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Implied CONTRACT
BETWEEN PROFESSION
AND PUBLIC

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FROM THE EDITOR

THE BANDWIDTH PROBLEM

My instinct is to tell others what I know rather than answering their questions. My bandwidth problem too easily and too often becomes one for others.

Capacity to receive a message without distortion is a function of bandwidth. Think of it as a window to the world. If the object to be viewed is about the right size, the message comes through fine. If it is too large to be handled, only a segment is received or it is distorted to match what can be handled or it is simply rejected. The demands on our bandwidth these days seem excessive and are growing exponentially.

There are experts working for commercial interests who are very skilled at understanding your bandwidth and mine. It behooves us to know something about this as well.

A little neurophysiology may help. The business of “taking something in” is a three-stage process. The amygdala system responds in a short circuit that bypasses the rest of the brain and permits responses such as ducking to avoid being hit by a flying object. All of this happens in nanoseconds, before we know anything about what we are responding to. We share with less developed creatures great skill at shielding ourselves from danger or even junk. Later and separately we may follow up on this. Via a separate route, stimuli are processed through the six layers of the various perceptual cortices. At the outer levels, objects are differentiated from background. At deeper levels, associations are brought in from other regions in the brain that add characterization

to the perception. All of this takes place in fractions of a second.

The third phase, storage, by contrast, cannot be rushed. The hippocampus sorts and re-sorts mental images, always with the intention of cleaning and tidying up the house. This reworking is largely unconscious and may continue for years for a given experience. The idea is to make workable approximations organized so that the most important are ready and at hand.

The neurobiology of perception is plastic. We grow new capacity and decommission functions that are no longer vital. We expand and shrink the bandwidth and center it on what matters. Becoming a dentist is essentially learning to see what is important to dentists.

Yesterday, according to the computer log, I managed 94 e-mail messages. My amygdala and the outer layers of my auditory cortex had the heaviest workout. I have no interest in buying knockout mice or attending conferences of the International Academy for Total Success held in some third-world resort. Processing takes about five seconds to block future messages from these sources. I am training the bandwidth for my computer.

Some messages get through, and I respond quickly. “Thank you for sharing the paper from the *Journal*

of Completely Useless Findings.”

“I am unable to meet with the IRB on Thursday afternoon. The full committee needs to look at application #315.” A few can take an hour or more, e.g., a dentist who wants to become involved in ethics and, because she has heard that I am also interested in the topic, wants me to tell her everything I know. These are the most demanding kinds of communications. They gobble up a fair chunk of my bandwidth, and I suspect that a lot of them bounce off the side of the recipient’s building rather than going through the window.

There are also tough ones: “Please review this manuscript for the *Journal of This or That*,” “Do you have a copy of the paper ‘somebody’ gave at a meeting a few years ago, I am not sure of the title?” or “We need a letter of support because we are nominating our mutual friend for a prestigious award.” What slows me down on these projects is my desire to match my bandwidth with that of the recipient. Three times reading the request is probably not enough. My instinct is to tell others what I know rather than answering their questions. My bandwidth problem too easily and too often becomes one for others.

There is a name for imposing my bandwidth on others. Procrustes was a notorious ancient Greek robber. He kidnapped and tortured his victims, often tying them in a bed. He only had one bed, and people who were too large to fit conveniently were “surgically

adjusted.” The term Procrustean refers to distorting one’s response to fit what is known rather than what is asked for.

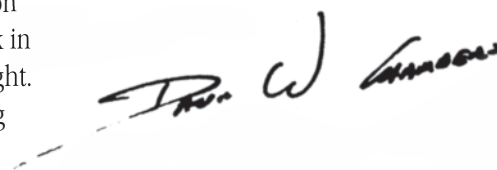
Bandwidth demands are different at professional meetings than they are in one’s native environment. Meetings are artificially focused—the bandwidth is comfortably but unrealistically narrow. That is why folks are so agreeable and why we overcommit.

I tested this recently at a convention of academics. I asked for contact information from a panel following their presentations. Literally, folks lined up to give me their cards or e-mail addresses scribbled on pieces of paper. I followed up with personal e-mail comments about what I liked in each presentation and asked for references to their work in this area. The response was one in eight. My favorite example of “self-shrinking bandwidth” involves readily given commitments to write, review, or participate on a common project. A *month* after the reply is due, it is not unusual to get an excuse such as “the past few *days* have been just crazy with unexpected interruptions.”

The solution to the bandwidth problem is not to get more bandwidth. There is only so much even the most intelligent and high-tech among us can handle in a meaningful way. Neither is the problem to invest in narrowing bandwidth to block out what we find

inconvenient. If we walked away from others at a meeting we would risk appearing rude and quite possibly miss the chance to meet someone really interesting. Because we can learn to train and focus bandwidth, we probably should do so. The great challenge, and potentially the most rewarding approach, is to harmonize our bandwidth use with others who are really important.

The digital world is most annoying when we receive broadcast e-blasts. That demonstrates a lack of respect for our bandwidth. We should be careful not to disrespect the bandwidth of others.



CAN DENTISTRY HAVE TWO CONTRACTS WITH THE PUBLIC?

David A. Nash, DMD, MS, EdD, FACD

ABSTRACT

The social contract is an implicit agreement between parts of society and society as a whole. Since the Middle Ages, the learned professions, recently including dentistry, have had a covenantal relationship with the public based on trust, exchanging monopoly privileges for benefiting the public good. Unlike commercial trade in commodities, professional relationships are grounded in ensuring an adequate level of oral health to all. A second contract is emerging where dentists relate to society as business operators, exchanging commodity services for a price. Recent actions by the Federal Trade Commission and the U.S. Supreme Court make it unlikely that dentistry will be able to enjoy only selected aspects of each contract while avoiding obligations that it finds unfavorable.

Social contracts have existed since early in human evolution. Humans are not hermits—we are social animals living in societies. Understanding a society requires understanding the roles and responsibilities of individuals living in it. In more primitive societies, such as hunter-gatherer groups, social contracts existed implicitly. In more advanced societies, such as in Greece and Rome, expectations became more explicit, eventually becoming formalized in law. In the Abrahamic religions, a contract was understood as a covenant, a relationship with a supreme being who structured the interaction of the people through a faith commitment.

The Enlightenment of the seventeenth and eighteenth centuries brought new theoretical understandings to social contract theory through the writings of philosophers such as Hobbes, Locke, and Rousseau. These individuals raised the issue of the natural rights of individuals versus the extent to which a government had the right to organize a society. They also provided the intellectual leadership for the founding principles of the American democracy.

Basic to social contract theory is determining the relationship of humans to one another. How can a society be organized in such a manner that reciprocity and mutuality exist among individuals, thus helping ensure that each person is safe, secure, and free to pursue his or her individual goals and

aspirations. What constitutes fairness in a society?

Change and transformation best describe the dynamic of a social contract; a society continually evolves. (Reference the recent dramatic change in American society relative to gay marriage.) Civilized societies differ in their understandings of how economic and social relationships of individuals should be structured. Thus, we have societies whose economies have an orientation toward socialism and others toward capitalism; societies that are democratic and others that are authoritarian. Some societies understand universal health care to be a component of their social contract, others do not. Ultimately, the foundation for a society's contract among its members is its assumptions regarding human nature, as well as its corresponding value system. Political action through government participation is the basis of the evolving social contract. A social contract is enforced by the laws and regulations of a society's governance structure. As will later be noted, the transformative changes occurring in American dentistry have their roots in government action—action ultimately guided by politics informed by societal values.

The American democracy is grounded on two principles espoused



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since the country's founding: *freedom* and *equality*. In 1971, Harvard professor John Rawls published *A Theory of Justice*, which has become a classic in political thought regarding the social contract. Rawls raised the question: "How is it possible that there exist over time a stable and just society of *free* and *equal* citizens profoundly divided by reasonable religious, philosophical, and moral doctrines?" American political differences today reflect this challenge. Some citizens are oriented more toward the value of freedom—*libertarians*, and others toward equality—*egalitarians*. For libertarians, the individual has a right to be left alone—to pursue the good life as personally conceptualized. The negative right of being left alone is emphasized—positive rights are deemphasized. Working for the common good would require society to take one's resources in the form of taxes to do things that may not directly benefit the individual. An example would be paying taxes to support government programs such as Medicaid in which one did not benefit. For libertarians, an open, free, and unregulated marketplace serves as a basis for justice in the social contract; the less government the better.

For egalitarians, equality is the ideal for a just social contract. Egalitarians believe that government is responsible for promoting and furthering equality; it is permissible to restrict an individual's freedom, such as in requiring the paying of taxes, in order to promote equality. Egalitarians stress positive rights; the

right to life's basic necessities of food, housing, education, health care, and a reasonable standard of living. The egalitarian criticism of the libertarian is that the right to be left alone does not mean anything if one lacks the resources to pursue a reasonable life. Egalitarians support a significantly regulated marketplace to ensure a measure of equality. (In our current presidential politics, Rand Paul represents a libertarian view of the social contract and Bernie Sanders an egalitarian one.)

In responding to his basic question, Rawls further asked what sort of social contract rational individuals would design if they were to assume an "original position"; that is, setting aside all personal preferences in order to consider what would constitute a fair society. To do this, he suggested a thought experiment of standing behind a "veil of ignorance" and designing a society into which one would be born as a result of the 'natural lottery,' but not knowing what status one would have: rich or poor, born to well-educated parents or to parents poorly educated, highly intelligent or not, black or white. Rawls concluded that a rational person, being somewhat risk adverse, would design a society in which being born among the worst off in society would

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still provide an opportunity to participate fully in the various positions of society, and the opportunity to pursue a good life. Rawls believed that the society designed by rational individuals behind such a “veil of ignorance” would be one in which individuals would have both equal liberty and equal opportunity. It is important to note that Rawls does not suggest that all individuals will be equal, but rather all would have equal opportunity. As individual skills, efforts, and contributions would vary, individuals would fare differently economically and socially. Rawls’ contractarian approach to the social contract bridges the tension between liberty and equality by focusing on equality being equality of opportunity. In doing so he strikes a balance between the libertarian and the egalitarian.

Some individuals are heavily libertarian and others are devoutly egalitarian on principle. Most of us have a general preference but are eclectic, favoring one or the other policy as the situation matches our needs.

The question this essay attempts to address is both the historical and current status of social contract between dentistry and society. How and why has it changed through time? Is it a fair contract? Would rational individuals, behind a “veil of ignorance” design the system of oral health care existing today, not knowing whether they were going to be a dentist or a Medicaid recipient? Additionally, the question emerges as to who determines the elements of the contract? The contract between society and dentistry is best understood functionally through the laws and regulations imposed by

society that affect the practice of dentistry, as well as dentistry’s contribution in providing access to basic oral health to society.

CLASSICAL UNDERSTANDINGS OF THE NATURE OF A LEARNED PROFESSION

The designation “learned profession” was historically assigned by society to certain groups of individuals as a result of the unique role they played in the functioning of society. What is that role—how did it evolve?

Traditionally, sociologists have considered the learned professions to be the clergy, law, and medicine—with dentistry as a specialty thereof. These classical learned professionals emerged in the late Middle Ages, when in human history the overwhelming majority of people were illiterate. In those societies, there arose groups of individuals who, as a result of education, could read and write and thus were able to provide practical and needed services for those who could not. Attorneys were able to draft contracts for the legal exchange of goods and property; physicians were able to read and study, thus learning of medicaments and procedures to palliate or cure disease; clergymen were able to study and interpret scripture for the unlearned. These groups of individuals had access to knowledge to which the average human had no access, and as a result possessed special power. Knowledge is power. Attorneys had power over property; physicians, power over personal physical well-being; and the clergy, power over divine providence. Lay people seeking assistance had to trust that these groups would use their knowledge in their best interest. Thus, the relationship was a fiduciary one; one grounded in trust. Attorneys, physicians, and clergyman professed that they would always use their knowledge, and the power it brought, to further not their

own personal best interests, but rather the best interests of their clients, patients, and parishioners. Even though essential, financial considerations were understood to be derivative.

