up care, but only a couple of respondents stated that they actually received information concerning the cause of their problem or how to prevent it from reoccurring. "This hospital is only a band-aid station. What I wanted was somebody to tell me what was going on and what to do about it, what to do to prevent it, and what to do to make it better. The only thing I could find out is what I already knew..." "They'll give you a pill and they charge you like a couple of dollars for that little pill and then they'll write a prescription out for you. They didn't tell me anything about preventing it or something like that." "I don't recall them giving me any information as to telling me what went wrong with my teeth."

Almost all participants were advised to see a dentist. Several participants were given referrals or a list of dentists to call. "From what the doctor's saying, I would need to go to a dentist. It was just a temporary fix to alleviate the pain until I could go to the dentist. I know I need to go to the dentist to really have it checked out and really be diagnosed, to be dealt with. So the doctor was something to get me out of some pain until I could get to a dentist and the doctor did say I should go."

Satisfaction with Medical Care Received. Participants were asked how difficult it was to be seen in the ED. Most participants complained of long ED waits; participants described sometimes sitting for three to six hours. In one group, participants mentioned that larger hospitals often had longer wait times and unfriendly workers, while they received more personalized care from smaller hospitals. In general, respondents reported that the visit was quick once they actually were seen. "The emergency room always takes a long time, so we had to wait before a doctor could see him, but when we got taken back to the clinic rooms, the doctor was able to come see him very quickly. They treated him very well."

Participants who received care from an MD generally reported more satisfaction in terms of wait times and the treatment provided than participants who went to EDs. One participant reported being able to contact her physician after hours and still being able to receive care. "My primary care doctor don't care for you to go to the emergency room. Even if you get sick on the weekend, you call him and he'll have another doctor call you who's going to meet you." When patients visited MDs, they established a more personal relationship with the healthcare provider. Patients stated that MDs spent more time with them and seemed more concerned about problems than EDs. "I mean, she breaks it down, I mean, like you all were saying, if you show an interest in your health, you know, she totally has no problem with sitting there, I mean, you

can spend like a half an hour, 45 minutes just talking..."

Next, participants were asked about satisfaction with their treatment. In general, participants were dissatisfied with ED care. Many stated that the antibiotics and painkillers were temporary and that their dental problem was still a concern. "No, the only thing he gave me was three pain pills and then he gave me a prescription. The time was really late at night and there was no pharmacy open. I was still in pain and the pharmacy still wasn't open." "I was very dissatisfied because they didn't do anything. They gave me a weak antibiotic and a narcotic and sent me home. The problem is not solved. It's still there." Some participants were satisfied with the treatment because it alleviated their pain. "I have to say I was satisfied because I left there and I wasn't in pain. I felt that I was satisfied because they tried to do something."

Lastly, participants were asked about their experience with the medical personnel they encountered. Experiences varied by location and race/ethnicity. Many participants felt discriminated against because of their race. Black participants in one group in particular stated that Whites and Hispanics received better services and treatment than Blacks in the area. Several participants mentioned being ignored or not looked at by the MDs. "They're looking at you and they're saying you're too damn stupid to go to the dentist, why are you here?" Others voiced concerns about feeling disrespected. "Well, I don't really have the patience to deal with the fact that you think I'm not significant so you're going to have me sitting here in pain for four or five hours, so, you know."

Nevertheless, participants generally (particularly in the rural areas) stated that they would return to the same place for treatment, not because the experience was positive, but because it was the only option to receive care. "We don't have much choice. You pretty much have to. If you want any kind of help, that wouldn't be much, you're going to have to." "If I had a recurring problem, I would go to a different hospital, but I would still rather just go to the dentist and try to deal with it." Urban participants generally had more treatment options, with more hospitals to choose from and with nearby dental schools.

Discussion

Overwhelmingly, pain from toothaches or more generalized jaw/face pain was the most frequent oral problem resulting in MD/ED visits. This finding is generally consistent with other reports (Cohen et al, 2008; Lockhart et al, 2000; Anderson, Richmond, & Thomas, 1999). Similarly, consistent with other reports, the severity of pain was the principal reason reported for seeking care from MDs/EDs rather than dentists, with financial barriers most often mentioned as the reason for not seeking dental care (Cohen et al, 2008; Lockhart et al, 2000). Across groups, financial barriers were the main reason for visiting MDs/EDs. Financial barriers to accessing needed dental services have long been recognized (U.S. Department of Health and Human Services, 2000). Also consistent with other reports, the participants indicated that they preferred seeking care from a dentist but could not due to financial and other barriers (Cohen et al, 2007; Cohen et al, 2008).

Participants' expectations of their MD/ED visit were generally consistent with the care they received; most participants did not expect the MD/ED to provide care beyond antibiotics or pain medications. They considered MD/ED visits to be short-term fixes or "band-aids" for their problems. None of the participants reported receiving definitive care. Consideration should be given by hospitals, based on an analysis of their dental problem-related utilization, to incorporating a dentist into the ED staff. This would provide an opportunity for patients to receive more definitive care for their dental problem while at the same time alleviating the workload of the medical staff.

Few participants were satisfied with the information they received concerning their oral problem. Information relating to the cause of their problems or methods for preventing recurrence was lacking. It appears that MDs/EDs should increase their educational efforts. The importance of health literacy in reducing health disparities has received increased attention (National Institute of Dental and Craniofacial Research, 2005; Rudd & Horowitz, 2005). Ultimately, the vast majority of participants were told to visit a dentist. This pattern of treatment was consistent with that reported elsewhere (Cohen et al, 2008; Lockhart et al, 2000).

Nearly all of the participants stated that they sought care from an MD/ED but were aware that they would eventually need to see a dentist. This finding differed considerably from a statewide survey of Maryland adults where only approximately one-third of the respondents attending MDs reported needing follow-up care from a dentist (Cohen, & Cotton, 2006). This difference did not appear to be related to the nature of the presenting problems, which were similar in both studies, but may be related to differences in the selection of the survey sample, that is, random versus purposive.

Participants seeing MDs were generally more satisfied than those who visited EDs. Lengthy ED waits were particularly problematic. Somewhat paradoxically, although participants

Many stated that the antibiotics and painkillers were temporary and that their dental problem was still a concern.

were aware that EDs would not provide definitive care, many appeared to resent that their ED visit did not resolve their problem. Many Blacks expressed concerns about racial discrimination; they felt they received poorer care than Hispanics or Whites. Concerns about racial disparities in health care have increased (Institute of Medicine Committee, 2002; Like, Steiner, & Rubel, 1996). Evidence exists that providing culturally sensitive care may result in more effective treatment for racial/ethnic minorities (Tucker et al, 2003). In particular, efforts at improving care must address issues of respect and communication (Hobson et al, 2003).

These findings should be interpreted with caution. The results are based on the comments of a relatively small number of low-income individuals and therefore cannot be generalized to higher income groups or the population at large. The findings, however, reflect the views of low-income Hispanic, Black, and White populations in Maryland. Focus groups and other culturally appropriate methods are needed to identify relevant group-specific treatment patterns (Siriphant, 2001). This is particularly important when attempting to understand the factors that influence the care decisions of minority populations.

Many low-income/minority individuals with oral health problems are likely to continue to use MDs/EDs for treatment. This raises several issues. EDs usually lack dental services and therefore do not provide definitive treatment (Burgess, Byers, & Dworkin, 1990). Similarly, MDs generally lack substantive dental training (Pennycook et al, 1993; Graham, Webb, & Seale, 2000) and, therefore are unlikely to provide definitive treatment. Several reports have provided guidelines to MDs on the management of oral problems (Comer et al, 1989; Clark, Album, & Lloyd, 1995; Pyle & Terezhalmy, 1995); such guidelines have proven useful in the ED setting (Ma et al, 2004). More recently, several family practice residency programs have begun to provide emergency dental training including clinical experiences with tooth extraction (Beetstra et al, 2002; Jenkins, 2006). Such programs will undoubtedly enhance physician's ability to provide effective emergency dental services. Continued studies are needed to determine the adequacy of the management of oral problems by MDs/EDs. ■

References

Anderson, M. H. (2005). Future trends in dental benefits. *Journal of Dental Education, 69*, 586-594.

Anderson, R., Richmond, S., & Thomas, D.W. (1999). Patient presentation at medical practices with dental problems: An analysis of the 1996 General Practice Morbidity Database for Wales. *British Dental Journal, 186*, 297-300.

Beetstra, S., Derksen, D., Ro, M., Powell, W., Fry, D.E., & Kaufman, A. A. (2002). A health commons approach to oral health for low-income populations in a rural state. *American Journal of Public Health, 92*, 12-13.

Burgess, J., Byers, M. R., & Dworkin, S. F. (1990). Pain of dental and intraoral origin. In J. J. Bonica (Ed.). *The management of pain*. Philadelphia, PA: Lea and Febiger,

Burt, C. W., & McCaig, L. F. (2001). Trends in hospital emergency department utilization: United States, 1992-99. *National Center for Health Statistics. Vital Health Statistics, 13, 150*.

Burt, C. W., & Schappert, S. M., (2004). Ambulatory care visits to physician offices, hospital outpatient departments, and emergency departments: United States, 1999-2000. *National Center for Health Statistics. Vital Health Statistics, 13,157*.

Clark M. M., Album M. M., & Lloyd R. W. (1995). Medical care of the dental patient. *American Family Physician, 52*, 1126-1132.

Cohen, L. A., Bonito, A. J., Akin, D. R., Manski, R. J., Macek, M. D., Edwards, R. R., & Cornelius, L. J. (2008). Tooth ache pain: a comparison of visits to physicians, emergency departments, and dentists. *Journal of the American Dental Association, 139*, 1205-1216.

Cohen, L. A., Bonito, A. J., Akin, D. R., Manski, R. J., Macek, M. D., Edwards, R. R., & Cornelius, L. J. (2009). Toothache pain: behavioral impact and self-care strategies. *Special Care in Dentistry, 29*, 85-95.

Cohen, L. A., & Cotton, P. A. (2006). Adult patient visits to physicians for dental problems. *Journal of the American College of Dentists, 73*, 47-52.

Cohen, L. A., Harris, S. L., Bonito, A. J., Manski, R. J., Macek, M. D., Edwards, R. R., & Cornelius, L. J. (2007). Coping with toothache pain: A qualitative study of low income persons and minorities. *Journal of Public Health Dentistry, 67*, 28-35.

Cohen, L. A., & Manski, R. J. (2006). Visits to non-dentist healthcare providers for dental problems. *Family Medicine, 38*, 548-556.

Comer, R. W., Caughman, W. F., Fitchie, J. G., & Gilbert, B. O. (1989). Dental emergencies, management by the primary care physician. *Postgraduate Medicine, 85*, 63-66, 69-70, 77.

Duncan, R. P., Gilbert, G. H., Peek, C. W., & Heft, M. W. (2003). The dynamics of toothache pain and dental services utilization: 24-month incidence. *Journal of Public Health Dentistry, 63*, 227-234.

Gilbert, G. H., Shelton, B. J., Chavers, L. S., & Bradford, E. H. (2003). The paradox of dental need in a population-based study of dentate adults. *Medical Care, 41*, 119-134.

Gilbert, G. H., Stoller, E. P., Duncan, R. P., Earls, J. L., & Campbell, A. M. (2000). Dental self-care among dentate adults: Contrasting problem-oriented dental attenders and regular dental attenders. *Special Care in Dentistry, 20*, 155-163.

Graham, D. B., Webb, M. D., & Seale, N. S. (2000). Pediatric emergency room visits for nontraumatic dental disease. *American Academy of Pediatric Dentistry, 22*, 134-140.

Green, B. L., Person, S., Crowther, M., Frison, S., Shipp, M., Lee, P., & Martin, M. (2003). Demographic and geographic variations of oral health among African Americans. *Community Dental Health, 20*, 117-122.

Hobson, W. L., Avant-Mier, R., Cochella, S., Hala, S. V., Stanford, J., Alder, S. C., & Croskell, S. E. (2005). Caring for the underserved: Using patient and physician focus groups to inform curriculum development. *Ambulatory Pediatrics, 5*, 90-95.

Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

Jenkins, D. R. (2006). *An evaluation of dental care at the Maine-Dartmouth Family Practice: A survey of patient satisfaction and resident training.* Paper presented at the Northeast Regional Society of Teachers of Family Medicine Meeting.

Lewis, C., Lynch, H., & Johnston, B. (2003). Dental complaints in emergency departments: A national perspective. *Annals of Emergency Medicine, 42*, 93-99.

Like, R., Steiner, P., & Rubel, A. (1996). Recommended core curriculum guidelines in culturally sensitive and competent health care. *Family Medicine, 27*, 291-297.

Lockhart, P. B., Mason, D. K., Konen, J. C., Kent, M. L., & Gibson, J. (2000). Prevalence and nature of orofacial and dental problems in family medicine. *Archives of Family Medicine, 9*, 1009-1012.

Ma, M., Lindsell, C. J., Jauch, E. C., Pancioli, A. M. (2004). Effect of education and guidelines for treatment of uncomplicated dental pain on patient and provider behavior. *Annals of Emergency Medicine, 44*, 323-329.

Manski, R. J., Moeller, J. F., & Maas, W. R. (2001). Dental services: An analysis of utilization over 20 years. *Journal of the American Dental Association, 132*, 655-664.

Meadows, L. M., Verdi, A. J., & Crabtree, B. F. (2003). Keeping up appearances: using qualitative research to enhance knowledge of dental practice. *Journal of Dental Education, 67*, 981-990.

National Center for Health Statistics. (2003). *Health, United States.* Hyattsville, MD: The Center.

National Institutes for Health (The invisible barrier: literacy and its relationship with oral health. (2005). A report of a workgroup sponsored by the National Institute of Dental and Craniofacial Research, National Institutes of Health, U.S. Public Health Service, Department of Health and Human Services. *Journal of Public Health Dentistry, 65*, 174-182.

Pennycook, A., Makower, R., Brewer, A., Moulton, C., & Crawford, R. (1993). The management of dental problems presenting to an accident and emergency department. *Journal of the Royal Society of Medicine, 86*, 702-703.

Pyle, M. A., Terezhalmy, G. T. (1995). Oral disease in the geriatric patient: The physician's role. *Cleveland Clinical Journal of Medicine, 62*, 218-226.

QSR.NVivo qualitative data analysis program. (2002). Melbourne, Australia: QSR International Pty Ltd.

Riley, J. L., Gilbert G. H., & Heft, M. W. (1999). Health care utilization by older adults in response to painful orofacial symptoms. *Pain, 81*, 67-75.

Riley, J. L., Gilbert, G. H., & Heft, M. W. (2005). Orofacial pain: Patient satisfaction and delay of urgent care. *Public Health Reports, 120*, 140-149.

Rudd, R., & Horowitz, A. M. (2005). The role of health literacy in achieving oral health for elders. *Journal of Dental Education, 69*, 1018-1021.

Siriphant, P. (2001). Response to the JPHD's guest editorial: Qualitative research-does it have a place in dental public health? *Journal of Public Health Dentistry, 61*, 68-69.

Trotter, R., & Schensul, J. (2000). Methods in applied anthropology. In H. R. Bernard (Ed.). *Handbook of Methods in Cultural Anthropology.* Walnut Creek, CA: AltaMira Press.

Tucker, C. M., Herman, K. C., Pedersen, T. R., Higley, B., Montrichard, M., & Ivery, P. (2003). Cultural sensitivity in physician-patient relationships: Perspectives of an ethnically diverse sample of low-income primary care patients. *Medical Care, 41*, 859-870.

Woodwell, D. A., & Cherry, D. K. (2002). *National Ambulatory Medical Care Survey: Summary. Advanced data from vital and health statistics, No. 346.* Hyattsville, Maryland: National Center for Health Statistics.

U.S. Department of Health and Human Services. (2000). *Oral Health in America: A report of the Surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

Issues in Dental Ethics

American Society for Dental Ethics

Correspondence relating to the Issues in Dental Ethics section of the *Journal of the American College of Dentists* should be addressed to:
James Rule
8842 High Banks Drive
Easton, MD 21601
jrule0870@verizon.net

Enhancing Professionalism Using Ethics Education as Part of a Dental Licensure Board's Disciplinary Action

Part 2. Evidence of the Process

Muriel J. Bebeau, PhD, FACD

Abstract

Pretest scores were analyzed for 41 professionals referred for ethics assessment by a dental licensing board. Two were exempt from instruction based on pretest performance on five well-validated measures; 38 completed an individualized course designed to remediate deficiencies in ethical abilities. Statistically significant change (effect sizes ranging from .55 to 5.0) was observed for ethical sensitivity (DEST scores), moral reasoning (DIT scores), and role concept (essays and PROI scores). Analysis of the relationships between ability deficiencies and disciplinary actions supports the explanatory power of Rest's Four Component Model of Morality. Of particular interest is the way the model helped referred professionals deconstruct summary judgments about character and see them as capacities that can be further developed. The performance-based assessments, especially the DEST, were particularly useful in identifying shortcomings in ethical implementation. Referred practitioners highly valued the emphasis on ethical implementation, suggesting the importance of addressing what to do and say in ethically challenging cases. Finally, the required self-assessments of learning confirm the value of the process for professional renewal (i.e., a renewed commitment to professional ideals) and of enhanced abilities not only to reason about moral problems, but to implement actions.

This is the second of a two-part series that describes a process and results of an effort to provide individualized ethics instruction for professionals who were the subject of disciplinary action by the Minnesota dental licensing board. Part 1 (Bebeau, 2009) presented the process and procedures that were used to interact with these individuals and described the assessment measures used to conduct a baseline assessment of the four ethical capacities that are necessary conditions for reflective, ethical practice.

This article, Part 2, provides an analysis of the effectiveness of the instructional programs described in Part 1. Specifically, it compares pretest scores for 41 professionals referred by the Minnesota Board of Dentistry between 1990 and 2005 with the mean scores of graduates from the University of Minnesota School of Dentistry. It also examines the effectiveness of the specially-designed ethics courses for the 38 referred professionals who completed one or more of the assessments following instruction and summarizes their perceptions of the value of the process. A secondary analysis relates deficiencies in the capacities assessed (sensitivity, reasoning, role concept, and ethical implementation) to the reasons for referral.

Dr. Bebeau is professor, Department of Primary Dental Care, School of Dentistry, University of Minnesota; bebea001@umn.edu

The process had been initiated by a request from the Board of Dentistry, developed by the author, and collaboratively refined over the years. The board's roles were to review the pretest report and approve or suggest modifications to the course of study and subsequently to reflect on the posttest report and other information they may have gathered from other course work or office inspections, in order to judge licensure reinstatement. Periodically, the board invited me to describe the process, partly for the benefit of new board members, but also to reflect on the effectiveness of the endeavor and to consider modifications. The analysis presented in this article is a summative evaluation of the effectiveness of the curriculum presented to the Board of Dentistry in June 2006. The size of the data set enables summary judgments about course effectiveness.

Methods

Performance data for 41 professionals (11 dental auxiliaries, 25 general dentists, and 5 specialists) tested for ethical decision-making abilities following the board's disciplinary action, were available for analysis. Data sources for the quantitative and qualitative analyses included: (a) public records for 41 referrals detailing violations of the Minnesota Dental Practice Act and stipulating the ethics course requirement; (b) pretest data on five well-validated measures—described in Part 1 of this series—for all 41 referrals; (c) posttest data (i.e., change scores) for 38 referrals who completed instruction and the posttest assessments on one or more of the moral capacities assessed; (d) participants' self-assessments of learning; and (e) a final assignment that requested a rethinking of the issues for which disciplinary action was taken.

Classifying Infractions

Whereas the identity of each individual referred for ethics instruction is a matter of public record and is not protected by confidentiality requirements, I have assumed a higher standard of privacy in reporting the findings. First, all identifiers (except for professional status) were removed prior to coding the data. Coding of both the public record and participant's self-assessment of learning was accomplished by a research assistant and the author. Second, recent referrals were excluded because time had not elapsed to judge recidivism and because the board began posting recent stipulations and orders on its Web site, making is somewhat harder to meet our privacy standard.

Public records for each referral cite one or more infractions as reasons for action, but the language to describe the infractions varied over time. The first task was to develop a set of categories for classifying a wide range of infractions. The following categories of infraction were devised: (a) allowing auxiliaries to perform duties that exceeded the limits set by the Dental Practice Act (DPA); (b) performing duties that exceeded the limits set by the DPA; (c) insurance or Medicaid fraud; (d) complaints about competence; (e) poor interpersonal skills (ranging from a failure to communicate to communication that was ineffective or disrespectful); (f) violation of infection control standards; (g) performing specialty care (e.g., orthodontics, prosthodontics, oral surgery, endodontics) below the standard of the specialist; (h) failure to maintain competence; (i) inappropriate physical contact with patients; (j) inappropriate relations with patients or staff; (k) misuse of nitrous oxide; (l) writing prescriptions for oneself or family members that were not dentally related; (m) poor record-keeping; (n) unprofessional conduct reported by either a patient, a colleague, or a subordinate; (o) failure to refer to a specialist; and (p) malpractice judgments.