Today the terms profession and professional can have somewhat ambiguous meanings. In one sense a professional is “someone who is not an amateur.” Thus we say that Serena Williams is a “professional” tennis player—clearly, she is not an amateur. Yet in the original usage and in a much more profound sociological sense, the word *profess* means “to promise” or “to vow.” So foundational to the notion of a learned professional is one who has taken a vow or made a promise. These professionals are individuals with sophisticated, but practical knowledge, gained through advanced study, who have promised to use their knowledge and skills in the best interest of the society they serve. Professions are professions because they pursue the good of society, not primarily or necessarily their perceived personal good. Professions are professions because they organize, not to protect their own interests, as do labor unions and trade associations, but rather to promote the public good. Professions are professions because they are committed to respecting the well-being of society as an end in itself, not simply as a means to the profession’s private ends.

Abraham Flexner, a public intellectual, and a major reformer of medical education in the early part of the twentieth century, identified the characteristics of learned professionals (1915). His characteristics have endured through the twentieth century, though they are under assault in contemporary society: (a) the work of learned profes-

sionals is primarily intellectual; (b) their work is based in science and learning; (c) their work is practical; (d) their work can be taught and learned through education beyond the usual level; (e) they organize into democratic collegial units; and (f) they exist to achieve societally defined goals, rather than the self-interest of their members. The last characteristic is to be emphasized: “learned professions exist to achieve societally defined goals, rather than the self-interest of their members.” He went on to say, “Professions are organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights for the protection of interests and privileges of their members.” It is salient to reconfirm that the designation profession is not self-appropriated, but rather is a sociological concept, an appellation of society as a component of the social contract.

UNDERSTANDING SOCIETY’S CONTRACT WITH PROFESSIONALS AS COVENANT

The noted biomedical ethicist, William May (1983), uses the metaphor of “covenant,” rather than contract to help explain or explicate the nature of the relationship of a learned profession with society. There are three elements in the classical concept of a covenant: (a) a pledge or promise; (b) an exchange of gifts; and (c) a change of being. Marriage is a well-understood covenant today. In marriage humans promise they will love and cherish one another; exchange gifts—wedding bands—as symbols of the promises made; and finally, they undergo a transformation of being. Professor May argues that dentistry as a profession has entered into a covenant relationship with society. Society has promised the profession of dentistry a monopoly to care for the oral health of the American public. Dentistry has promised society that it will faithfully

care for society’s oral health. Society grants dentistry the gift of self-regulation, and in most instances a dental education that is partially state-supported; as well as student loans that are tax-subsidized. Dentistry gives society its knowledge and skills. As a result of the promises made and the gifts exchanged, dentistry has undergone a transformative change. Dentistry has become a profession; society has become the profession’s patient. May argues that understanding dentistry’s relationship with society as a covenant emphasizes the importance of reciprocity in the relationship.

The guiding principle of dentistry as a profession is that oral health is a primary human good, an end in itself. Means become subservient to ends in a profession. Helping society gain the benefits of oral health makes methods, including delivery systems, subsidiary. As a profession, the goal of dentistry is gaining the good of oral health for all Americans, however it can be gained. Social justice, fairness in the social contract, is the touchstone for a profession. The attitude of a profession is egalitarianism. If oral health is a basic human need, as it is, then it is a basic human good. Therefore, all members of society should have equal opportunity to gain the benefit of this human good.

While speculative, it can be judged that dentistry’s historical status as a profession, which society has granted, at least until recently, is the legacy of previous generations of practitioners who, in advocating for water fluoridation and personal preventive therapies, were seen and understood by society as placing the public good above personal

It can be judged that dentistry’s historical status as a profession, which society has granted, at least until recently, is the legacy of previous generations of practitioners who, in advocating for water fluoridation and personal preventive therapies, were seen and understood by society as placing the public good above personal monetary gain.

Professions are professions because they organize, not to protect their own interests, as do labor unions and trade associations, but rather to promote the public good. Professions are professions because they are committed to respecting the well-being of society as an end in itself, not simply as a means to the profession's private ends.

monetary gain. Historically, dentistry has focused on serving the oral health needs of patients and society, with the financial gain derived being a natural and appropriate consequence of the service provided.

LEARNED PROFESSION VERSUS PROPRIETARY ENTERPRISE

The eminent free market theorist, Adam Smith, in his 1776 *The Wealth of Nations* (1981), drew a distinction between social goods and consumer goods. He argued that for a market economy to function, it must be based on a foundation of what he called social goods. Among the identified foundational social goods are safety, security, education, and health. Such social goods were for Smith outside the marketplace and not subject to the forces of supply and demand. Rather they were seen as basic human needs and imperatives to be met by a society in order for a marketplace to even exist. It is difficult to imagine a market-based economy surviving without citizens having a strong sense of personal safety and security, the physical health with which to work, and a basic education in the cognitive skills necessary to function in the marketplace. A "decent, basic minimum" of oral health is a social good, not a consumer good. Oral health care is not analogous to purchasing furniture or buying a television. Basic oral health care that is not elective, care that is focused on preventing or eliminating oral disease, is not a commodity to be purchased in the marketplace.

Professor emeritus Kenneth Arrow (1963) of Stanford University won

the Nobel Prize in Economics in 1972 partly because of his ability to demonstrate that health care cannot be considered a commodity of the marketplace due to the complexity of medical knowledge that creates a significant power differential between health professional and patient, precluding the patient from being able to correctly determine the relationship between the cost and value—a requisite for a marketplace transaction.

Talcott Parsons, for many years professor of sociology at Harvard and frequently referred to as the "dean of American sociology," put it this way: "The core criterion of a full-fledged profession is that it must have means of ensuring that its competencies are put to socially responsible uses...professionals are not capitalists...and they certainly are not members of proprietary groups" (1968).

Rashi Fein (1982), the noted Harvard health economist, expresses distress regarding the transformations occurring in contemporary society: "A new language has infected the culture of health care. It is a language of the marketplace, of the tradesman, and of the cost accountant. It is a language that depersonalizes both patients and health professionals, and treats health care as just another commodity. It is a language that is dangerous."

Arnold Relman, long-time distinguished editor of the *New England Journal of Medicine*, put it bluntly: "Health care is not a business" (1980).

The esteemed American medical educator and ethicist, Edmund Pellegrino (1999), concluded an article in the *Journal of Medicine and Philosophy*: "Health care is not a commodity, and treating it as such is deleterious to the ethics of patient care. Health is a human good that a good society has an obligation to protect from the market ethos."

The Federal Trade Commission and the U.S. Supreme Court have not shared the understanding of the nature of learned professionals' historical contract with society, nor the doctor-patient relationship, nor even the economics of health care generally. They have not agreed with America's sociologists, economists, physicians, and ethicists as quoted. Certainly they have not appreciated Adam Smith's distinction between consumable and social goods. In the mid to late 1970s, the FTC in a series of rulings, with subsequent support by the U.S. Supreme Court, determined that the codes of ethics of attorneys, physicians, and dentists prohibiting these learned professionals from advertising was a restraint of trade (Goldfarb, 1975; Virginia State Board of Pharmacy, 1976; Bates, 1977; American Medical Association, 1979; American Dental Association, 1979). The argument had always been made by the American Bar Association, the American Medical Association, and the American Dental Association that their members were professionals with a primary goal of service, and were to be distinguished from trades or businesses. Thus, they should be able to prohibit advertising, a tool of commerce in which to promote business and profit.

The FTC and the U.S. Supreme Court, serving as instrumentalities of society, altered the social contract with learned professionals. Henceforth, these professionals were to be assigned the status of a trade. The FTC chairman at the time declared that a "way to control the seemingly uncontrollable health sector could be to treat it as a business and make it respond to the same marketplace influences as other American businesses and industries" (Federal Trade Commission, 1978). The commission's perception of health care was that of a "commercial marketplace

in which goods and services are bought and sold." A strong case can be made that these rulings have resulted in the environment that exists today in dentistry and health care generally.

It can be further speculated as to why the FTC and the courts took the perspectives they did. A number of possibilities present themselves. As indicated by the FTC chairman, the commission thought healthcare costs were increasing significantly and needed to be controlled. Deregulating advertising by the health professions was viewed as a mechanism to accomplish increased competition and reduced costs. It is also possible that a motivating factor was the increased valuing of and commitment by society to capitalism and the free market that was occurring in the 1970s. Possibly there was perceived societal concern that the learned professions were not providing access to their services for significant numbers of society members, and that moving to a marketplace approach would result in expanding services. Access to the services of learned professionals was an issue then as it is today. It is also possible that society had come to believe that the learned professions were beginning to focus on their own economic self-interest at the expense of their service commitment to society; again, with advertising seen as a means of reducing costs. Bioethicist William May's 1977 comment that Americans stood a better chance of fair dealings in the marketplace than in the offices of learned professionals can be understood to be supportive of the action of the FTC and the courts.

As a learned profession, dentistry serves the end of human well-being, that is, oral health for individual patients and for society at large. While professionals derive financial gain from their life's work, it is truly derivative; a byproduct of fulfilling the promise or vow they made in becoming a professional. A

profession is a way of life, a vocation, not only or simply a way of making a living (Nash, 1994). As a trade, dentistry is to be understood as a business viewing the oral health of patients, not as ends in themselves, but merely means to the dentist's personal ends. Dentistry as a trade serves the end of personal profit, with oral health being understood as a means to that end. Understanding dentistry as a trade places dentistry in the marketplace, where oral health care becomes a commodity produced and sold for a profit. The marketplace model of selling cures undermines the traditional learned professional model—a model rooted in a tradition of caring. Certainly there are relevant business dimensions to operating as a learned professional, as professionals must pay overhead costs, provide for their families and certainly deserve an honorable financial return for their services to individuals and society,

THE CURRENT ENVIRONMENT OF THE PROFESSION

In surveying the environment of dentistry today, it becomes obvious that, in contrast to the views of Adam Smith and other notable scholars previously identified, dentistry is existing in the marketplace of health care. For-profit corporations have become significantly involved in the delivery system; dentists understand themselves to be the proprietors of small businesses; students are graduating from dental schools with significant levels of debt, essentially coercing them to focus on making money—lots of money.

Contrasting this situation with the traditional concept of the role of health professionals in society suggests prob-

It seems patently unreasonable for an individual seeking oral health care today to seek care from an individual in whom they do not trust. Being able to trust a dentist to care for a patient's best interest is a critical ingredient of the contract between a dentist and a patient.

lems. Accepting dentistry's existence in a market-driven economy immediately restructures the role of a dentist, both in attitude and practice. The marketplace is a place of competition between seller and buyer. Sellers want to sell as much of their product as possible and at the highest price possible. Buyers want only the desired amount of the product and to purchase it at the lowest price possible. Thus, the relationship becomes one of competition. While this works in commodity transactions, it does not work in a healthcare profession where the primary dimension of the relationship between professional and patient has to be one of trust. This references again the reason learned professions emerged initially in the social contract. They had the power of knowledge, power unavailable to their client. Thus individuals seeking their assistance had to trust them. It seems patently unreasonable for an individual seeking oral health care today to seek care from an individual in whom they do not trust. Being able to trust a dentist to care for a patient's best interest is a critical ingredient of the contract between a dentist and a patient.