Helping professionals see that their peers are less willing than they are to act without the approval of professional colleagues is a useful way to raise consciousness about professional standards.

Although malpractice judgments are not specifically cited in the stipulation and order from the board as a reason for disciplinary action, such judgments were often a precipitating cause for involvement by the Board of Dentistry. This category was included based upon interviews with the referral. Table 1 lists each referral and the number of infractions that resulted in disciplinary action.

Analysis of Pretest and Posttest Data

All but two of the 41 professionals tested were required to take a specially designed ethics course (See Part 1; [Bebeau, 2009]), based on identified deficiencies in one or more of the abilities during pretesting. Of the two that were not required to take a special course, one (DDS #29) asked to do so anyway. He cited, as reasons, his interest in the topic and his desire to further expand his abilities. Though not required to take the posttest, this individual provided an extensive self-assessment of learning. His articulate reflection on his experience (see Sidebar) provides insights as to what referrals often state they experience in the assessment process.

For 38 participants who completed both pretest and posttests, change scores were computed. After establishing that statistically significant differences existed between pretest and posttest mean scores, effect sizes (Cohen's d) were calculated to judge the magnitude of the change for each measure. This statistic is defined as the difference between mean scores divided by either the pretest standard deviation or the pooled standard deviation. Following Borenstein's (2009) recommendation, I adjusted the pooled standard deviation by an estimate of the correlation between the pretest and posttest. Effect sizes can be interpreted as a representation of the mean differences in standard deviation units. Thus, a d = 1.0 indicates that the two means differ by a full standard deviation. For the referred professionals, pretest mean scores were typically about one standard deviation below the mean for Minnesota dental graduates who had participated in an ethics curriculum of demonstrated effectiveness (Bebeau & Thoma, 1994; Bebeau, 2006). For example, in the case of moral reasoning, mean DIT pretest scores for referrals were below the average score of 46 for entering Minnesota dental student (with cohorts ranging from 42 to 49 across 15 classes tested), but posttest mean scores were within the range of dental graduates (cohorts ranging from 47 to 55 with a mean of 51.4 [Bebeau, 2002]).

Effect sizes, as Cohen (1988) recommends, can also be used to compare treatment effects in a domain of interest where meta-analysis of intervention studies have been conducted. In a review of intervention effects for DIT scores, Bebeau (2002) noted that the largest effect size observed for a four-year liberal arts college program was .80. Yet, growth in moral reasoning is not evident in post baccalaureate professional education programs (medicine, veterinary medicine, dentistry, and law) in the absence of a validated ethics curriculum. Even then, effect sizes tend to reflect moderate gains. Bebeau & Thoma, (1994) report an average effect size of .36 (with a range of .12 to .71) across four years for the Minnesota dental ethics curriculum. Schlaefli, Rest, & Thoma (1985) observed an average effect size of .41 (with a range from .28 to .56) in a meta-analysis of 23 intervention studies.

Analysis of Participants' Self-Assessments

Also available for analysis were participants' self-assessments of learning and final assignments reflecting a rethinking of the issues for which disciplinary actions was taken. The self-assessments included responses to the self-assessment taken at the conclusion of the learning experience and consisted of approximately 80 pages of single-spaced material. These were analyzed for themes following a three-stage iterative process. The first stage involved identification of themes running through responses to each of three questions. Data from the smaller data set (the auxiliaries), were analyzed first, by the investigator and a research assistant who independently read and agreed upon themes for Question 1: What do you think you learned from the ethics course? and Question 3: What changes will you make (in the practice of your profession) as a result of the experience you had with the State Dental Board?

The second stage involved an additional review to assess the extent to which the participants' responses supported each theme. A third stage involved selecting quotes that exemplified different dimensions for each theme. Because cases were extensively used during the instructional phase, some comments referred to lessons learned from particular cases or to lessons learned from completing the final assignment where the individual needed to devise a case and commentary reflecting the issues for which disciplinary action was taken. For Question 2 (Which cases had the greatest impact on your learning?), a simple tally was calculated to determine whether the full range of cases presented during instruction were evenly represented in the responses. Quotes were then selected that reflected perceptions of the value of the case or cases.

Results and Discussion

Themes from the Self-Assessments

For auxiliaries, three themes were apparent in review of Question 1 (What do you think you learned from the ethics course?): (a) feeling renewed about their profession; (b) enjoyment of the individ-

Table 1. Specific infractions resulting in disciplinary action for each referral.

Referral	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sum
DDS 1	Y						Y	Y									3
RDA 1		Y															1
RDA 2		Y															1
RDA 3		Y															1
DDS 2	Y										Y					Y	3
DDS 3	Y															Y	2
RDA 4		Y															1
RDA 5		Y															1
RDA 6		Y															1
RDA 7		Y															1
DDS 4	Y		Y										Y				3
DDS 5	Y																1
RDA 8		Y															1
RDA 9		Y															1
RDH 1		Y															1
RDA 10		Y															1
DDS 6	Y																1
DDS 7	Y																1
DDS 8	Y																1
DDS 9	Y																1
DDS 10	Y			Y				Y			Y	Y	Y		Y		7
DDS 11	Y		Y	Y				Y					Y				5
DDS 12	Y		Y	Y		Y	Y						Y			Y	7
DDS 13	Y		Y	Y		Y		Y					Y		Y	Y	8
DDS 14			Y	Y		Y		Y					Y	Y			6
DDS 15	Y		Y	Y		Y		Y					Y				6
DDS 16	Y		Y	Y			Y	Y				Y	Y	Y			8
DDS 17			Y	Y		Y		Y								Y	5
DDS 18	Y		Y	Y				Y									4
DDS 19			Y											Y			1
DDS 20			Y	Y				Y				Y		Y			5
DDS 21					Y				Y	Y	Y	Y					5
DDS 22				Y	Y								Y			Y	4
DDS 23				Y		Y					Y		Y			Y	5
DDS 24					Y										Y		2
DDS 25			Y	Y	Y		Y	Y					Y	Y		Y	8
DDS 26			Y	Y			Y	Y					Y			Y	6
DDS 27					Y		Y						Y			Y	4
DDS 28			Y				Y	Y					Y				4
DDS 29					Y		Y					Y	Y	Y		Y	6
DDS 30			Y											Y			2
Totals	16	11	15	14	6	6	8	13	1	1	4	5	15	7	3	11	136

Infractions included: (1) allowing auxiliaries to perform duties that exceeded the limits set by the Dental Practice Act (DPA); (2) performing duties that exceeded the limits set by the DPA; (3) insurance or Medicaid fraud; (4) complaints about competence; 5) poor interpersonal skills; (6) violation of infection control standards; (7) performing specialty care (e.g., orthodontics, prosthodontics, oral surgery, endodontics) below the standard of the specialist; (8) failure to maintain competence; (9) inappropriate physical contact with patients; (10) inappropriate relations with patients or staff; (11) misuse of nitrous oxide; (12) writing prescriptions for self or family members that were not dentally related; (13) poor record keeping; (14) unprofessional conduct reported by either a patient, a colleague, or a subordinate; (15) failure to refer to a specialist, and (16) malpractice judgments.

Table 2. Pretest scores on measures of ethical development for dental professionals who completed a remedial ethics course

	Remediating Professionals				Comparison Group Dental Graduates	
Ethical Abilities	n*	Mean	S.D.	Range	Mean	S.D.
Ethical Sensitivity (DEST Scores)	38	48.8**	8.4	31.7 – 68.5	50.0	7.6
Moral Reasoning (DIT Scores)	41	37.5	12.2	18.0 – 66.7	51.4	13.3
Dental Ethical Reasoning (DERJT)	19	41.8	11.7	20.0 – 65.0	59.2	13.1
Action Choice	19	40.6	15.0	9.4 – 63.5	59.7	20.8
Justification Choice	19	43.1	16.5	3.5 – 66.5	58.6	14.6
Role Concept (Essay Scores)	38	3.8	1.9	0.0 – 8.0	—	—
PROI Scores						
Authority	24	35.6	4.4	26.0 – 43.0	36.4	4.5
Responsibility	24	44.0	5.9	36.0 – 55.0	42.7	4.6
Agency	24	43.1	8.0	22.0 – 54.0	38.6	6.0
Autonomy	24	40.3	7.3	27.0 – 58.0	34.8	7.4

**All participants completed the DIT, but initially the Role Concept essay was not required, and the PROI and DERJT were introduced in later years.*

***DEST scores are reported as standard scores, as Form A has more items than Form B.*

ual sessions and enjoyment of the course as a whole; and (c) broadening of perspectives or the processes learned for thinking about complex issues. Quotes judged to be representative of points of view expressed in responses by the 11 auxiliaries form the bases for conclusions described in the following sections.

For dentists, four themes were apparent in responses to Question 1: (a) enjoyment of the class sessions; (b) broadening of perspectives derived from thinking about complex issues; (c) sense of renewal; (d) enhanced communication and implementation skills. Notice that three themes were similar to themes for auxiliaries, but for dentists, the theme related to a sense of renewal, was extended to include "new understanding of the profession and the code of ethics." The fourth theme—present in some auxiliaries' responses though not as prominently—was the empowerment felt by dentists as a result of improved communication and implementation skills. Quotes judged to be representative of the points of view of the dentists form the bases for conclusions.

Change Reflected on Measures of Ethical Abilities

Table 2 shows the range of performance scores for each of the measures. Instruction was required for those professionals whose pretest score was lower than the mean score for dental graduates on a particular measure. Table 3 reports change scores for those professionals required to complete instruction specific to an identified deficiency. Statistically significant change, with effect sizes greater than 1.0, was evident for ethical sensitivity, moral reasoning, and role concept essays. More importantly, posttest scores indicate that referrals caught up with dental graduates who had benefited from an ethics curriculum of demonstrated effectiveness (Bebeau & Thoma, 1994; Bebeau 2006) and in some cases exceeded the scores achieved by recent graduates. Such gains are impressive, especially when compared with the average effect sizes reported for ethics interventions.

Statistically significant change was also evident for the Authority and Responsibility dimensions of the PROI (Professional Role Orientation Inventory [Bebeau, Born, & Ozar, 1993; Bebeau, 2006]), but not for the Agency and Autonomy dimensions. Whereas highly significant change scores were evident for some individuals whose pretest scores demonstrated a perception of agency or autonomy that was aberrant (i.e., either much higher or lower than the norm group), the reporting of means

Table 3. Change scores on measures of ethical development for dental professionals who completed a remedial ethics course

Ethical Abilities	n*	Pretest Mean	Pretest S.D.	Posttest Mean	Posttest S.D.	p	Cohen's d**
Ethical Sensitivity (DEST Scores) ***	24	43.9	5.3	58.4	10.1	<.0001	2.50
Moral Reasoning (DIT Scores)****	30	36.9	11.8	51.8	14.5	<.0001	1.28
Role Concept (Essay Scores)	36	3.7	1.9	11.2	1.1	<.0001	6.55
PROI							
Authority	20	35.5	4.4	38.0	5.3	<.0057	.38
Responsibility	20	43.0	5.7	47.1	4.8	<.0020	1.72
Agency	20	43.8	8.6	43.7	8.6	<.5883	
Autonomy	20	40.4	7.2	39.1	6.8	<.9625	

**41 professionals completed the pretest; 39 professionals took the course and completed one or more of the posttests. Change scores are reported for participants required to complete both pretests and posttests.*

***The effect size reported here for DIT scores exceeds the average effect size of d=.41 (with a 95 percent confidence interval ranging from .28 to .56) reported by Schlaefli, Rest, & Thoma (1985) in a meta-analysis of 23 intervention studies. It also exceeds the average effect size of d=.36 (with a range of .12 to .71) reported by Bebeau and Thoma (1994) for eight classes of dental students who completed an ethics curriculum.*

****Form A is used for pretest; Form B was used for posttest. Scores reported are standard scores.*

*****DIT-1 is used for the pretest; DIT-2 is used for the posttest.*

masked these changes. Nonetheless, aberrant scores on the Agency and Autonomy dimensions were useful in providing feedback to referrals as to possible reasons why they failed to do what "others"—e.g., the board and peers—thought they ought to have done or to have refrained from doing. Helping professionals see that their peers are less willing than they are to act without the approval of professional colleagues is a useful way to raise consciousness about professional standards.

Whereas professionals varied greatly in their sensitivity, reasoning, and ethical implementation abilities, one shortcoming was noted for 39 of the 41 referrals: an inability to clearly express societal expectations of the dental professional. Thus, as seen in Tables 2 and 3 in the scores for Role Concept essay, points were assigned for full expression (2 points), partial expressions (1 point), or omission (0 points) of each of six concepts (Bebeau, 1994). At pretest, the scores of individuals (Table 2) ranged from 0 to 8 out of a possible 12 points, with a mean of 3.8. In contrast, at posttest (Table 3), the mean was 11.2. Whereas change in the ability to articulate responsibilities that resulted from instruction and was also a valued part of the instruction, it was helpful to observe the frequency with which these concepts were omitted at pretest in order to provide insight into reasons for moral failings. This is illustrated in Table 4, which shows: (a) the responsibility to abide by the profession's code of ethics was cited least (76.3% made no reference to this concept); (b) the responsibility for lifelong learning was next (68% made no reference to this concept); (c) the basic ethic of the profession (to place the interests of patients before the self and the interests of society before the interests of the profession)—55% made no reference either to placing the interest of patients before the self or the profession's collective responsibility to society while 42% articulated the obligations to put patient interests before self, but only one individual articulated the broader sense of commitment described by Rule and Welie (2009); (d) a sense of responsibility for self-regulation and monitoring of one's profession (39.5 % omitted this concept, whereas 47% partially attended to the responsibility); (e) a responsibility to acquire the knowledge of the profession to a set of external standards (44.7% made no reference to this concept); and (f) a sense of responsibility to serve society. For the latter responsibility, 34.2% professionals failed to mention any responsibility over and above serving

Table 4. Presence of six concepts at pretest for 38* referrals who completed the Role Concept Essay

	Omitted		Partial		Full		Total	
Acquire Knowledge	17	44.7%	8	21.1%	13	34.2%	38	100%
Lifelong Learning	26	68.4%	5	13.2%	7	18.4%	38	100%
Serve Society	13	34.2%	16	42.1%	9	23.7%	38	100%
Abide by Code	29	76.3%	6	15.8%	3	7.9%	38	100%
Ethic of Profession	21	55.3%	16	42.1%	1	2.6%	38	100%
Self-Governance	15	39.5%	18	47.4%	5	13.1%	38	100%

**Three of the 11 auxiliaries were not asked to complete the role concept essay.*

those who can afford care. Whereas service was the most likely to be expressed responsibility, some expressed an unbounded sense of responsibility toward others—a willingness to compromise the self that bordered on martyrdom.

Of particular interest was the number of referrals who, on the DERJT (Dental Ethical Reasoning and Judgment Test [Bebeau & Thoma, 1999; Thoma, Bebeau & Bolland, 2008]), selected certain action choices as the best option when ethics experts deemed them as the worst choices. Typically, such individuals also had low DIT (Defining Issues Test, [Rest, 1979; Rest, Narvaez, Bebeau, & Thoma, 1999; Thoma, 2006]) scores. The correlation between DIT scores and DERJT scores (both measures of moral judgment) is .41 (Thoma, et al., 2008), whereas the correlations between DIT scores (or essay scores) and DEST scores are in the range of -.06 to .1 (You, 2007). Low scores on the DIT and DERJT were particularly helpful in explaining violations 1, 2, 7, 8, and 16 (Table 1). Low scores on the DEST (Dental Ethical Sensitivity Test [Bebeau, Rest, & Yamoor, 1985; Bebeau, 2006]) were particularly helpful in explaining violations 1, 3, 4, and 5. Following are specific examples of the explanatory power of the deficiencies in the measured abilities that help explain moral failings.

Linking Violations of the Dental Practice Act with Ethical Abilities

In almost every case, low scores on one or more of the performance assessments provided insight as to why the professional had gotten into difficulty with the board, and each referral was provided with that insight. However, this section will attempt to find commonality across cases. In some instances, data from the self-assessment of learning are cited to support the perspective.

Fraud. Some version of insurance or Medicaid fraud was cited for 15 of the referrals, but serious infractions requiring substantial financial restitution were cited for five individuals. These five dentists characteristically predated or postdated insurance forms or submitted claims for a different procedure than the one performed. Each of the practitioners involved with fraud exhibited an unusually high score on the responsibility dimension of the PROI, and (as expressed in the Role Concept Essay) a paternalistic and an unbounded, yet heartfelt, positive responsibility to serve those in need of care. The evidence seemed to support the referrals' assertions that actions were motivated by a desire to help a patient who seriously needed care for which they were unable to pay. In these cases, instruction focused on helping the professional empower patients to take responsibility for their own care, improve their personal assertiveness, and work within legal and ethical boundaries.

Providing Specialty Care Below the Standard of Care. Of the eight dentists (one of whom was a specialist) cited for providing specialty care (either orthodontics, prosthodontics, oral surgery, periodontics, or endodontics) below the standard of care, all but one (a generalist) were also cited for poor record-keeping. In most of these cases, the dentist found he or she was unable to support his or her clinical decisions because of a lack of documentation. In some sense, lack of evidence to support one's decisions served as an easier bridge (perhaps as a face-saving device) for addressing incompetent care, rather than having to come to grips with whether the care actually failed to meet specialty standards. In each of the cases of "probable incompetent care," the

board required a course to address the specific clinical competence in question together with a course in record-keeping. All eight of these dentists had acceptable ethical sensitivity scores, but seven of the eight (DDS #29, described in the sidebar was the exception) had moral reasoning scores below the mean for dental graduates, and five of the eight had very low reasoning scores (P scores in the low 30s for the DIT). Two of the five cases with very low reasoning scores, but acceptable scores in ethical sensitivity, were dentists cited for providing orthodontic care that failed to meet specialty standards of care. In fact, patient complaints following malpractice judgments brought these cases to the attention of the board. Both of these individuals were susceptible to patient complaints about the high cost of orthodontics and took on cases that were beyond their competence–though at the time they did not realize it. Orthodontists often argue that one of the difficult distinctions in providing orthodontic care is distinguishing easy from difficult cases: something that gets generalists into difficulty. Both individuals resolved, as a result of instruction that provided an opportunity to reflect on the orthodontist's perspective, to discontinue providing orthodontic care in the future.

Misuse of Auxiliaries. Sixteen dentists were cited for misuse of auxiliaries. For nine of these dentists, misuse of auxiliaries was the primary reason for disciplinary action. A review of these cases revealed some idiosyncratic reasons for their failures, rather than common ethical shortcomings. Four examples are provided.

First, in two of the cases, the dentists were unassertive solo practitioners who allowed the staff to perform procedures that were both outside their level of training and prohibited by the Dental Practice Act. In both cases, the profes-

A Prototypical Reflection on the Assessment Experience

When asked what he learned, DDS #29 shares what many of the referrals say they experience in the assessment process: "I feel I learned an incredible amount concerning ethics and the dental profession. First of all, I learned a volume of information about myself concerning ethics and the profession. The "Assessment" portion of the course came as a total surprise to me because I had no inkling of what this process would be. At my first meeting with Professor _____, I was a little nervous about what this process would entail. The first half hour was an interesting discussion/lecture concerning moral development and the moral reasoning process. I found this interesting and fascinating in that it had never been presented to me in this manner. The next task was the "Evaluation" phase for me. A brief description was given to me with respect to the separate measurement instruments, and I was led to a seminar room to begin this daunting task. I had no idea how long this would take and in what depth it should be done. I really felt rushed concerning the amount of material. Then I was left waiting for weeks for the results. I anxiously waited in fear, not knowing where I stood in terms of my ethical knowledge and skills. I learned a little about being patient in waiting for the results. When the results were provided to me, I was actually totally overwhelmed by the volume of information and analysis that these measurements provided. My prior knowledge and skills in ethics are reflected in Professor _____'s pretest report to the board. I feel that level of knowledge was enhanced tremendously through these course activities and interactions."

A second excerpt reveals his assessment of what was learned from feedback on one of the measures: "I learned a lot about my personal level of 'Ethical Sensitivity.' I learned how I compare to students and other professionals regarding this measurement. Using the four cases of this test, I learned that such situations are highly complex and must be approached from a different viewpoint with ethical principles and skills rather than from a casual standpoint. These four hypothetical cases were reexamined later in the coursework to provide a learning experience with respect to how to use language that avoids shame or blame to the patient. I learned how to distinguish between descriptive language and evaluative language and how to attempt to use descriptive words and phrases when speaking with patients. I learned how to try to enhance my respect for patients and their ability to understand explanations and make the best decisions in accepting care and treatment recommendations. I learned where I stood at the start with respect to my level of respect for the patients' rights to choose and when these choices have been compromised. I learned where I stood, based on my hurried responses to the patients and dentists in these cases under the test circumstances, with respect to my presentation of positive and negative consequences of various treatment options."