Medical ethicist Ezekiel Emanuel (1995) has emphasized that trust is the quintessential quality of the doctor-patient relationship. How is such trust possible in a culture and climate of a competitive marketplace? The aggressive advertising and marketing strategies of for-profit businesses emerging in the dental environment are inconsistent with the historical practice of learned professionals. The abuse of children

by corporate practices, some owned by offshore equity firms, has and is continuing to be documented. Such is not only inconsistent with the practice of learned professionals, it is immoral. There is evidence that it is not uncommon for corporate dental practices to impose daily financial quotas on their dentist-employees. Practice management courses encourage dentists to set daily revenue goals for their practices. Overtreatment by dentists, ostensibly to generate more revenue, is being increasingly commented upon by thoughtful observers. Overtreatment is inconsistent with the practice of learned professionals. It is immoral, deviating as it does from standards of evidence-based care.

Dentistry's monopoly by society to care for the oral health of society exposes an additional problem. Fair reciprocity, even if one accepts a marketplace culture, requires that the profession provide access to basic care for all. Marketplace economics abhors monopolies; they are anticompetitive. How should society respond to a profession to which it has granted a monopoly when that monopoly fails to serve all members of society? Theoretically, one might suggest that the monopoly be dismantled allowing others to perform the function of dentists. In fact, this appears to be how society is beginning to adjust its contract with the dentistry. There is increasing advocacy for expanding the functions of dental hygienists, as well as for introducing the international concept of the dental therapist to the workforce. Many in dentistry lament these changes. However, they are occurring due to the failed responsibility of the profession in honoring the reciprocity and mutuality expected in society's contract with the profession which is, as suggested, potentially a reason for the FTC's ruling initially. Additionally, when inadequate

access to care affects children, a key element of Rawls' just social contract is challenged—there is a negative impact on equal opportunity.

The monopoly dentistry has previously enjoyed is being eroded on another front. The U.S. Supreme Court, in a six-three decision, recently sided with the FTC and against the North Carolina State Board of Dental Examiners when it upheld Fourth U.S. Circuit Court of Appeals ruling that the Dental Board illegally suppressed competition when it told nondentists to stop offering teeth-whitening services (North Carolina Board of Dental Examiners, 2015). Again, society through its regulatory agencies and courts are continuing to revise the social contract, reaffirming that dentistry and the health professions are simply businesses engaged in competitive commerce not unlike any other business.

CONCLUSION

The deeply entrenched and pervasive marketplace culture in the United States has breached the traditional culture of the learned professions in the social contract. Learned professions have become trades; dentists have become proprietors in the marketplace. To employ Adam Smith's distinctions, American society has endorsed basic health care, including nonelective dental care, as a consumable good, not a social good. John Rawls would join Smith in affirming that a social contract that does not include health care (including basic oral health care) does not meet the demands of a society of freedom and equal opportunity—a just society. It is highly unlikely there will be a return to that era in which dentistry was assigned special consider-

ation as a learned profession. Rather, marketplace economics will not only continue, but will strengthen as the basis of the contract between the profession of dentistry and society. ■

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A CLOSER LOOK AT THE NORTH CAROLINA BOARD OF DENTAL EXAMINERS AND WHO CAN PRACTICE DENTISTRY

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ABSTRACT

On February 25, 2015, the U.S. Supreme Court rendered a six-to-three opinion in favor of the Federal Trade Commission in their dispute with the North Carolina State Board of Dental Examiners concerning teeth-whitening services provided by nondentists. That decision was the culmination of almost nine years of arguments and allegations that began with a disagreement regarding the definition of the practice of dentistry. The ethical aspect of this dispute resides in the one's perspective regarding the motivation behind the actions taken in the North Carolina State Board of Dental Examiners.

In order to appreciate what transpired in North Carolina regarding teeth-whitening by nondentists, it is important to understand the parties involved and the state statutes that relate to the practice of dentistry.

The Federal Trade Commission (FTC) is an independent, bipartisan agency of the federal government. The FTC is divided into three major divisions or bureaus, the Bureau of Competition, the Bureau of Consumer Protection, and the Bureau of Economics. The FTC also includes an Office of Administrative Law Judges that performs the initial adjudicative fact-finding in the commission's administrative complaint proceedings such as the one involving the North Carolina State Board of Dental Examiners. Administrative law judges are independent decision-makers, appointed under the authority of the Office of Personnel Management.

The case brought by the FTC against the NCSBDE was adjudicated by the Bureau of Competition. Therefore, any testimony or evidence relating to consumer protection issues was ruled to be inadmissible throughout the adjudication process.

The NCSBDE or "dental board" was created by public laws promulgated in 1879 and 1915. The dental board was further defined by state statute in the 1940s as "the agency of the State for the regulation of the practice of dentistry." The NCSBDE office is located in Morrisville, North Carolina.

In the majority of states, members of occupational licensing boards are

appointed by the state legislature or the governor. That is not the case in North Carolina. Therefore, when the FTC began its investigation into the nondentist teeth-whitening case, the first areas to receive scrutiny were the board composition and the board selection process.

The North Carolina Dental Practice Act states that the dental board will be composed of eight members. Six of the eight members must be licensed dentists engaged in the active practice of dentistry. The seventh member must be a licensed, practicing dental hygienist. The dentists and dental hygienist are elected by their licensed peers. The final member is defined as a "consumer" and is appointed by the governor.

Most, if not all, of the dentists who have served on the NCSBDE are members of the North Carolina Dental Society. The majority of dental board members are Fellows in the American College of Dentists. Many have served in positions of leadership in all three organizations.

Founded in 1856, the North Carolina Dental Society (NCDS) is one of the oldest state dental associations in the United States. It is also the largest membership organization in the state representing the dental profession. The NCDS is governed by an Executive Committee, a Board of Trustees, and a House of Delegates. All governance



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positions are occupied by volunteer dentists. The NCDS office is located in Cary, North Carolina, and has a full-time staff of nine people.

The Board of Trustees is the administrative body of the NCDS. It is customary for the executive director to provide a report to the Board of Trustees prior to each meeting. An important objective of that report is to inform members regarding emerging issues. Beginning in 2008, almost every Executive Director Report or legal update included information regarding the nondentist teeth-whitening issue.

THE CONFLICT

The practice of dentistry in the state of North Carolina is defined by state statute 90-29, using a prescriptive list of activities that characterize the profession. The statutory language relevant to the topic of teeth-whitening by nondentists appears below:

- (a) No person shall engage in the practice of dentistry in this State, or offer or attempt to do so, unless such person is the holder of a valid license or certificate of renewal of license duly issued by the North Carolina State Board of Dental Examiners.
- (b) A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry:

- (2) Removes stains, accretions, or deposits from the human teeth;
- (7) Takes or makes an impression of the human teeth, gums, or jaw;
- (13) Represents to the public, by any advertisement or announcement, by or through any media, the ability or qualifications to do or perform any of the acts or practices set forth in subdivision (1) through (10) above.

Before dental board members begin their term of service, they must take an oath pledging to uphold the statutes of the State of North Carolina as they relate to the practice of dentistry. Their interpretation of these statutes was the genesis of the dental board actions that the FTC, and ultimately, the U.S. Supreme Court, found to be anticompetitive.

Members of the NCDS Board of Trustees, as well as an overwhelming majority of dentists in North Carolina, were supportive of actions taken by the NCSBDE against nondentists performing teeth-whitening procedures. To the dental community and others without a legal background, the issue appeared to be a logical progression.

- State statute defines the NCSBDE as “the agency of the State for the regulation of the practice of dentistry in this State”;

Seeing highly respected, ethical colleagues described in this manner angered many dentists. There is no doubt that members of the NCSBDE fully understand that their accountability lies first and foremost to the citizens of North Carolina.

- The practice of dentistry is prescriptively defined in statute;
- One of the procedures included on the prescriptive list of procedures exclusively limited to performance by licensed dentists is “the removal of stains, accretions, or deposits from the human teeth”;
- Whitening products remove stains from teeth;
- nondentists were providing teeth-whitening services;
- Therefore, the nondentists performing teeth-whitening services appear to be engaged in the unauthorized practice of dentistry.

But that logic did not prevail.

THE TIMELINE

In the spring of 2006, the NCDS first became aware of NCSBDE concerns regarding nondentists providing teeth-whitening services to the public in North Carolina when this was presented as a discussion topic at the annual Tripartite Meeting. The Tripartite Meeting is a gathering of representatives from the NCSBDE, University of North Carolina School of Dentistry faculty, and the NCDS.

The Tripartite Meeting is a forum to share information regarding issues confronting each organization. No minutes are taken during the meeting, and there are no “action items” or resolutions collectively discussed or agreed upon. A summary report of each Tripartite Meeting is provided to the NCDS Board of Trustees.

Later that year, NCDS staff began receiving calls from dentists and consumers requesting information about teeth-whitening kiosks located

in shopping malls, salons, and other commercial venues. Some were seeking information regarding ownership of the kiosks. Others were interested in knowing the training of kiosk employees. A few questioned the safety of the whitening materials being used. On the other hand, several callers assumed that the operators/employees were dentists or dental hygienists, since kiosk workers were dressed in surgical scrubs or white lab coats. A few callers, upon discovering that the employees were not dental professionals, felt that dressing in such a manner was a deliberate attempt to mislead the public. NCDS staff members were instructed to refer these inquiries to the NCSBDE staff.

The NCSBDE included teeth-whitening by nondentists as a topic of discussion at the Tripartite Meeting again in 2007. By this time, the issue was on the radar of several state dental associations as well as state licensing boards. The American Dental Association (ADA) Legal Division served as a national clearing house of information.

During the summer of 2007, the number of telephone inquiries to the NCDS escalated. Several callers had complaints regarding their teeth-whitening experiences. The most frequent complaints about treatment involved soft tissue problems (burning or redness of gingival tissue) with a lesser number of consumers mentioning tooth sensitivity.

In late 2007, NCDS staff began receiving calls from consumers who were considering having their teeth whitened for the upcoming holiday season. Callers contemplating giving a holiday gift card for teeth-whitening to a friend or relative asked questions regarding consumer safety issues associated with the whitening process delivered in nonclinical environments.

The growing consumer interest in whitening kiosks prompted local television stations to send reporters to investigate and interview kiosk employees. Transcripts of interviews with kiosk personnel often revealed a lack of knowledge about the whitening process. Kiosk workers exhibited varying degrees of knowledge regarding the type of whitening agents being used, how whitening agents work, possible risks and side-effects, and how post-whitening problems would be addressed. However, all of the kiosk employees stated that their teeth-whitening agents removed stains from teeth.

In March of 2008, a consumer filed a formal complaint with the NCSBDE stating that he had been injured as a result of the teeth-whitening procedures performed in a mall kiosk in Raleigh. The teeth-whitening procedures were performed shortly before embarking on a ten-day cruise vacation to the Mexican Riviera. The complaint stated that the post-whitening pain became so intense it necessitated follow-up care by a dentist while in Mexico. The patient received prescriptions for pain medication and an antibiotic. The complaint further alleged that there was permanent damage to the gingival tissue adjacent to his mandibular anterior teeth. This incident became fodder for several interviews and stories in both the local newspaper and on television.

THE INVESTIGATION

In July, 2010, I attended an annual meeting of state dental association executive directors hosted by the ADA in Chicago. Part of that meeting included an overview from the ADA Division of Legal Affairs describing current legal issues confronting the dental profession.

One of the major discussion topics was the surge in number of teeth-whitening operations springing up in malls, salons, and spas across the country. The major question arising from these discussions was whether these operations, when offered by nondentists, were lawful or if they constitute the unauthorized practice of dentistry.

When I returned to my office on July 22, I noticed a large Federal Express envelope on top of a stack of unopened mail that had arrived while I was away. Upon opening the envelope, I was surprised to find a subpoena from the FTC requesting copies of multiple NCDS documents. Noting a 30-day response deadline, I immediately contacted the ADA Legal Division to obtain a list of potential law firms experienced in association antitrust matters.

The month of August was spent gathering the requested documents. The subpoena demanded copies of the past five years of the NCDS membership directories; NCDS officers and committees; publications; minutes from all NCDS board, council, and committee meetings; the NCDS organizational chart; information regarding all NCDS subsidiaries; and all written, electronic, recorded, or voice communications regarding whitening kiosks, tooth/teeth bleaching, carbamide peroxide, and other whitening agents, the unauthorized practice of dentistry, and the nondentist ownership of dental practices.

Although initially bewildered by the list of requested documents, I later learned that there was a “theory” within the FTC hypothesizing that the NCDS was in collusion with the NCSBDE to create an anticompetitive economic climate in North Carolina. The genesis of this theory may have been recognition of the unique selection process for NCSBDE members and the FTC’s realization that all of the dentists

serving on the NCSBDE at the time of the complaint, as well as the previous ten years, were NCDS members.

This “theory” appeared to have been constructed upon the suspicion of a self-serving circle of leadership within both the NCDS and the NCSBDE, with the goal of controlling the practice of dentistry in North Carolina. The collusion theory was based upon the following tenets:

- FACT: The NCSBDE is a state agency and therefore cannot introduce legislation.
- FACT: The NCDS is a professional membership organization with an active government affairs program, including a team of contract lobbyists.
- SUSPICION: The NCDS aspires to protect the economic interests of its members and the dental profession.
- SUSPICION: Therefore, the NCDS encourages and supports select NCDS leaders to run for open positions on the NCSBDE. Once elected, the former NCDS leaders identify and suggest to the NCDS specific legislative activities that would further enhance the economic interests of its members.
- SUSPICION: The dentists serving on the NCSBDE would use their regulatory authority to control competition.

In early September 2010, the FTC began deposing dentists currently serving or who had previously served on the NCSBDE since 2005. Most of these depositions lasted the entire day. The longest lasted for ten hours.

Recent information from the FTC suggests that the U.S. Supreme Court decision may not have a significant impact on the NCSBDE. In fact, it appears to be manageable without major changes to the current construct of the dental board. And, there will be no need to alter the board composition or the election process.

Members of the NCDS Board of Trustees, as well as an overwhelming majority of dentists in North Carolina, were supportive of actions taken by the NCSBDE against nondentists performing teeth-whitening procedures.

Later in September, the NCDS learned of FTC plans to send subpoenas for documents to 15–30 dentists who had contacted the NCSBDE regarding teeth-whitening kiosks. Despite what has been published, none of the dentists who called the NCSBDE to inquire about teeth-whitening kiosks expressed concerns regarding fees or unfair competition. All of the concerns expressed by dentists were related to patient safety issues.

The NCDS contracted with a local law firm to provide legal assistance to the dentists targeted to receive subpoenas from the FTC. The dental society directed the law firm to contact the dentists and offer legal and moral support to ensure compliance with the subpoena requests. All legal fees associated with this process were the financial responsibility of the dental society.

The FTC elected to use different methods to deliver the subpoenas. Some were mailed, while others were hand-delivered by a delivery service. However, some were delivered by uniformed law enforcement agents who arrived unexpectedly and announced their purpose to those in the reception room. Similar examples of intimidation were observed at various times during other interactions with the FTC, especially during depositions.

The dentists served with subpoenas were initially informed that their depositions would be taken at the FTC office in Washington, DC. Realizing that appearing before a group of FTC attorneys in Washington would be an intimidating and costly inconvenience for each dentist, NCDS legal counsel

convinced the FTC to convene the depositions in North Carolina.

Also in September, the NCDS received notification that three dentists would be receiving subpoenas for depositions. During the depositions, all practicing dentists were required to declare their practice gross income, their personal net income, and the amount of income received from teeth-whitening services. U.S. Supreme Court documents state that dentists serving on the dental board earned “substantial fees” from teeth-whitening procedures. However, transcripts of dentists testifying under oath indicate teeth-whitening procedures accounted for less than 1% of the gross income of their dental practice.

On February 1, 2011, the administrative complaint against the NCSBDE was filed by FTC attorneys. The complaint accused dentists in North Carolina, acting through the instrument of the NCSBDE, of colluding to exclude nondentists from competing with dentists in the provision of teeth-whitening services.

THE DECISIONS

The administrative complaint hearing took place on February 17, 2011. On June 14, 2011, an administrative law judge held that the NCSBDE had illegally precluded nondentists from offering teeth-whitening services in North Carolina, in violation of Section 5 of the FTC Act. Although an appeal brief was filed, the appeal was denied and the final order was filed on December 7, 2011. Neither the NCDS nor the NCSBDE were surprised by this decision.

On May 31, 2013, The U.S. Court of Appeals for the Fourth District upheld the FTC ruling that the NCSBDE illegally impeded lower-priced competition by engaging in anticompetitive activities to prevent nondentists from providing teeth-whitening services to consumers.

In issuing their decision, members of the court held that a board entity composed of participants in a regulated market, chosen by and accountable to their fellow market participants, are “private actors.”

The ruling by the Fourth District Court of Appeals was extremely disheartening to the North Carolina dental community. Seeing highly respected, ethical colleagues described in this manner angered many dentists. There is no doubt that members of the NCSBDE fully understand that their accountability lies first and foremost to the citizens of North Carolina.

In the fall of 2013, NCSBDE attorneys petitioned the U.S. Supreme Court, requesting that the high court consider hearing their case regarding the regulation of teeth-whitening kiosks operated by nondentists. The ADA, along with other professional associations and regulatory boards as well as 22 state attorneys general, submitted amicus briefs supporting the request.

The decision by the U.S. Supreme Court to uphold the Fourth Circuit Court’s decision against the NCSBDE was made public on February 25, 2015. This ruling was a proverbial “kick in the stomach” for those within the dental community. Unlike the situation in some states, the NCDS and the NCSBDE have historically enjoyed a collegial relationship with open lines of communication. Despite this setback, the dental society will continue to support the NCSBDE to ensure that the public will have access to competent, safe, and ethical practitioners in the dental profession.

As a former practicing dentist and past president of the NCDS, I have had the opportunity to work with colleagues serving on the NCSBDE and dental board staff for over 20 years. While in

private practice, I volunteered as a deputy examiner several times during the period when North Carolina conducted a single state clinical licensure exam. I came away from those experiences with great admiration for the dedication and integrity of everyone associated with the dental board.

Closing Observations

There is another aspect of this case that is disturbing. For reasons that many members of the North Carolina dental community have yet to comprehend, there was virtually no comment or engagement by state agencies or state officials in the multiyear battle between the NCSBDE and the FTC. Instead, the North Carolina Attorney General and the North Carolina General Assembly remained silent, despite the fact that an agency of the federal government had initiated a high-profile legal challenge to the interpretation of statutes adopted by the North Carolina General Assembly. In fact, of the 22 state attorneys general submitting amicus briefs on behalf of the NCSBDE, the Office of the North Carolina Attorney General was one of the last.

To facilitate the understanding of decisions rendered by the U.S. Supreme Court, the “Reporter of Decisions” publishes a preamble outline of the facts of the case, known as the Syllabus. The Syllabus also describes the path that the case has taken to get to the U.S. Supreme Court. In the case of the *NCSBDE v. FTC*, the Syllabus correctly stated that the North Carolina Dental Practice Act does not specify that “teeth-whitening” is “the practice of dentistry.” In fact, the act does not specify that the placement of dental restorations, such as fillings, is “the practice of dentistry.” It will be interesting to see how the NCSBDE, the U.S. Supreme Court, and the FTC respond to nondentists who elect to

perform other procedures, some of which may be invasive and irreversible, that are not specifically defined by the North Carolina Dental Practice Act as the “practice of dentistry.” I anticipate that such an occurrence could create quite an ethical dilemma.

Recent information from the FTC suggests that the U.S. Supreme Court decision may not have a significant impact on the NCSBDE. In fact, it appears to be manageable without major changes to the current construct of the dental board. And there will be no need to alter the board composition or the election process. Suspicions regarding the unauthorized practice of dentistry will be referred to local law enforcement agencies, the North Carolina Office of the Attorney General, or other state agencies whose input and guidance would satisfy the definition of active supervision.

In retrospect, the entire issue was not really about tooth-whitening. Instead, it appears to have been an instance of a federal government agency flexing its muscle. Shortly after the U.S. Supreme Court decision was made public, FTC Commissioner Maureen Ohlhausen stated, “A particular concern I have is that occupational licensing regimes can create artificial and, in many cases, unnecessary barriers to entry for entrepreneurs seeking to take their first step on the economic ladder.” It will be interesting to see how the FTC elects to expedite their agenda. ■

How Will the U.S. Supreme Court's Decision in North Carolina Dental Affect the Regulation of the Professions?

Rebecca LeBuhn, MA

ABSTRACT

The contract between the public and the professions is between two parties; so it is reasonable to expect that there might be at least two perspectives when a ruling is given regarding the interpretation of the contract. The Citizen Advocacy Center recently convened a conference to look at the U.S. Supreme Court decision in the functioning of the North Carolina Dental Board in balancing protection of the public with availability of oral health services. New questions are being asked.

“How will the U.S. Supreme Court’s decision in *NC Dental* affect the regulation of the professions?” was the title of a meeting convened June 23, 2015 by the Citizen Advocacy Center to examine the implications of the U.S. Supreme Court’s decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission (NC Dental)*. Since 1987, the Citizen Advocacy Center (CAC) has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. A not-for-profit 501(C)(3) organization headquartered in Washington, DC, CAC offers training, research, and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.

CAC’s mission is to increase the accountability and effectiveness of these boards by:

- Advocating for a significant number of public members;
- Improving the training and effectiveness of public and other board members;
- Developing and advancing positions on relevant administrative and policy issues;
- Providing training and discussion forums;
- Performing needed clearinghouse functions for public members and other interested parties.

It is not surprising that CAC wants to closely monitor reactions to the *NC Dental* decision. This decision makes us reexamine the fundamentals of professional self-regulation—the composition of licensing boards; the potential for conflicts of interest when members of the regulated profession dominate; and the impact of board actions on access to safe, affordable healthcare services. We urge public members to challenge tradition when changes in society suggest that new relationships may be in order. *NC Dental* raises those kinds of big questions.

It is not yet clear how states will adjust to the *NC Dental* decision, but some clues may appear during the 2016 legislative season. Based in part on the conversations at the June 23 meeting, CAC is preparing a White Paper that will examine the pros and cons of various strategies states may choose to pursue.

The CAC is pleased to provide a forum for a discussion of the implications of the U.S. Supreme Court’s decision in *NC Dental*. Will this decision come to be viewed as a turning point in the way we perceive and conduct professional and occupational regulation? Perhaps.



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At a minimum, the U.S. Supreme Court's decision presents us with an opportunity to reexamine longstanding regulatory structure, including board composition, behavior, and accountability.

We find ourselves at this juncture because one licensing board tripped up on what critics warn is one of the inherent dangers of professional self-regulation. The board used the power of the state to try to drive out of business competitors that threatened a revenue stream for dentists.

Teeth-whitening services constituted commercial competition, not an invasion of dentistry's scope of professional practice.

The board's actions exceeded any of the recognized purposes of regulation:

- To ensure the public that licensed individuals can practice in a safe and competent manner;
- To protect the public from unscrupulous and unethical practitioners;
- To discipline licensees who violate accepted standards of practice.

The U.S. Supreme Court looked beyond the board's behavior and pinpointed some of the conditions that made that behavior possible. As you know, they singled out the board's composition and the State of North Carolina's failure to preempt the board's antitrust actions.