Each of the practitioners involved with fraud exhibited an unusually high score on the responsibility dimension of the PROI, and (as expressed in the role concept essay) a paternalistic and an unbounded, yet heartfelt, positive responsibility to serve those in need of care.

sionals expressed embarrassment about being disciplined. Whereas both dentists exhibited reasonable sensitivity to ethical issues, reasoning about moral issues was not well developed. In one of the cases, both the dentist and three of his office staff were all referred for instruction, as specified by the board as permissible sanctions for registered dental assistants (RDA) and registered dental hygienists (RDH). What became obvious during the problem-solving sessions was the dentist's lack of assertiveness. He would allow the staff to decide on a course of action even when he did not agree with it. Much of the course was devoted to helping the auxiliaries see the shortcomings of their thinking and building respect for the perspectives of the dentist. Both of the dentists involved in these cases were encouraged to seek further assertiveness training.

In a second example, a group practice involving two specialists and four auxiliaries was referred for an ethics course because auxiliaries were performing prohibited duties. In this case, the dentist who trained the auxiliaries to perform the prohibited practices exhibited exceptionally low scores on moral reasoning, but very high scores on ethical sensitivity. In contrast, his associate (who joined the practice after the prohibited practices were instituted) exhibited high scores on moral reasoning but exceptionally low scores on ethical sensitivity. Deficiencies in these two abilities illuminated both the reasons for the problem and the dentists' reaction to disciplinary actions by the board. In the intake interview, the dentist who trained the auxiliaries said he knew the procedures were prohibited, but offered justifications for his actions: others did it (including board members, he thought), the rules were archaic (some states allowed the prohibited procedures), he was working to change the rules, no patient had been harmed (though malpractice charges had been filed), and so on. In contrast, his associate said he honestly did not realize the duties were prohibited. In discussions, he was quick to see the fallacies in his partner's arguments. He was also less angry about the disciplinary action—as he did not see himself being "above the law."

A third example also involved a specialist and his staff—three RDAs and one RDH. The specialist had very low scores on the DIT and moderate scores on ethical sensitivity, but of all the referrals, he made the most remarkable progress, both on measures of the abilities and in attitude. Initially, he challenged the validity of the measures and seemed very wary of the benefits of instruction. He also had to pay the costs for all his staff. A clearly gifted individual, he had not developed his ethical abilities, but when given the opportunity he spent a great deal of time reading and reflecting on professional practice. He expressed particular gratitude for a case discussion during the instruction period involving a decision by a generalist as to whether to offer orthodontic care. This common dilemma has been a powerful case for discussion in the University of Minnesota dental ethics curriculum. It asks a student to consider whether to expand his or her practice to offer orthodontic care. Many generalists offer orthodontic care, which is a great source of irritation to the orthodontic community—principally because of the potential for substandard care that often results in irreversible harm. Generalists often fail to appreciate the complexity of care and describe specialists as greedy purveyors of dental services. The case enables students to consider the perspective of the specialist and to consider the importance of the generalist-specialist relationship.

The specialist, DDS #5, remarked: "The case in which the young dentist had to decide whether he should do ortho-

dontics or not was most enlightening. The conclusions reached in our discussions were similar to the conclusions I had always reached, but was unable to voice or express a firm conviction about. I always felt he should not, but felt my opinion was not very good because of 'prejudice and self-interest.' The principles of developing a good moral argument were very helpful in giving me the confidence to change my mind from 'he should not, but he has a right to' to 'he should not and he has an obligation not to.'"

In the fourth example, four dentists from a group practice were referred for misuse of auxiliaries. The intervention from the board was the result of employee complaints. Within this group, there was variation in reasoning and in ethical sensitivity that would not account for either a failure to recognize the ethical issues or to reason well about them. However, the dentist who assumed management responsibilities for the practice was particularly low on both ethical sensitivity and reasoning, and it became evident that because of his effective interpersonal style, the others deferred to his judgment. Further, the four did not appear to collaborate on decision making; rather each seemed to run a private practice with little interaction among them. None of them were particularly effective in empowering patients or achieving consent for treatment. This group was particularly influenced by discussions of professionalism and the exercises on ethical implementation. Their comments reflect this.

DDS #7: "As you may already be able to tell from my previous responses, this concept of empowerment has moved me. The characteristics, especially those of knowledge, promises, professional ethic, a duty to the ethic, when understood, yield tremendous power and responsibility through our successful ability to empower patients to be able to take responsibility for their care. I see it every day—misunderstandings arise when the patient did not understand and therefore did not take responsibility. I would like to get better at this by continuing the development of these skills. It would help me also with staff and at home. I don't need to be a caretaker in the sense of being responsible for everything and everyone. It makes me tired!"

DDS #8: "The course was an awakening. It made me realize that I had a 'right' to practice, with many more obligations and duties than I have professed over the past years. It has made me realize that in every phase of practice, one must take into account moral and ethical issues, the affected parties, and the consequences of each action. I am far more sensitive to the effects of the interrelationships between the profession, colleagues, society, family, and myself."

Responding to questions about which case had the greatest impact, DDS #8 said: "I think all of the cases had a great impact. In both the moral judgment and ethical sensitivity cases, I was very saddened to learn that my scope as a professional was quite narrow, and received much help in this dilemma in reviewing all of the cases. The basic concepts of how a professional should handle each case instilled in me a new sense of total responsibility to the profession, society, patients, and family."

With respect to changes, DDS #6 remarked: "I believe the most important change is an improvement on informed consent of the patient. I have learned what the patient relationship means to me, and I want to educate and empower the patient in my practice. Before this class, informed consent was a patient's signature on a piece of paper. Now, I realize informed consent is the profession educating the patient well enough for that patient to make an informed decision and consent to the work. I have also learned to 'regulate myself' and my peers and have had open conversations with my employees concerning the Dental Practice Act, what it means, and that I want to be informed of any problems they see with conforming to the Act. I realize that I am the ultimate sentinel on my practice and will also help others who need to be reminded of their obligations.

Professionals' Self-Assessment of the Elements of Instruction that Facilitated Learning and Change

The qualitative analysis of the self-assessment data indicated that professionals found the lectures and discussion of the societal expectations of the professional the most uplifting and helpful in restoring a sense of pride in their chosen work.

Nearly all made statements such as this specialist (DDS #19): "I learned so much about ethics and dentistry. The most important for me was the real definition of a professional. That has changed my outlook on dentistry. I realize that my being a DDS is a privilege, that I have a role to serve the community and, as such, will begin volunteering at a free clinic in the fall. I also am much more aware of professional monitoring of colleagues' treatment. I feel much more comfortable in calling colleagues after seeing one of their patients and informing him or her of findings on their patient (i.e., amalgam overhangs, periodontal disease noted on panoramic

radiographs, etc.). This course has given me a far better outlook on the dental profession as a whole."

A general dentist (DDS #17) commented: "What I have learned is vast. The experience, though traumatic, has been wonderful. Learning a new way of looking at things has been rewarding. As an experienced practicing dentist, I feel (felt) that I had a very good ethical basis. I know that the 100% commitment to the 'basic ethic' of the profession has been practiced all along– do no harm, put the health interests of the patient above self and the interest of the profession. I have done a good job at that. What I have not been so aware of is how my actions have affected others, and that there are 'issues' that I needed to be more open to, those issues that were not 'formerly taught,' but were learned in passing. I was aware of the basic 'six attributes' of a professional, but had not thought too deeply before about self-regulation, how the dental profession rose to where it is today, and our role as professionals in society as a whole. What I learned was vast, but the organization of it was fascinating–that there was a 'substructure' to ethical 'learning.' There was no question that what I did to get here was deserving of the stipulations. What was hard to deal with was 'who' put me here. I accepted that challenge and I feel good about what I have learned."

The sense of empowerment and renewal was most evident for this auxiliary's response–but was not atypical. RDA #7: "I learned that there is much more to being a professional than saying that you are, or just doing a job. Even though I'm 'only' a dental assistant, I believe that in most ways we have some of the same duties and responsibilities that a DDS does. We must acquire as much knowledge about our profession as possible. We must abide by a code of professional conduct. We must also put rights of patients above self-interest. I realize that we are here to provide a service to society, maybe not on as much of a grand scale as a DDS, but nonetheless the rights of society must come before the rights of a profession."

Later, when asked what changes she would make as a result of her experience with the board, RDA #7 said: "I will start to act and think as a professional. Before this course I thought of my work as just that, 'work' or that it was only a job comparable to any other job. I have come to realize that I don't just have a job. I have a profession. To be a member of a profession, there are certain concepts that I need to uphold." (At this point, she reiterated her very thorough understanding of the expectations of a professional.)

When asked what case was the most interesting, both dentists and auxiliaries often commented on the practical value of what was learned and, rather than singling out a particular case, commented on the practical value of all the cases. DDS #17: "All of the cases had impact on my learning–the discussions that followed with Dr. _____ were more involved and helpful for 'every day' use than I thought they were going to be. Things that I took for granted popped out at me. Some cases took an hour just on one small facet. Lots of 'vernacular' was discussed. I am an expert on the physical side of dentistry. I thought I was also very good at patient relations. I found out through case discussion what a truly gifted person sounded like, picked up on ('That must have been horrible for you! Tell me about it.'). I was duly impressed and took a lot of insight with me (not as much as I would have liked). The most difficult case: 'The Sandy Johnson Case'–how to deal with potentially life threatening situations–how potentially complicated they can be ('California Disclosure Case'). The most difference of opinion was 'The Margaret Herrington Case'–as an introvert what to do was clear after discussion–talk to the dentist who did work, get action, or help patient to a better solution."

Of particular interest, from the perspective of the Board of Dentistry, would be DDS #30's perspective on the value of the capstone assignment wherein the referral had to develop a personal dilemma reflecting the circumstances for which his or her disciplinary action was taken, and develop a well-reasoned argument on a more defensible course of action. [For me, the most important case was the "Dr. Sanders Case"], "because it was the culmination of everything I learned in the course as applied to my individual situation–a real-life intellectual study that had very much meaning for me. I could re-read my own analysis and answer my own questions as to what was 'wrong' with what I did regarding this whole DDS #30-Board-Medicaid Issue. The Dr. Sanders case is a feather in Dr. _____'s cap in that it is the distillation of all she was trying to teach me. Moreover, the lesson was learned, articulated, and greatly appreciated. The paper says it all."

When asked what changes the professionals would make as a result of the instructional programs, their responses cited particular professional responsibilities and often expressed ways the course helped the professional overcome anger about the disciplinary action. A typical example: DDS #19: "I am much more aware of the issues involved in my dealings with the board. I am very aware of insurance reporting and will make no more mistakes with that. I am also very aware of the need for self-policing

within the profession. I know my responsibility in dealing with colleagues who consistently perform sub-par treatment. In addition to being enlightened by the board as to my responsibilities as a professional, I am also grateful for the requirement to take the ethics course. I wish this had been available when I went to dental school; I probably would not have had my experience with the board. I also now have a new respect for the board and the tremendous responsibility that they hold."