Now, other states and other boards need to ask themselves some questions:

- Should they change the way boards are composed and how the members are selected?

- Should they arrange for more active supervision by the state?
- Should they seek the simple solution of forgoing anticompetitive behavior in the first place?

Not since the Pew Health Professions Commission's recommendations in the 1990s have regulators been this seriously challenged to rethink how they go about business. The Pew Commission's recommendations were controversial and generated backlash, but they did inspire some incremental change.

Like Pew, this U.S. Supreme Court decision and the fallout from it have also been controversial. As you may know, CAC signed on to a letter to the country's attorneys general asking them how they plan to take the U.S. Supreme Court's ruling into account. CAC's decision to sign the letter was greeted alternately with praise and criticism.

CAC signed on to this letter not to be provocative, but to join other respected advocates in an appeal to attorneys general to examine the need for change in their states and, if change is needed, to help make it come about. We signed on believing that the U.S. Supreme Court has presented the states with an opportunity to evaluate whether their approach to professional and occupational regulation is the most effective way to accomplish the goal of that regulation, which is public protection.

This decision makes us reexamine the fundamentals of professional self-regulation—the composition of licensing boards; the potential for conflicts of interest when members of the regulated profession dominate; and the impact of board actions on access to safe, affordable healthcare services.

At a minimum, the U.S. Supreme Court's decision presents us with an opportunity to reexamine longstanding regulatory structure, including board composition, behavior, and accountability.

Discussion and debate among well-meaning individuals, we believe, can lead to improvements in policy and administration.

It is not new to question whether the current model of professional self-regulation is the best way to do things. Ben Shimberg, CAC's first board chair and a celebrated observer of occupational and professional regulation, wrote several books on the subject, including one with co-author Kara Schmitt, entitled *De-Mystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*. Published in 1996, the content resonates still today. Here are just a few tidbits from the book:

The authors quote psychologist-lawyer Daniel Hogan who considered licensure laws to be a significant factor in:

- Unnecessarily restricting the supply of practitioners;
- Decreasing their geographic mobility;
- Inflating the cost of services;
- Making it difficult for paraprofessionals to perform effectively;
- Stifling innovations in the education and training of practitioners and in the organization and utilization of services; and
- Discriminating against minorities, women, and the aged.

A more folksy quote comes from one-time Virginia state official H. Lynn Hopewell: "The great truth that is never spoken directly, but anybody in the field with two bourbons in them will tell you, is that these boards work primarily to protect the practitioners

and have little or nothing to do with protecting the public." (Talk about a provocative statement!)

For years, the FTC has raised questions not only about commercial antitrust activities by boards, but also about scope of practice restrictions and how they affect competition and consumer access to safe, affordable healthcare.

And the U.S. Supreme Court itself has visited this territory before. For example, in 1976, the court ruled that the Virginia Board of Pharmacy's ban on price advertising as "unprofessional conduct" was an unconstitutional infringement on free speech.

About board composition, Shimberg and Schmitt wrote 20 years ago: "Even though there has been a change in the composition of regulatory boards, particularly when it comes to public members, lively discussions ensue in response to the question: 'Who are the best people to serve on boards?'"

They went on to point out that some observers say that all board members should come from the professional association; others say nobody should come from the professional association. Some say mostly practitioners; others say mostly public members. Some say educators; some say specialists; some say generalists. Whoever the board members are, Shimberg and Schmitt wrote, "They need to remember their role on the board—to serve the public and ensure competent practice."

This brings me back to my original point: Whatever is or is not done to reconfigure the regulatory system to meet the U.S. Supreme Court's tests, the simplest fix would be to take seriously the public protection mandate and refrain from anticompetitive behavior.



WHAT CONTRACT? WITH WHOM? FOR WHAT PURPOSE?

Gordon H. DeFrieze, PhD

ABSTRACT

The central point in the U.S. Supreme Court upholding the Federal Trade Commission's action against the North Carolina State Board of Dental Examiners was that they acted without proper supervision from the State of North Carolina in curbing commercial activity: issuing cease and desist orders to teeth-whitening businesses, for example. It appears unlikely that the law of the land will allow professions to enforce and may substantially limit a profession's voice in defining nearby commercial activity. The line between professional services and commercial ones is not clear. Vending whitening agents, as drug stores do, is commercial but may not be professional. Providing such services in the dental office certainly should be professional, but is also certainly commercial. As dentistry becomes more overtly commercial in nature, it is likely that the profession will have less say over defining and enforcing oral healthcare practices.

In thinking about this special issue of the *Journal of the American College of Dentists*, I took the opportunity to read British sociologist Mike Saks's 1995 book entitled *Professions and the Public Interest*. Saks raises the critical point related to questions posed in this special issue in his introduction to his book:

(If) professions in the Anglo-American context do now more resolutely and frequently claim to serve the public interest, notwithstanding the greater emphasis that has recently been placed on market forces by governments in Britain and the United States in areas previously regarded as the prerogative of the state, do these elite occupational groups in fact embody a special moral standard based on the ideal of service? Or should such claims, which are often used in defense of professional privilege, be viewed with rather more cynicism?

The book then examines "the extent to which professional self-interests (in a number of disciplines) are actually subordinated to the public interest," which Saks maintains has been inadequately studied in the sociology of the professions.

But, this is a fundamental issue if one is to deal with the kind of situation that arises when a set of procedures or services has previously been considered part of the domain of "professional" practice, only to be legally performed

by persons who have a special license granted by an agency of government. The way in which Saks frames the question is not at all concerned with evidence-based research (assuming such evidence exists) showing that only persons with specialized (or even general) training in a professional discipline are able to perform these services with a sufficiently high likelihood of a quality outcome and the minimization of personal risk. He is only concerned with whether one could argue that the restriction of the legal right to offer these services for fee to those with specialized training and state-offered credentials assures that those providing these services do so with the public interest as a primary motivation.

The professions, especially the healthcare professions, have become accustomed to near complete autonomy with regard to both the definition of what constitutes the legal scope of professional practice, the credentialing of those who are licensed to perform these services, and regulating the quality of services provided when questions arise with regard to the performance of individual practitioners. The autonomy



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given to professions with regard to credentialing is, as Cohen (1973, p. 73) has argued, "tantamount to self-regulation." Hence, the presumption in the title of this special issue of *JACD* that there is an "implied contract" between the general public and the professions that with the privilege of self-regulation comes the obligation to protect the public interest as its highest priority. But, when nonprofessional businesses propose to offer some set of services and procedures that have been defined by professional licensure boards as within the scope of practice of a given profession, do these licensure boards have, as an important part of their public interest protective responsibility, an obligation to intervene? When "professional acts" are subdivided into small parcels that can be taught to others, threats to professional autonomy arise. Must these licensure boards have more than anecdotal evidence that can substantiate the claim that more than trivial risk to the public health exists? If such services and procedures are provided by persons who lack requisite educational credentials, are those providing these services acting in violation of state practice acts? And by denying these providers the legal right to offer these services, is access to such services limited by the fact that they cannot be provided unless offered by or under the direct supervision of a licensed health care professional?

It is interesting that the sorts of questions recently raised in the North Carolina case only become matters of widespread public concern and issues of interest to the mainstream print and television media when it appears that a

professional group takes umbrage over the commercial offering of a distinct type of procedure or service that has heretofore been seen as one only performed by licensed professionals. These media accounts of the controversy almost always take the perspective of a licensed "profession" having resisted, through the actions of its licensing board, the intrusion of a "nonprofessional" group into a their exclusive domain, and with the insistence that such intrusions present an unacceptable risk to public health. Unfortunately, all too often, licensing boards can rarely point to no more than anecdotal evidence to substantiate their claims that they have acted primarily in the interest of protecting the public from such risks.

In the North Carolina case, the providers of whitening services maintain that they are not "practicing dentistry" inasmuch as they are only providing the solutions and the applicators (e.g., oral trays) through which clients can administer these services "on their own." That is, they are merely assisting with an act of esthetic "self-care," and not performing an oral care procedure at all. In fact, every drug store in our state sells a variety of teeth-whitening solutions and applicators for those who prefer to administer these "self-care" whitening procedures without any assistance whatsoever.

THESE ISSUES ARE NOT LIMITED TO DENTISTRY

Dentistry is not alone in its experience of these sorts of sociological and legal confrontations. Saks himself uses the case example of the way in which acupuncture has been viewed, even as a form of "alternative medicine," in Britain and the United States. Yet, over a period of several decades we have seen in this country dozens of allopathic and osteopathic medical schools, as well as hospitals, now offering acupuncture

services and an increasing number of providers of these services, which are no longer seen as threatening when practicing in their own premises.

Some physicians remain skeptical of the effort of advanced practice nurses, such as nurse practitioners, nurse midwives, and nurse anesthetists, to offer their services directly to the public without explicit oversight by a physician. Physician assistants (PAs) have generally avoided such controversies by the very nature of their predominant modes of education and co-practice with a licensed physician in most states. Some dermatologists may be less than happy over the way in which certain esthetic skin treatment services are offered in spas and other settings by persons who have no other credential than a license as a cosmetologist, if that.

The reason this set of concerns has gotten so much recent attention in dentistry is that the North Carolina case involving nondentist providers of teeth-whitening services has been seen by the judicial system as a matter of restraint of trade with virtually no consideration of the potential health risk associated with the provision of these services by a non-licensed, nondentist provider who may not be able or qualified to render care for any coincident circumstances that might arise in the course of rendering these services. The specific set of services at issue in this case is defined in such a narrow way, to the exclusion of any operative procedure involving anything other than the application of whitening agents to the teeth, and the performance of these services is viewed as requiring low-to-minimum technical skill and therefore not requiring the presence of or the performance by a dentist or hygienist working under the supervision of a dentist.

THE IMPACT OF THE COMMERCIALIZATION OF PROFESSIONAL SERVICES

The professions generally have only themselves to blame for what is an attitude among the general public that those who have specialized and advanced education and call themselves “professionals” are no less concerned with the business aspects of their work than others who provide specialized services for a fee. The commercial aspect of most professions is now so plainly evident that it is difficult to see those who claim a “professional” identity as fundamentally different from other service occupations.

If one drives from Raleigh, North Carolina, eastward toward the North Carolina coast along U.S. Highway 70, it is astonishing to see how many so-called “professionals” find it necessary to purchase and display huge billboards promoting their practices. There are billboards promoting the services of attorneys (malpractice, personal injury, worker compensation, divorce and family law, automobile accident and moving traffic violations), plastic surgeons (liposuction and body contouring), dentists (dentures and teeth-whitening), and chiropractors (acute low back pain), plus numerous ads for hospitals, birthing centers, disease-specific clinics, and urgent care and heart centers.

It is no wonder that the public seeing this panoply of commercial messages as they travel our major highways or read our daily newspapers get the impression that a very large part of the life of our “professional” workforce is the marketing of the services and products being offered.

It may be claimed that these messages communicated via these media and other means are part of the effort of the professions to assure the accessibility of such services by making their availability more widely known. But, the essence of these messages is one

that clearly says that the marketing of these services is essential to the financial stability of these professional practices.

How different is the case for commercial teeth whitening from the practice of drug stores offering magnifying reading glasses without a prescription? Or, how different is it from the marketing of over-the-counter pharmaceutical products for common ailments?

THE ROLE OF “CONSUMER CHOICE” IN HEALTH CARE

Having spent many years doing formal research on the matter of medical “self-care,” I have been amazed at the wide spectrum of approaches to health and illness symptoms, and even choices with regard to what might be considered “cosmetic” health services, that consumers of health care can and do make almost every day. Most people, certainly most adults, take some sort of initial action with regard to the symptoms of ill health or functional limitations *before* seeking formal medical (or dental) care. There are literally dozens of businesses offering a wide variety of self-care options for most common medical symptoms. The shelves of any neighborhood pharmacy are filled with such options for one’s experimentation with possible relief of symptoms, or the day-to-day management of pain, discomfort, or disabling conditions. If one wanders through the shelves offering beauty and cosmetic products in these same business establishments one finds products that suggest that various conditions of the human body might be made more attractive or less obvious if applied as directed.

The decisions to be made by most health care consumers when minor

Does the restriction of the legal right to offer these services for fee to those with specialized training and state-offered credentials assures that those providing these services do so with the public interest as a primary motivation?

In the North Carolina case, the providers of whitening services maintain that they are not “practicing dentistry” inasmuch as they are only providing the solutions and the applicators (e.g., oral trays) through which clients can administer these services “on their own.”

symptoms appear are: (a) What is the urgency of doing anything at all? (b) What can I do for myself with little or no cost? (c) When is the situation so serious that it would be best to seek “professional” attention?

If one looks in the mirror each morning and is aware of the lack of brilliance in the color of one’s dentition, such a decision process takes place—for some more quickly than for others. Knowing that there are alternative sources of help for this self-diagnosed condition, the consumer may then ask: Do professional dentists (or hygienists who work as part of a dental office team) offer a given service in a different way, with a different probability of a preferred outcome? Are the services offered roughly equivalent in price? Are there risks involved in choosing to go to either provider of such a service? Many consumers probably do not make a distinction between having a dentist or hygienist insert a tray of whitening agent into one’s mouth, versus having the tray filled by a person working in a shopping mall kiosk and then handed to the customer for self-insertion.

HAS A SOCIAL CONTRACT BEEN BROKEN?

If there is a “contract” acknowledging the special educational credentials of the dental profession, one that awards a high level of autonomy and the right to self-regulation of professional conduct, it is not only *implied*, but probably widely acknowledged by the public. However, the contract in question is not so broadly constructed as to limit the access of anyone to the means by which self-care for oral health, including the esthetics of teeth whitening, can be restricted only to services provided by, or under the supervision of a dentist. Though

professional dentists may offer these services as part of a broad spectrum of oral health care for their patients, these narrowly defined services are probably not seen as requiring skills presumed to be only able to be performed by professional dentists or hygienists.

The comforting conclusion to be drawn from this particular confrontation over the legality of nonprofessional offering of whitening services, and the secondary question of the autonomy of state licensure boards to regulate all performance of services under the profession’s definition of its “scope of practice,” is that the general public continues to have high regard for the profession itself and will seek to have a meaningful and sustained relationship with its fully licensed practitioners. Furthermore, in matters of oversight and discipline of those who hold professional licensure, boards of dental examiners continue to have the key role in assuring the public interest in matters related to dental professional credentialing and the quality of care.

In thinking about the public’s view of the commercial whitening situation, one is reminded of Yogi Berra’s often quoted aphorism, “If people don’t want to come to the ballpark, how are we going to stop them?” ■

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STATE DENTAL BOARDS AND PUBLIC PROTECTION

FULFILLING THE CONTRACT

Guy S. Shampaine, DDS, FACD

ABSTRACT

Dental boards are agents of the state, sworn to protect the public. They combine the skills of professional training with responsibility to ensure that patients receive safe and effective care. They can play a vital role in ensuring that the profession does not invite more regulation by working to maintain the public's trust. Two cases are presented illustrating that one's perspective can cloud the sense of what is right and that it is wrong to pass ethical responsibilities on to others.

On February 25, 2015, the U.S. Supreme Court issued its decision in the case, *North Carolina State Board of Dental Examiners v. the Federal Trade Commission*. In its opinion the court focused heavily on the conflict of interest that arises when market participants are also regulators. It also made reference to the fact that professionals may be subject to codes of ethics that are developed outside the legal system. Although the purpose of this paper is not to analyze the U.S. Supreme Court's recent decision, the decision itself is in part a harbinger of what may happen when a profession and its regulatory board loses a measure of public trust.

In 1926 in the report titled *Dental Education in the United States and Canada, A Report to the Carnegie Foundation for the Advancement of Teaching*, William Gies proposed the protocols and recommendations which were hoped to advance dentistry from a trade to a learned profession trusted by the public. The report was a sequel to the Carnegie Foundation's report on medicine in 1910. Although the substance of his work was primarily focused on improving dental education, Gies described in detail the responsibilities of state dental boards in ensuring that the profession would maintain the public trust through the work and efforts of the "disinterested" members of state dental

boards. Gies felt that dental boards should be involved in dental school accreditation, licensure, discipline, and professional regulation. Protection of the public and preservation of the patients' interests are particularly important components of state dental board activities in regulation and discipline. It is an uncomfortable reality that much of the activities undertaken by state dental boards puts the members of the dental board in the position of dental "internal affairs."

In general, dental boards do an outstanding job under very difficult conditions in their mission of protecting the public. However, we are in a time of increasing public scrutiny and consumerism. Even very infrequent failings in the very difficult duties of state dental boards can jeopardize the entire system of self-governance of the profession.

When dentists and dental hygienists are appointed to the state dental boards there is an understanding by the appointing authority that their purpose is to represent patients and their interests;



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that their dental expertise is needed to understand many of the issues that a patient would not, but not to protect their own interests or the interests of the profession. That responsibility belongs to others. In order for dental board members to carry out their work in a fashion which upholds their obligation to the public, every decision must be framed by what the dentist would require if they were the patient. Dental board members should take great pains to avoid deliberations which take into consideration the thought that "There but for the grace of God go I." In other words putting themselves in the position of the dentist rather than the perspective of the patient.

Dental boards in the United States generally fall into three authority categories. In the first group are dental boards that have full authority to promulgate regulations; to independently investigate, adjudicate, and decide discipline cases, subject to review only by the courts. The second category of dental board authority subjects the dental board's decisions to a superior agency, such as a Department of Health, but its decisions and recommendations are usually given deference and hold sway with its supervising agency. In the third level of supervision state dental boards are merely advisory entities to a superior state agency which usually is not composed of dental professionals. The three levels of board authority can be an indication of the confidence of state government and the public in the board's ability to carry out its responsi-

bilities on behalf of the public rather than the dental profession. It also can have a significant influence on the types of decisions made by dental boards.

State dental board members will oftentimes find themselves in conflict with organized dentistry, either in their locality or nationally. It is imperative that members of dental boards understand this inevitability, and are prepared to protect the interests of the public in spite of the potential backlash from colleagues. In fact, this independence is what the public expects will occur with state dental boards. In many states, dental board members are required to go through ethics training and pledge themselves to the principle of public protection.

How Do Boards Work?

In examining the function of state dental boards, it must first be understood that they are legal entities which must function within the authority of the governing statutes and regulations of the state. For example, almost without exception state dental boards do not have the authority to regulate or discipline non-licensees. This is most baffling to dentists who often ask a dental board why they cannot stop someone who is practicing dentistry without a license. The statutory answer is usually very simple, the dental board only has authority over licensees, and the offending individual does not hold the license. Often patients are also confused by the statutory governance of discipline. In order for a dental board to be able to discipline a dentist, the statute must include the behavior as grounds for discipline. Patients will often complain to dental boards that the fees they were charged were too high and they would like the dental board to intervene on their behalf. Almost universally dental statutes do not allow dental boards to set fees or intervene

in dentists' ability to charge fees they feel are appropriate.

Statutory authority can also be a limiting factor in a dental board's ability to represent the interests of the patient. Because legislation is a result of multiple interested parties lobbying for their own interests, the resulting statute may be in conflict with patients' best interest and therefore the board's ability to respond may be thwarted. In fact, in most legislative initiatives the dental boards have little influence in comparison to organized dentistry and other communities of interest.

For example, in Maryland it is illegal for a dentist to forgive patient copayment—that is accept the insurance payment as payment in full, without informing the insurance company prior to submitting the claim. Most insurance contracts do not require insurance companies to pay dental claims when the patient copayment is not required. This legislation was lobbied for by both organized dentistry and insurance companies. Dentistry, when originally lobbying for this legislation, felt it would sustain fees by not allowing dentists to accept the insurance payment as payment in full. The insurance companies lobbied for the legislation because they knew that if the copayment was required it would decrease utilization of insurance benefits. Although the law arguably is appropriate for advocacy entities such as professional associations and insurance companies, this certainly is not in the patients' best interest. The law has the unintended effect of decreasing access to care. Equally important is the fact that the state dental board must enforce the law with its licensees.

When fashioning regulations for promulgation, state dental boards should focus on the requirements necessary for public protection, rather than professional market protection. One example that boards are commonly faced with is the scope of practice for allied health professionals. There is general agreement that well-thought-out regulations that allow allied health professionals to perform tasks for which they are properly trained and supervised can increase access to care and decrease costs. Too often regulatory professional boards consider the potential impact on their professions economics or the feared potential future growth of the allied health profession. In addition, in an effort to preserve the dentist's ability to be the gatekeeper of billing, the dental board can be faced with pressure from their professional colleagues to preserve the status quo. Interestingly, the preponderance of the evidence seems to indicate that most of these fears are unwarranted. The focus in these cases should instead be the appropriate training and environment for safe delivery of care. If the dental profession is to maintain public trust, the dental board in the end must champion the options that they feel will best represent the patient.

Dentistry differs from medicine in the areas of peer review and quality assurance. In medicine, there is continuous and lifelong peer review, credentialing, quality assurance, and outcome assessments for all physicians practicing in hospitals. The result of this process can affect credentials and privileges. Physicians practicing in hospitals must also maintain board certification, a process that requires recertification every seven to ten years to help assure continued competency. Possibly as a result, discipline among physicians occurs disproportionately and

primarily in physicians without hospital privileges and in solo practice.

Dentistry most often has none of these institutional safeguards for patients. Dentists rarely practice in institutional settings and therefore are not subject to real peer review, quality assurance, and outcome assessments. General dentistry does not have board certification, and even the majority of dental specialists, with the exception of oral and maxillofacial surgeons, do not have board certification. This reality holds a critical significance for dental boards in their deliberation on promulgation of regulations as well as disciplinary issues. This practice milieu also is critical for dental boards as for not the dental board is essential the only entity that can at least in part carry out the process of outcomes assessments in dentistry. When promulgating regulations dental boards must formulate educational requirements which best protect the patient and ensures adequate training to provide competent care. In carrying out this responsibility, when considering credentialing a dentist for an advanced treatment modality, for example sedation and general anesthesia, the dentist should not consider how difficult it would be for their own ability to begin to perform the procedure being addressed, but only the requirements for safe practice. Regulations should be developed with the requirements that the dentist believes should be in place if their family or loved one is the patient receiving the care.

It is an uncomfortable reality that much of the activities undertaken by state dental boards puts the members of the dental board in the position of dental "internal affairs."

Even very infrequent failings in the very difficult duties of state dental boards can jeopardize the entire system of self-governance of the profession.

Discipline is a major function of dental boards and a foundational pillar in its public image and maintaining the public trust. If the public perceives that the dental board is acting to protect the dentist, public trust will rapidly erode. Approximately 3% of licensee's consume over 80% of dental board resources and comprise the overwhelming majority of complaints. The frequency of complaints among this small number of dentists is extraordinary. It is actually in the interest of both patients and dentistry to either eliminate or remediate this very small number of dentists. However, all too often dentists put themselves in the position of the defendant and attempt to institutionalize roadblocks to correcting poor dentists.