For the auxiliaries, the sense that they were involved in a profession seemed to be most empowering, and this realization contributed to a sense of renewal and self-worth. As with the dentists, the course experiences were broadening—often enabling them to change their minds about prior beliefs and to engage their colleagues in addressing issues of professionalism.

RDH #1: "I will not perform tasks that are not specifically designated by the state Dental Practice Act. In addition, I will inform other auxiliaries so they are aware of what the Dental Practice Act states, and encourage them to refrain from doing prohibited procedures. In the future, I will try to critically analyze specific procedures and think about what is best for the patient, society as a whole, and the profession, and then will work within the system to change and/or establish laws that are in the best interest of all concerned."

Educational Significance

Most practitioners came to the session readily admitting their own shortcomings, even though they may have been angry about what happened to them. Some of the main outcomes of the course are the opportunity to reflect with others on mistakes and missteps, to assess the personal shortcomings that make one vulnerable to patient dissatisfaction and subsequent disciplinary action, and to implement action plans to address the issues.

Based on a review of both the change scores and self-assessments of learning, several things stand out. First, the various assessment measures employed (ethical sensitivity, etc.) helped the practitioners gain insight about those personal shortcomings in ethical abilities that contributed to their moral failings (see Sidebar for an example). Second, based upon practitioners' reactions to assessment and instruction, it is evident that the framework of ethical abilities (Rest's Four Component Model) provides a powerful foundation for engaging in learning. As was evident from the self-assessment data, beginning the instructional process with a discussion of the distinguishing features of a profession and the expectations that follow is uplifting and renewing. Further, the cases used to facilitate ethical sensitivity and reasoning clearly were viewed as relevant to professional practice. Finally, it appears that practitioners highly valued the emphasis on ethical implementation. Instead of stopping with "What is happening?" and "What ought to be done?" as is typical of much ethics instruction, the courses spent time focusing on how to implement an action plan, including what to say and how to say it. This is a neglected area in much of ethics education—what Fisher and Zigmond (2001) working in research ethics refer to as "survival skills." For students and practitioners alike, there is a clear hunger for help with strategies and language to deal with human interaction problems that have clear ethical implications. For a more extensive discussion of curriculum and resources to promote ethical implementation, see Bebeau and Monson (2008).

There appeared to be a kind of hunger for engagement with others around ethical issues of the profession.

Having an opportunity for guided reflection on a significant event, like a disciplinary action by a licensing board, has real potential for helping the practitioner make improvements in practice that bring enhanced personal satisfaction and improved practice.

Reflecting upon both the qualitative and quantitative data, it is important to ask whether the observed changes in performance and perspective on learning represent real change that will have a lasting effect. Certainly the circumstances under which respondents completed the course are important to consider. All practitioners were required to complete the course, the assessments, and the self-assessment of learning—often at great personal expense. Since reinstatement of their license was at stake, one would expect referrals to engage in a certain amount of impression management, i.e., to say positive things about the course and the instructor.

It is certainly possible that as designers of the experience, we have been duped into thinking the benefits were greater than they actually were. To address this concern, we asked ourselves about overall impressions. What stood out—after reviewing approximately 80 single-spaced pages of self-assessment data? For the research assistant who has also analyzed several years of self-assessment data for dental students' reactions to ethics instruction (using similar questions), the following things stood out. First was the large number of comments about enjoyment of instruction, coupled with the detailed responses indicating how particular activities and cases were of benefit. Second was an overwhelming impression that the referrals really appreciated the educational experience. This was particularly impressive in cases where the individual exhibited some residual anger about the disciplinary action. Also impressive were the number of referrals who commented about their newly acquired understanding and appreciation for the role of the Board of Dentistry, and the number of referrals who commented about future intentions—to be more involved in organized dentistry and to be more involved "giving back to their communities" by providing pro bono care.

Anecdotal evidence gave credence to these impressions. The course seminars, scheduled in two-hour blocks, rarely ended on time—not because the instructor was expounding on some fine point, but because participants were actively engaged in discussion and resisted efforts to bring things to a close. There appeared to be a kind of hunger for engagement with others around ethical issues of the profession. Other anecdotal evidence comes from the number of practitioners who have maintained a friendship with each other and with the course director since the experience. It is not uncommon to receive notes of appreciation years after the experience. Further, for the last several years, referrals have volunteered to speak to dental school classes about their experience and about the professional expectations they found most difficult to fulfill. The most important message they have delivered is a willingness to admit to personal shortcoming and to address the importance of self-regulation and engagement with their professional association.

Sadly, two individuals who completed instruction have encountered subsequent problems. One decided to retire his license—following repeated misuse of auxiliaries; one was disciplined for subsequent unprofessional conduct. On

the other hand, 38 individuals have not had a second encounter with the board. To date, we have been unable to identify comparable data to our findings.

Conclusions

Findings from this study support the explanatory power of measures based on Rest's Four Component Model for understanding moral failings and the power of a remedial course for improving ethical decision-making abilities and for restoring a sense of professionalism. An important take-away message for ethics education is the clear need to focus more attention on ethical implementation. What practitioners actually say and do is where the rubber hits the road. Having an opportunity for guided reflection on a significant event, like a disciplinary action by a licensing board, has real potential for helping the practitioner make improvements in practice that bring enhanced personal satisfaction and improved practice.

What began as a pilot project to remediate problems board members sensed in their colleagues who had experienced disciplinary action, has matured into a working program with a beneficial effect. This analysis, undertaken to evaluate the program, supports its effectiveness. Both the board and the practitioners who have experienced the program support its continuance. As one referral wrote me following his hearing for licensure reinstatement: "Thank you for making a difference in my life... I will remember that time always." ■

References

Bebeau, M. J. (1994). Influencing the moral dimensions of dental practice. In J. Rest & D. Narvaez (Eds.), *Moral development in the professions: Psychology and applied ethics* (pp. 121-146). New York, NY: Erlbaum Associates.

Bebeau, M. J. (2002). The Defining Issues Test and the Four Component Model: Contributions to professional education. *Journal of Moral Education, 31*, 271-295.

Bebeau, M. J. (2006). Evidence-based character development. In N. Kenny & W. Shelton (Eds.), *Lost virtue: Professional character development in medical education, Volume 10 (Advances in bioethics).* Oxford, UK: Elsevier Ltd., 47-86.

Bebeau, M. J. (2009). Enhancing professionalism using ethics education as part of a dental licensing board's disciplinary action: Part 1. An evidence-based process. *Journal of the American College of Dentists, 76* (2), 38-50.

Bebeau, M. J., Born, D. O., & Ozar, D. T. (1993). The development of a professional role orientation inventory. *Journal of the American College of Dentists, 60* (2), 27-33.

Bebeau, M. J., & Monson, V. E. (2008). Guided by theory, grounded in evidence: A way forward for professional ethics education. In D. Narvaez & L. Nucci (Eds.), *Handbook on moral and character education* (pp. 557-582). Hillsdale, NJ: Routledge.

Bebeau, M. J., Rest, J. R., & Yamoor, C. M. (1985). Measuring dental students' ethical sensitivity. *Journal of Dental Education, 49* (4), 225-235.

Bebeau, M. J. & Thoma, S. J. (1994). The impact of a dental ethics curriculum on moral reasoning. *Journal of Dental Education, 58* (9), 684-692.

Bebeau, M. J., & Thoma, S. J. (1999). "Intermediate" concepts and the connection to moral education. *Educational Psychology Review, 11* (4), 343-360.

Borenstein, M. (2009). Effect sizes for continuous data. In H. Cooper, L. V. Hedges, & J. C. Valentine (Eds.), *The handbook of research synthesis and meta-analysis* (2nd ed.) (pp. 221 – 235). New York, NY: Russell Sage Foundation.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Fisher, B. A., & Zigmond, M. J. (2001). Promoting responsible conduct in research through "survival skills" workshops: Some mentoring is best done in a crowd. *Science and Engineering Ethics, 7*, 563-587.

Rest, J. R. (1979). *Development in judging moral issues*. Minneapolis, MN: University of Minnesota Press.

Rest, J. R., Narvaez, D., Bebeau, M. J., & Thoma, S. J. (1999). *Postconventional moral thinking: A neo-Kohlbergian approach*. Mahwah, NJ: Erlbaum.

Rule, J. T. & Welie, J. (2009). The access to care dilemma: Symptom of a systemic condition, *Dental Clinics of North America, 53* (3), 421-433.

Schlaefli, A., Rest, J. R., & Thoma, S. J. (1985). Does moral education improve moral judgment? A meta-analysis of intervention studies using the Defining Issues Test. *Review of Educational Research, 55* (3), 319-352.

Thoma, S. J. (2006). Research on the Defining Issues Test. In M. Killen & J. G. Smetana (Eds.), *Handbook of moral development.* (pp. 67-92). Mahwah, NJ: Erlbaum Associates.

Thoma, S. J., Bebeau, M., & Bolland, A. (2008). The role of moral judgment in context-specific professional decision making. In F. Oser, & W. Veugelers, (Eds.) *Getting involved: Global citizenship development and sources of moral values.* (pp. 147-160) Rotterdam, The Netherlands: Sense Publishers.

You, D. (2007). *Interrelationships and gender differences among components of morality for dental students.* Unpublished doctoral dissertation, University of Minnesota, Minneapolis.

Moral Hazard

David W. Chambers, EdM, MBA, PhD, FACD

Abstract

Civil societies set aside a common pool of resources to help those with whom chance has dealt harshly. Frequently we allow access to these common resources when bad luck is assisted by foolishness and lack of foresight. Sometimes we may even help ourselves to a few of those common assets since others are doing so and they are public goods, the cost of which is shared and has already been paid. Moral hazard is the questionable ethical practice of increasing opportunity for individual gain while shifting risk for loss to the group. Bailout is an example. What makes moral hazard so widespread and difficult to manage is that it is easier for individuals to see their advantage than it is for groups to see theirs. Runaway American healthcare costs can be explained in these terms. Cheating, overtreatment, commercialism, and other moral problems in dentistry can be traced to the interaction between opportunistic individual behavior and permissive group responses common in moral hazard.

When I first heard the phrase, I thought it was clever. "It is easier to ask for forgiveness than to get permission." Now I see it for what it is: bragging about a disregard for common courtesy. I have yet to think up a good comeback to someone who sits there with no shame claiming that it is somehow more admirable to take the easy road than the right one and is proud of having gotten away with it. "Lighten up," a little voice mumbles in the back of my head. "It's not like someone really did something bad; it's more like shoplifting a candy bar." I had never really thought much about the fact that I pay a little more than I should for my candy bars because others just take them when they feel the need.