CASE #1: FAIRNESS IS NOT A MATTER OF WHO YOU ARE

Here is an illustration of how "the right thing to do" can become over-personalized. The ACD for years sponsored Lunch and Learn sessions for senior students at a dental school. I participated in many of these sessions and had the opportunity to observe how one's perspective is so important in professional decision making. Something like the following case was presented. Assuming each student was a practicing dentist, they received a new patient and, after examination, found the patient had fixed bridges with periodontally involved abutments with

recurrent decay and defective margins, general periodontal disease, as well as defective margins on multiple restorations, and two recently restored teeth that were endodontically involved. The patient had just transferred from a former dentist and asked you to retrieve their records and x-rays and review them prior to presenting a treatment plan. You discover that all of the restorative and fixed prosthodontics work had been completed within the last year. In addition, the endodontic and periodontal condition of the teeth had been present pretreatment by the last dentist. On the return visit you present your treatment plan, as well as alternatives and risks and benefits of the proposed treatment to the patient. The patient then states that this work had just been completed and wanted to know whether or not the previous dentist had done anything wrong. What do you tell the patient?

Students work in groups, and often discuss various approaches for as long as 55 minutes. In almost all cases the students would not inform the patient that the previous dentist had done anything wrong, but would equivocate and offer statements that they were not there during the previous treatment, they were not knowledgeable about the patient compliance, etc. Typically they would not get through all of their explanations before the allotted time was up. The scenario was then changed.

The only difference in the modified scenario was that the patient was the student's daughter visiting a dentist across the country. Now what do they get to know about the previous dentist's work? Almost without exception students answer immediately that they deserved the full story and an explanation about the previous dentist's treatment. The effect of a change in

perspective is obvious. For nearly an hour students nibbled around the edges of the issue when they took the perspective of a dentist. It only takes a minute to see what needs to be done from the patient's point of view.

UNETHICAL BEHAVIOR IS A HABIT

This case highlights another issue. Human beings are tribal; it is encoded in their DNA. All living beings behave in self-interest ways. It is not easy to take the ethical path because sometimes it is in conflict with our self-interest. There is a general reluctance for dentists to criticize members of the dental profession, both because they are members of our "tribe," as well as the desire not to be criticized ourselves, either now or sometime in the future. However this reluctance to criticize another dentist, or for example to serve as an expert witness when appropriate, at its worst becomes a "jailhouse ethic," unworthy of a profession desirous of being self-policed. Typically when I work with students as in the case above I find them focused on the treatment of this one patient. They often do not consider the other 4,000 to 5,000 annual patient visits that dentist would have and the potential harm that could be caused by a lack of transparency. Finally, none of the students ever offered the option of reporting the treating dentist to the dental board. This is not a criticism of students at all, they were taught these values, and practicing dentists will most often follow the same pattern.

Dental boards can also fall prey to a similar failing, focusing on the one patient and not on patterns. Because the disciplinary process is an adversarial judicial process it can be expensive in both time and money for dental boards. Sometimes in an effort to expedite the process, the board may fashion in agreement more favorable to the respondent. This typically allows the

respondent to agree to an order which describes the infraction as either less serious or characterized as something other than discipline, so that the order will not have to be reported to the National Practitioner Data Bank. Although in some cases this may be appropriate and may have the desired effect of expediting the disciplinary process, it also has the untoward effect of oftentimes preventing reciprocal discipline in other states in which the dentist is licensed. It also may prevent third-party payers from learning about the board order. In the worst of cases dental boards have agreed to allow a respondent to surrender a license in lieu of discipline, without a public order if they would agree to leave the state. This has the effect of "passing the trash" and thus endangering patients in other states. Although these events are rare, they can be a result of the board member identifying with the dentist rather than the patient.

For the ethical contract between patients and the dental profession to be fulfilled, all of the principals—organized dentistry, dental boards, insurance companies, legislators, and patients—must fulfill their obligations under the contract with integrity as well as collaboratively. Otherwise the system fails. Dental boards alone cannot effectively protect the public without the cooperation and participation of the profession.

CASE #2: DO NOT PASS IT ON

Here is a sad story, but a true one (even though I have altered some particulars out of concern for privacy). A 32-year old female patient sought the help of a malpractice attorney. She had had a Class I restoration done on tooth #30.

The next day the tooth was sensitive and she contacted her dentist. The dental office was closed so she contacted her insurance plan which referred her to an endodontist. Her past dental history included only one restoration on tooth #19. All of rest of the teeth in her mouth were healthy, without caries or restorations. The endodontist recommended that tooth #30 needed root canal therapy and that teeth #29 and #31 also needed root canal therapy, all of which was performed. The patient experienced ongoing pain and by the end of the year had had endodontic therapy and apicoectomies on all her mandibular teeth and eventually loss of all mandibular teeth. The treatment cost in excess of \$58,000 dollars, which she paid by mortgaging her home, which she eventually lost. Although she had sought a second opinion from another endodontist during the treatment, she was advised to return to the original endodontist. This treatment course forced her to seek help from the attorney.

The attorney had great difficulty locating an expert witness but eventually obtained an expert review of the case from the chair of an endodontic department. In reviewing the radiographs and dental records it appeared

The ideal dental board will have no dentists as members. Instead, it will be composed entirely of patients, most of whom happen to be dentists.

that there was gross negligence and that the original sensitivity on tooth #30 was caused by a restoration that was shallow at the DEJ. The experts felt that not only was there no justification for the endodontic treatment, but that the treatment itself was done far below the standard of care and was the proximate cause of the loss of the teeth.

In deposition testimony the expert opined that the course of treatment was more accurately characterized as “criminal activity than dental treatment.” In further evaluating the case, the attorney researched previous malpractice cases involving the practitioner. Multiple cases were found in another state. The experts in those cases were contacted, and they confirmed that the treatment patterns were the same in these previous cases, unnecessary and poor treatment resulting in the unjustified loss of teeth.

The out-of-state contact was asked whether the previous cases had ever gone to the state dental board. They had, but that the board allowed the offending dentist to surrender the license and leave the state. The same malpractice carrier had insured the endodontist in both states, but had not cancelled coverage in spite of multiple malpractice verdicts.

This case is an illustration of failure on the part of every component of the profession. The reluctance of one dentist to testify against another,

the failure of an insurance company to cancel a dentist but rather just raise premiums across their subscriber pool, and a dental board that allowed a dentist to surrender the license and protect citizens in their own state while knowingly endangering another state’s citizens.

TIME FOR A LOOK AT HOW BOARDS CAN PROTECT PATIENTS

The February 2015 U.S. Supreme Court decision for the first time presents a real possibility to question the long-term viability of the self-policing by the dental profession by the dental board members who are dentists and are currently charged with that mandate. The FTC is already formulating guidance to regulatory boards from their perspective and interpretation. If the system is to survive, the ideal dental board will have no dentists as members. Instead, it will be composed entirely of patients, most of whom happen also to be dentists. ■

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EMERGING DENTAL SPECIALTIES AND ETHICS

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ABSTRACT

This paper discusses ethical dimensions related to the formal recognition of emerging dental specialties. It explores several issues related to the potential emergence of several new dental specialty areas. There are good reasons that dentistry should open the door to these new specialties, and patients would benefit. The ethical considerations for and against formal acceptance are examined.

Expanding the number of dental specialties requires a thorough discussion of the issues involved. These issues include such things as new technologies, patient access needs, questions of diagnostic and therapeutic efficiency, increased competition within the profession, conflicts of interest, fairness, commercial free speech, and associated ethical challenges. All of these will affect any decision by the profession to recognize more dental specialties.

An evaluation of the medical and dental communities' divergent pathways regarding the recognition of emerging specialties will provide insight into some of these ethical concerns. Expansion is the natural inclination of any field of knowledge, and newly emerging areas typically become relatively separate subdivisions. These separate subdivisions tend to become areas of specialization within each larger clinical discipline. With continuing increases in knowledge

and experience, the natural tendency is for professions to continue to form new specialties. That said, the process of dental specialty recognition and the administration of that process is fraught with ethical issues (Bishop, Gelbier, & Gibbons, 2001; DePaola et al., 2002; Hendricson et al., 2004; and Mattheos et al., 2008)

The following are the critical moral standards concerning emerging dental disciplines/specialties considered in this analysis. Yeager (2002) has suggested that the critical moral obligations for dentists are commitments to professional competence, professional responsibilities, honesty with patients, patient confidentiality, improving quality of care, improving access to care, maintaining appropriate patient relationships, and maintaining trust by managing conflicts of interest. Additionally, Reid et al. (2014) and Reid & Greene (2013) have suggested that the ethical foundations of health care include altruism, sacrifice, trustworthiness, and dedication to patient welfare. With regard to ethical dental advertising, Graskemper (2009) noted that the important issues were professionalism, beneficence, and veracity.

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MEDICAL AND DENTAL SPECIALIZATION: A LOOK AT HISTORY

The American Medical Association (AMA) controlled medical specialty recognition until the 1930s. In 1933 there were only four recognized medical specialties, ophthalmology, otolaryngology, obstetrics-gynecology, and dermatology (and syphilis). The refusal of the AMA to recognize emerging medical specialties such as orthopedic surgery, pediatrics, radiology, cardiology, and internal medicine led to the creation of the Advisory Boards of Medical Specialties, later named the American Board of Medical Specialties (ABMS), the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS), and the American Board of Physicians' Specialties (ABPS). Presently, there are over 20 recognized medical specialties (Siegel, 2005). The ABMS, AOABOS, and ABPS supervise and accredit the diplomate certification and re-certification processes for physicians within their recognized medical specialties. Specialty recognition in medicine varies by state, depending on which of these specialty recognition boards are accepted in each.

In 1937, the ADA established the Council on Dental Education (CDE) which led to the recognition of the first dental specialties. In 1947, there were only five ADA-recognized dental specialties. These specialties were oral surgery, orthodontics, prosthodontics, periodontics, and oral pathology. Relatively shortly thereafter, pedodontics and public health dentistry were added

to the list. But such relatively new dental specialties as endodontics and oral and maxillofacial radiology were not added until 1963 and 1999 respectively. In 1954, the Federal Commissioner of Education established the CDE as an accrediting agency for dental education.

In 1975, the ADA established the Commission on Dental Accreditation (CODA) to take over the accreditation responsibilities of the CDE as an accrediting agency granted authority by the Department of Health, Education, and Welfare, which today exists as the U.S. Department of Education (USDE). According to the ADA Web site, CODA now accredits "...over 1,400 accredited programs in the following discipline-specific education areas: predoctoral dental education, postdoctoral general dentistry (advanced education in general dentistry and general practice residency), advanced general dentistry (dental anesthesiology, orofacial pain and oral medicine), the nine recognized specialties, dental hygiene, dental assisting, and dental laboratory technology." The accrediting process is a multilevel review process that provides an objective systematic review regarding the development of standardized curricula and clinical education processes. Furthermore, the USDE has oversight over the accreditation processes. Currently CODA is the only body recognized by the USDE to accredit dental and dental-related education programs at the postsecondary level (Chancellor, 2002). Therefore, the USDE and CODA ensure the standards of residency education programs, allowing the public to have confidence regarding the clinical education of dentists who have completed such programs. The ADA has not and does not supervise nor accredit the diplomate certification or recertification processes of ADA-recognized specialties.

THE ADVANTAGES AND DISADVANTAGES OF SPECIALIZATION

There are a number of advantages to clinical healthcare specialization. A specialty provides evidence-based didactic education and clinical training educational opportunities for dentists to advance their knowledge and training in a specific clinical field. With advanced education and training, it is reasonable to expect that specialists are able to provide better care to patients with specific conditions within the area of their expertise, compared to clinicians without the advantage of such added education and training. Specialty education focuses upon the specific diagnoses encountered within the particular field, which allows the specialist to rule-in or rule-out condition entities either within their realm of knowledge or outside the bounds of their clinical specialty. This is an advantage for patients with an uncommon condition, as they can reasonably be assured of having a more accurate diagnosis than they might receive from a nonspecialist. As such, the specialist is more likely to require fewer diagnostic visits to arrive at the correct diagnosis, and may use special instruments and equipment. Also, the specialist would be more likely to have prior experience and education in actually treating a condition diagnosed within their specialty. Furthermore, specialists spend their time diagnosing and treating relatively few conditions, increasing efficiency and excellence compared to the nonspecialist, who may perform these procedures only in rare instances.