The effect is known as moral hazard. If you are interested in doing some background reading on the topic, check the economics literature rather than moral philosophy. It has been principally a matter of concern to those in the insurance industry.

It is good, both economically and morally, that groups are concerned with protecting their members from swings of fortune. Family groups have served this purpose since the fortunes of the hunt were shared among those who participated, regardless of who actually made the kill. It is a mark of a moral community to care about its members and to provide so they still have the essentials when struck by sickness, accident, predation, or other factors beyond their control. The immigrant experience is especially marked with mutual self-help organizations. In "advanced" societies, the mechanism is a bit more difficult to distinguish as the government takes over such functions and the boundaries of moral community become blurred. But the concept of insurance, the pooling of resources to be shared with those who through no fault of their own find themselves in need, is a clear and worthy notion.

Smokers should be able to purchase health insurance to protect themselves and their families from the costs of respiratory diseases. Dentists should be able to purchase malpractice insurance to indemnify them from bad outcomes in practice. It makes sense for the Federal Deposit Insurance Corporation to underwrite bank deposits of people who are trying to earn a profit by putting their excess income out to work. But there are potential abuses to these good ideas.

Some individuals mislead the community when they join. A heavy smoker may lie on the application for insurance and deny his or her habit and the risk it carries. A few dentists may have such shaky skills or questionable standards that they would be refused malpractice insurance if the facts were known. These are abuses of unfair contracting *before* the fact. The result is that risk is shifted from the dishonest members of the community to the honest ones. On average, solid members of the community get less of the common resources and the bad actors get an unfair abundance of common resources. The good citizens pay part of the fare for the free riders.

If free riding can be detected and managed in some fashion, there is a natural tendency for the sound citizens to want to segment the pool of shared resources and join with others like themselves and not with the abusers. This fragments the community, driving down the costs in some areas and driving up the costs in others. This phenomenon is called adverse selection. One of the great moral problems is how much adverse selection to allow in a community. Most of us are willing to pay a small tax (a set-aside to clean up the problems caused by a few motivated bad actors) in order to preserve the community intact. We do this because of the other benefits we derive from sharing common resources. Every organization—your synagogue, the dental office, and the ADA—eventually comes to the conclusion that it is better to go along with some inefficiency rather than to go it alone.

The second abuse of the principle of pooling community resources, and the topic of this essay, involves deception *after* the fact. Research shows that individuals who get health insurance increase their smoking rate. People who have car insurance are less likely to lock their cars than those without insurance. People with no co-pay on their health insurance are "sicker," or at least use healthcare services at a higher level.

This is moral hazard. The definition is abuse of common resources by shifting risk from opportunistic individuals to the group as a whole after an agreement has been reached to share the risk evenly. It is easier to ask for forgiveness than to get permission. AIG is a poster child for moral hazard.

Adverse selection—risk shifting from the individual to the group before the fact—can take two forms: the individual may mislead the group either about how much they have contributed to the common resources or about how much of the pooled resources they are likely to need. Chrysler Motors might overstate its contributions to local economies in order to get tax incentives from a state where it wants to locate a plant or get federal bailouts, or it might understate the downside risk. Similarly, moral hazard—risk-shifting from the individual to the group after the fact—can take the forms of engaging in escalated risk after getting access to resources (as Enron) or cutting back on responsibilities to replenish the common pool of resources (as some people do once they are elected into prestigious organizations).

Moral Hazard and the American Way of Life

As a nation, America is addicted to moral hazard. Our banking system is constructed by law to be "too important to fail." As a result, Bank of America took bailout TARP funds because it had over-leveraged itself and used those funds to purchase Countrywide Home Mortgages and Merrill-Lynch, thus accelerating its leverage again with federal funds. General Motors took its federal bailout money, intended to reduce risk, and purchased Delphi, a

On average, solid members of the community get less of the common resources and the bad actors get an unfair abundance of common resources. The good citizens pay part of the fare for the free riders.

parts supplier it had previously spun off as too risky so that bankruptcy could shear the debt. This is basically a form of government-sponsored debt laundering. The public is outraged over multimillion dollar bonuses paid to AIG hedge fund operators who have cost the nation billions of dollars but are too important to the recovery process to be financially offended. These are rare and high-profile examples of moral hazard. The larger scandal is that fact that "shrinkage," the amount of disappeared inventory, personal photocopies, tax write-offs for personal expenses, pay for hours not worked, and shoplifted candy bars is placed at between 30% and 40% of the cost of running American business. That is the average across all businesses in the country. It has been going on for years, and it is paid for by the typical consumer out of what he or she can get on the side. There is a Soviet-era saying that captures this attitude: "If you are not stealing from the government (or the company), you are stealing from your family."

This is how it looks schematically: An individual takes a little of the public goods for personal use, not realizing that he or she is part of the public that has to make up the loss. But even if the obligation to replenish the public resources is recognized, the individual realizes that he or she will still be behind unless they take more since others are doing it. There is little will to change the system since many of us think we are really more clever than the others at taking advantage of the system. I cannot prove this, but the fact that no modern society has been able to rein in moral hazard leads me to believe that we cannot do the math accurately when it comes to comparing their dollar to mine, and a dollar coming looks more attractive than one going. It is hard to castigate the culture of moral hazard as an ethical issue, since it is practiced on such a wide scale and by individuals who, in their own eyes, lead moral lives.

Nowhere is this moral hazard more apparent than in our healthcare system. Of every dollar that changes hands in the United States for any purposes whatsoever, 15 cents of it is touched by a physician, dentist, nurse, hospital employee, pharmaceutical company, or employee of an insurance company. That is about $6,000 per person per year. This is also about twice the investment of other industrialized nations, and vastly more than developing countries. There is nothing ethically troubling about the gross figures, even when considering the fact that we are generally a bit less healthy than the citizens of other developed countries. That is our choice about what we want to purchase.

But a bit of dis-ease begins to creep in when we look at the distribution of resources. Health is substantially a community benefit; we mean it to be so. We guarantee a minimal level of care to all citizens and to all who are in this country whether citizens or not through the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), which is supported out of the common pool of resources. Where ethics comes in is the matter of distribution. If there are $100 dollars in the pool, it would be foolish for anyone to leave an extra dollar on the table. There are communities that overuse Medicaid resources, even as much as twice as much as communities with comparable health needs. In fact, it is the financially well-off who actually over-consume from public health resources. Even when health care is paid by private insurance, it is often viewed as a right to access to unlimited resources rather than as a prepayment for potential needs. Once in the system, there is pressure to over-consume. Ten percent of the population consumes two-thirds of health goods; half of individuals consume 97% of services. Anyone who is left out must either compete for these resources that they feel they have already paid for by consuming more or must lobby for more funds to be added to the pool in hopes of getting some of the increase. Both of these strategies are inflationary. President Bush's Health Savings Account program has not been overwhelmingly successful (about 3% market penetration) and no changes in health lifestyle have been detected in those who have assumed a larger responsibility for financing their own heath care.

Our legal system exists in substantial part for the purpose of spreading responsibility from individuals to society as a whole. Undoubtedly, there are cases of society suing individuals; but it usually goes the other direction because that makes better economic sense. Recently, a motorcyclist successfully sued the State of California for several million dollars as a result of his running into a wild hog that was crossing the highway. The state was found negligent in not having posted a sign warning bikers that there might be hogs in the area. The fact that the biker was legally drunk was not deemed relevant to the case. This is an extreme example of moral hazard. Most of us expect that the state will assume responsibility for public safety and that they can do so more effectively than can individual citizens. In fact, the state specifically prohibits individuals from posting suggested speed limits or signs warning of possible hogs near their homes. Each of us pays a few dollars in taxes for highway safety plus two bits extra for moral hazard. The biker may not be as lucky, however, as it first appears. In the United States in 2002, the average split of awards in tort cases was 42% to the plaintiff and 58% to the attorneys, plus taxes on all citizens to

run the legal system. Recently, malpractice carriers for dentists have begun taking cases to trial rather than settling them out of court. The result has been a decline in malpractice premiums directly attributable to decreased moral hazard.

The Dynamics of Moral Hazard

Moral hazard is a stable feature in groups. It works on the difference between concrete individual benefits and general collective costs. And a certain gain is always worth more than a probable cost. If it is thought that others may be benefiting from available public goods, would not it seem naïve or foolish not to get one's share of the extra as well as one's share of the common good? What man could reasonably refuse commandeering an unguarded lifeboat on the sinking Titanic to save his wife and children instead of bringing the overlooked boat to the attention of the ship's crew to be added to the pool of boats to be allocated by lot? A little commercialism in dentistry may be okay if it appears that the others who are also engaging in it are drawing away patients, just self-protection. Cheating on exams, in order to supplement what has already been learned through diligent study, seems reasonable if everyone else is doing it and to forego it would create a false unfavorable comparison with others who are also competing for coveted post-graduate slots. Moral hazard becomes a feeding frenzy of self-reinforcing behavior in groups. Finally, there is the matter of small increments. You are late, through no fault of your own, and you cut across the grass, despite the sign that clearly says "Stay Off the Grass!" The porter scowls and asks sarcastically whether you can read. Your first instinct will probably be to note that one person walking across the grass one time will cause no damage. In fact, you may challenge your challenger to point out the evidence of any ill effect he can detect from your actions.

But the moral hazards we should be worrying about are not the multimillion dollar ones, but the little ones that are repeated by many people. There are normally no bright lines that distinguish moral hazard from legitimate use of common resources. Even if there were, it would still be in most of our interests to cross the line regularly by just a small amount. The right amount of moral hazard to engage in is just shy of what it would cost to detect and punish abuse.

The Stability of Moral Hazard

Each of us can think of an example of moral hazard that offends us at a deep level; we can also think of examples that are so trivial that we would not bother to comment on them. In between, there are plenty we engage in personally. The problem is that our personal scale is likely to differ from the scale used by others. Even worse, if we are too public about our own scale we run the risk of appearing morally tainted to some and of exciting competition for public resources among others.

There is an underlying dynamic in moral hazard that causes abuses of the common good to reach a stable level and then remain in equilibrium. Consider the case of managed care. Fifteen years ago the rate of "covered mouths" in the United States was increasing at such a rate that organized dentistry sounded the alarm, including an ADA dues increase for a direct reimbursement alternative. The moral hazard in managed care is the contractual obligation to provide needed oral care for individuals enrolled in a plan, regardless of their health status and level of personal responsibility. The attractive part of managed care is spreading the risk in ways that allow greater access to care; the unattractive part is the potential for abuse by extremely high users who are getting free access to common resources beyond what other patients would have chosen had they had full information. Some risk-shifting is appropriate; some is not.

As a nation, America is addicted to moral hazard.

Capitation programs have not been driven from the field, and direct reimbursement has not taken hold. The rapid increase in managed care has reached a stable plateau. This equilibrium is determined by a complex of forces, most notably by the number of reasonably healthy individuals who are willing to select a somewhat less personalized oral health plan. Carriers cannot sell packages of potential patients that contain too many cases with the chance of escalating treatment demands. Neither can they sell packages of patients with predictably low needs—others will undercut them in the market. Now that all the

The right amount of moral hazard to engage in is just shy of what it would cost to detect and punish abuse.

"right sized," bundlable patient pools have been recruited and sold, the equilibrium has been reached. There will be fluctuations around this stable point caused by demographic factors such as the overall economy, degree of mobility in the population, and number of dentists working for other dentists, but managed care has achieved equilibrium.

Other examples of this self-adjusting mechanism for moral hazard can be found in dentistry. The profession's reputation for putting the patients' oral health first (which is a vary valuable common resource) is borrowed after the fact by the commercialists who invest little in maintaining that reputation while using it to advance their personal agendas. Journals trade on their reputation for peer reviewed papers while engaging in the moral hazard of attaching supplements wholly sponsored by firms with something to sell that contain papers with no data. A certain level of overtreatment is understood to exist in various communities, usually more in urban areas with transient populations. The prevalence of cheating reported in dental schools seems to have been stable for the past half century.

The level of abuse of common resources is stable in communities and is largely determined by characteristics of the community, not characteristics of individual members. Groups are designed, through shared goals, incentives, reward and punishment standards, and degree of tolerance for hypocrisy to generate a small and stable number of ethically deviant individuals. The moral tenor of a community cannot be found by taking the average of what individuals would do if they were not part of the group. Individuals will behave differently in the various groups to which they belong. Moral tone is negotiated within the group; it is not an average.

The number of bad actors in a group cannot be controlled by eliminating bad actors without also altering the conditions that allow them to flourish. New ones will take the place of those who are expunged if the vacancy is attractive enough. The strategy of cleaning a bad barrel of a few bad apples is a form of guaranteed employment for enforcers such as lawyers.

The basic roles available to members of a group include *good citizens* trying to get on with life without engaging the system and accepting a little moral hazard as the price of doing business, opportunists taking advantage of moral hazard without drawing attention, *deviants* who threatens the community by taking "too much." There are also *concerned citizens* who are willing to confront those who abuse the public good. Other roles include martyrs, cranks, and editors.

Reinhold Niebuhr took a realistic view on the mechanisms available to us for improving ethics: "Men will not cease to be dishonest, merely because their dishonesties have been revealed to them or because they have discovered their own deceptions." There is a difference between telling others what they should and should not do and making it easy or difficult for others to behave in ways that add to the common good or detract from it. Too often we are satisfied with identifying questionable behavior or even disapproving of it, while maintaining the system that permits or encourages it. We build a culture where it is easier to get forgiveness (or even having our transgressions ignored and tacitly approved) than to work out with others what is in the group's best interests and ensure that we are all playing by the same expectations.

Good citizens have a largely benign effect on the moral tone of their communities. They are doing well with the status quo and are willing to accept a little moral hazard in order to preserve the system that generally works for them. A little grumbling is appropriate, but it should not be taken too seriously. The author of *Rip Van Winkle* and *The Legend of Sleepy Hollow*, Washington Irving, was U.S. ambassador to Granada in the 1830s. His book *The Alhambra* is a marvelous early example of a travel blog. In it he recounts preparing for the mule trip from Seville to Granada. He was curious about the small packets of money the guide was hiding in various parts of the luggage. "Oh, the robber's purse," he was told. "We will be held up several times on our trip through the mountains. These packets contain about the expected amount for each encounter." I believe the current rate in dentistry is

5%—at least that is the last figure I saw for bad debt, and that is what I expect, as a good citizen, to be paying as a surcharge on my bill. The great challenge for the good citizen is to avoid sounding too moralistic about abuses he or she is not prepared to try to change.

There are several classes of active citizens—those willing to do something to curb moral hazard through their own personal involvement. The ones I admire most are those who are willing to speak out gently when they see something they feel hurts the moral community. They do not laugh at the racist joke; they quietly tell a colleague in the hall that they are concerned over some of the work they have seen recently and ask whether there is something they can do to help; they serve on their state dental board. These are not hatchet men; they are healers. Their contribution is subtle and may not be accurately recognized. They are not self-appointed enforcers of their interpretation of how the system should work. They are the system they value. They are one of the forces for a higher equilibrium. Mahatma Gandhi is widely misunderstood as favoring noncoercive social change. He did advocate nonviolent noncooperation, but he was willing to embrace methods that created coercive effects on others. His campaign in the 1930s to boycott British linen imports caused great misery for England's working poor. What distinguishes Gandhi's moral improvement program from the hooliganism of the Irish separatists was Gandhi's willingness to share the cost of change with others.

A second response to moral hazard is to actually endorse or promote various risk shifts in access to the common good. Congress has enacted legislation that curbs the power of banks to take resources from American citizens. The regulations were opposed by banks that argued that this would restrict access to funds in the country. This argument was perceived as lame because access to funds could also be enhanced by banks taking smaller profits. The same reasoning is being rehearsed in the debate about healthcare reform. Congress is seeking to reengineer the allocation of risk in the country and they are getting lots of help from lobbyists in this chore. There are social engineers in oral health who honestly believe that the current levels of moral hazard, risk shifting in favor of the underserved, is too small. It is reported that physicians and dentists reclassify diagnostic codes and alter treatment dates "for the benefit of patients." This is intentional manipulation of moral hazard for what are believed to be ethically acceptable reasons. I have more respect for those who seek to change the structure that controls moral hazard in a public fashion (by asking permission) than for those who are sneaky about it (asking for forgiveness if caught).

Those who enforce the existing system and "correct" transgressors are technically either part of the good citizen group or outside the system. Their "job" is to protect the status quo; they do not adjust the system and thus do not directly affect the likely number of future transgressors. This group includes lawyers, dental school administrators, state board enforcement officers. A similar example would be insurance consultants. The latter must be one of the most difficult jobs in the world since they are restricted to interpreting the terms of each patient's contract and are strictly prohibited from substituting their judgment about what is good dentistry and especially what is the best dentistry. Oftentimes, such individuals combine the roles of enforcing existing systems with seeking to subtly improve them. That is a difficult and conflicted task, and one that is not calculated to produce personal satisfaction. There is a reason the hangman wore a mask and at least one member of the firing squad was randomly given a blank cartridge.

The most direct example of someone attempting to improve the moral tone of culture involves enlisting the help of others in changing the forces that control the behavior in a community. This is leadership for the common good. Public relations campaigns to educate patients about the benefits of continuous, comprehensive, competent, and compassionate care are preferable to complaining about colleagues who do not deliver it. Education programs on ethics for practitioners and rehabilitation for practitioners who have violated the trust of their license are effective adjustment to the system of incentives. Publicity about positive ethics and public service are also examples. The leader in promoting ethics tends to focus on increasing the common good across the boards rather then picking off a few abusers. Raising the general level of the moral climate in a group is usually more effective than fretting about a very few bad actors. Of course the would-be leader faces intrinsic resistance when proposing a change in the existing system of incentives that govern the equilibrium of moral hazard. Resistance is unlikely from the abusers (they rely more on cleverness than power); it will come from the good citizens who have the means and self-interest to block any change that increases the uncertainty in the current system that rewards them handsomely. ■

Recommended Reading

There is a very small body of literature on moral hazard, and much of the work is technical in nature. Summaries are available for the four recommended readings with asterisks. Each is about six 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 20 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 moral hazard; a donation of $50 for summaries of all the 2009 leadership topics.

Fradin, Gary (2007).
Moral Hazard in American Healthcare: Why We Can't Control Our Medical Expenses*
Publisher Unknown. ISBN 1-4196-6226-0; 113 Pages; Cost about $20.

Americans spend much more on health care than any nation and have lackluster outcomes to show for it. A review of our current Medicare system, indemnity programs, HMOs, various quality review systems, Bush's plan for Health Savings Accounts, and a comparison with the British single-payer system reveal that customers demand moral hazard and providers comply. Fradin suggests that we accept this and experiment with small changes such as electronic health records, mandatory private health insurance, and attempts to reduce errors.

Haski. Stan (2005).
The Arrogance of Distance: Moral Hazard and the Rise and Decay of Individual Freedom and Responsibility*
New York, NY: iUniverse. ISBN 0-595-36717-8; 391 pages; about $26.

Moral hazard is defined as "the kind of behavior when the legitimate expectations of one party, usually based on the other party's pronouncements, are flouted by the actions of the other party." [A more commonly used definition is the tendency for individual or organizational risk to increase when it is perceived that the risk can be shifted to others–for example, smoking is more frequent among those who are insured.] The analyses of this problem have generally been cultural, building either a culture of collective responsibility or a culture of individual responsibility. Haski uses a combination of history and data from contemporary society to show that neither approach has proven particularly successful. The major premise of the book is that "the contemporary Western societies are societies where the ever-present danger of moral hazard is dismissed and rarely, if ever, taken into account."

Niebuhr, Reinhold (1932).
Moral Man & Immoral Society: A Study in Ethics and Politics*
Louisville, KY: Westminster John Knox Press. ISBN 0-664-22474-1; 284 pages; about $20.

Niebuhr proposes a duality of morality. The individual works on a system of transcendence of the physical self to a purity of selfless spirit. Society strives for justice in a perpetual battle of conflicts between groups that are compelled to advance their own interests. Society cannot face the inescapable lack of morality it harbors and so it indulges in hypocrisy. Society is justified in using coercion, but as minimally as necessary. Nonviolence (noncooperation) is the strongest form of coercion because it deprives one's opponents of moral ground. Niebuhr wrote this book in the late 1930s against the uncertain background of Gandhi's India, fascism in Germany and Italy, socialism in Europe, and communism in Russia.

Tuck, Richard (2008).
Free Riding*
Cambridge, MA: Harvard University Press. ISBN 978-0-674-02834-0; 222 pages; about $30.

Is it rational for an individual to exert effort toward a collective end (voting, for example) if it is clear that an individual action has virtually no likelihood of making a difference to the outcome? This is a challenge to the rational basis for cooperation. In game theory or economics, it makes sense to consider others' potential moves if there are few players (monopoly or even oligopoly), but not in a pure market. Tuck searches for a threshold value of potential impact and argues for a counterfactual view of causation where an action is said to cause an outcome if it could have been a sufficient cause even though it was not so in fact. Tuck also presents an interesting history of the philosophical literature on contract theory and utilitarianism and an equally interesting chapter on the history of economic thought on market action.

American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

Periodicals Postage
PAID
at Gaithersburg, MD