Specialists have advanced clinical training within a limited area of expertise, and are available as referral sources for general dentists (and other

specialists) when they are confronted with clinical situations beyond his or her capabilities. Furthermore, there are advantages with regard to specialization even within areas of general care, such as family medicine, internal medicine, and presumably general dentistry. The combination of advanced training and board certification empower the public with the knowledge of physicians' and dentists' training, expertise, and credentials related to their particular area of clinical practice. With regard to diagnosis, the patient may also benefit when a specialty procedure is not necessary. With lower overhead, more focus on a smaller number of procedures, and greater technical proficiency, it is also possible that the cost of a procedure to the patient could be less. Fewer mistakes and less need for repeat procedures could also reduce patient costs, inconvenience, and even suffering.

There are also disadvantages to healthcare specialization. The concept of specialty practice and the increased expense and time for education and training typically ensure that remuneration is above that of the generalist when fees are compared for the same or similar procedures. The greater expense of specialty practices compared to generalists' patient services is a negative patient issue. Furthermore, specialists rely upon patient referral from generalists (and other specialists). This tends to lead to particular marketing issues for the specialists which are different from those of the generalist. The specialist's "customers" are essentially the generalists and sometimes patients. Specialists have been known to "wine and dine" generalists to encourage patient referral. Therefore, patient referral by generalists may be influenced by specialists' self-promotion rather than clinical expertise. Furthermore, specialization tends to produce a narrowed focus. There is a tendency for specialists in endodontics

to view oral diagnostic concerns as endodontic issues first, just as there is a tendency for specialists in periodontics to view oral diagnostic concerns as periodontal issues first. Specialization has a tendency to move clinicians away from a more holistic approach to diagnosis and treatment, which may be construed as counter-productive. While specialists are trained to keep an open mind, years of specialty practice may result in a narrowed focus of attention (Brown, 2011).

COMPETITION AND COMPETITIVE ADVERTISING ISSUES

As there are always clinical crossover areas of specialty expertise, there will always be competition within these specialty and generalist areas of practice where more than one area of clinical expertise serves the same patient clinical concerns. For example, oral and maxillofacial surgeons and endodontists both perform root canal therapy, and several types of specialty practitioners place implants. General dentists often perform the same procedures that specialists perform, such as periodontal surgery, exodontia, orthodontics, and endodontic procedures. Another example is that virtually all dental specialists and general dentists engage in the interpretation of radiographs (a recognized specialty). Such competition may be perceived as both good and bad, in that competition would tend to influence clinical expertise, education, advertising, self-promotion, and clinical patient fees. With regard to advertising, certain phrases have ethical and competitive implications. To say that your practice is "limited to (specific field)" implies specialization. While

Therefore, the USDE and CODA ensure the standards of residency education programs, allowing the public to have confidence regarding the clinical education of dentists who have completed such programs. The ADA has not and does not supervise nor accredit the diplomate certification or recertification processes of ADA-recognized specialties.

With regard to veracity, the ADA's code of professional conduct stipulates that those specialists that are not recognized by the ADA, such as oral medicine, orofacial pain, implant dentistry, and dental anesthesia, must place a qualifier in advertising that they are not recognized by the ADA as specialists, noting that they are general dentists, when in fact they are not general dentists.

patients may not know the difference, an assertion that you are a diplomate of a particular board implies that you are a specialist. The ADA has determined that it is unethical to advertise using the term "practice limited" unless the practice is indeed limited to a formally recognized ADA specialty. The ADA has determined that it is unethical to advertise using the term "diplomate" of a board unless that particular board is an ADA recognized specialty board or unless the qualification states that the diplomate boarded dentist is actually a general dentist. So although a dentist may limit his or her practice or have completed board certification and attained diplomate status within a certification board, such dentists, according to ADA ethical standards, cannot ethically advertise these statements. The following is quoted from the *ADA Principles of Ethics and Code of Professional Conduct* (ADA Website):

"A dentist who is qualified to announce specialization under this section may not announce to the public that he or she is certified or a Diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or Diplomate status based on the following: a) the dentist's successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months' duration; and b) the dentist's training and experience; and c) successful completion of an oral and written examination based on psychometric principles; and
2. The announcement includes the following language: [Name of announced area of dental practice]

is not recognized as a specialty area by the American Dental Association."

Grasskemper (2009) noted the three types of advertising that apply to dentistry, and these were comparable, competitive, and informational advertising. "Comparable" was described as comparing the advertiser and others within the same market, usually noting differences with regard to quality or superiority. "Competitive" was described as essentially providing competitive pricing, and "informational" was described as providing information. With regard to comparable advertising, Grasskemper also notes that the ADA's Principles of Ethics and Code of Professional Conduct states: "Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication that is false or misleading in any material respect." He further observes, regarding this document:

Statements shall be avoided which would: (a) contain a material misrepresentation of fact, (b) omit a fact necessary to make the statement considered as a whole not material misleading, (c) be intended or be likely to create an unjustified expectation about results the dentist can achieve, and (d) contain material, objective representation, whether express or implied, that the advertised services are superior in quality to those of dentists, if that representation is not subject to reasonable substantiation.

Clearly, dentists advertising as specialists would have a competitive advantage compared to generalists with patients having specific concerns related to particular specialties.

Grasskemper (2009) goes on to discuss the concepts of beneficence and veracity. Beneficence involves the duty to promote the patient's well-being. Therefore, ethical advertising should

not economically benefit the dentist at the expense of the patient's well-being. Veracity is the principle of being truthful. With regard to advertising Grasskemper continues, "Statements referring to the dentist as the 'best' or the 'only master' or that identify the dentist as a 'Fellow' imply to the patient that the dentist is a specialist or has professional qualifications that are superior to other dentists who do not have such credentials, and are thus misleading. The same may be said about those who promote themselves as specialists in 'cosmetic dentistry,' 'TMJ,' or 'implants,' when such specialties are not recognized by organized dentistry."

However, there are specialty areas not recognized by the ADA that are informally recognized by the dental profession. These include: oral medicine, orofacial pain, implant dentistry, and dental anesthesia. The American Board of Oral Medicine (ABOM) was established in 1956, and it currently has six residency programs which are CODA accredited. Furthermore, oral medicine is accepted as an academic discipline by the American Dental Education Association (ADEA). Oral medicine clinicians have been representing the ADA in many capacities for a number of years with regard to medical issues important in dental care. Examples include the ADA's scientific council, advising dentists regarding antibiotic prophylaxis, and service as the present editor of the journal of the ADA (Brown, 2012; Brown et al., 2001).

With regard to veracity, the ADA's code of professional conduct stipulates that those specialists that are not recognized by the ADA, such as oral medicine, orofacial pain, implant dentistry, and dental anesthesia, must

place a qualifier in advertising that they are not recognized by the ADA as specialists, noting that they are general dentists, when in fact they are not general dentists. Placing a qualifier such as "general dentist" may mislead patients as to the areas of practice in which dentists have special skills by virtue of practice concentration. Full disclosure according to the ADA ethical standards states that areas of practice not yet formally recognized (what we will call emerging specialties) must state that they are not ADA recognized specialties. However, there is no complementary requirement for informing patients that the ADA is not an agency that certifies dental specialties. Although the ADA's ethical standards state: "Specialists shall not announce their credentials in a manner that implies specialization in a non-specialty interest area," ADA specialists do list in advertisements such areas of clinical practice as implant dentistry and TMJ treatment, when in fact their education and training are not necessarily equivalent, and frequently less than specialists in such unrecognized dental specialties as oral medicine, orofacial pain, implant dentistry and dental anesthesia.

The application process for the emerging dental specialty to become recognized as an ADA specialty consists of satisfying several concerns listed in the application. One of the concerns essentially eliminates new emerging specialties when the new emerging specialty involves procedures that other existing specialties or general dentists presently perform. As such, this particular restriction runs against the historical trend of accepting the last two ADA approved specialties, endodontics in 1963, and dental radiology in 1999. Both of these specialties typically involve procedures that other ADA recognized specialties and general dentists practice.

We contend that there is a conflict of interest that limits or eliminates further competition from new approved dental specialties. Furthermore, even when the application evaluation committee agrees that all the application concerns have been successfully met, the recognition of the emerging specialty is still not established. The application must then be voted upon by the ADA House of Delegates. This step involves a significant and obvious conflict of interest, as delegates of recognized dental specialties and general dentists with perceived economic competitive conflicts may vote against the emerging dental specialty out of self-interest. Such a vote has the potential to encourage delegates to favor their pocketbooks at the expense of the potential benefits for patient care. Mashni (2014) reported strenuous lobbying by the American Association of Oral and Maxillofacial Surgeons against the specialty recognition of dental anesthesia.

As noted above, Grasskemper (2009) asserts that "statements shall be avoided which would: omit a fact necessary to make the statement considered as a whole not material misleading..." But it appears that this so-called ethical concern is entirely devoted to disclosing the fact that he or she is not an ADA recognized dental specialist rather than educating the public on one's training. Other omitted facts do not appear to be of any concern. As an example, a dentist within an ADA-recognized specialty is not ethically required to report that he or she was at the bottom of the class of

specialty residents, that his or her specialty training program did not adequately cover therapeutics or oral chronic pain diagnosis and treatment, or if the training program had accreditation deficiencies documented by CODA. These are certainly concerns that could inform patients seeking care. Furthermore, the lack of a statement disclosing that there is no certifying oversight agency for ADA-recognized dental specialty board certification examinations appears to be an important omission.

Currently, the majority of state dental boards have deferred to the ADA to determine which areas of dentistry are specialties and to allow only these ADA-recognized dental specialties the freedom to advertise as such. These state statutes compel dentists to abide by lawmaking determinations of state boards based upon the decisions of the national organization. Therefore, the ADA effectively serves as a regulatory state entity. Through state laws, these state dental boards and state governments have allowed the ADA to violate the federal right to commercial free speech. When these state laws regarding diplomate credentials and commercial free speech have been challenged, the courts have found in favor of the plaintiffs. The courts have ruled that allowing a trade organization—the ADA—to make sole determinations of who may advertise diplomate credentials is a violation state and federal law (*Ducoin vs. Viamonte Ros*, 2009; *Potts vs. Stiger*, 2010). These court decisions were both based on the premise that the dental boards and state legislatures are not allowed by state and federal statutes to singularly take the opinion of a trade

organization as to who is allowed commercial free speech. i.e., to be able to advertise as a specialist, practice limited to, or diplomate.

Four emerging dental specialties—oral medicine, orofacial pain, implant dentistry, and dental anesthesia—all demonstrate positive reasons for specialty recognition. All represent areas of clinical practice with little overlap of currently recognized dental specialties and general dentistry. Oral medicine specifically covers the medical management of oral conditions; orofacial pain specifically covers the diagnosis and treatment of orofacial chronic pain conditions; dental anesthesiology specifically covers anesthesia for any dental treatment; and oral implantology covers global dental implant diagnosis and therapy which includes treatment planning, implant placement, and implant restoration. While other specialties may cover some of these aspects, there are no specialties with these particular foci. These four dental disciplines also demonstrate records of scientific inquiry and a long-term history of educational clinical residency programs. (Miller et al., 1997, 2001; Leyman, 1999; Friction, 2002; Schiffman et al., 1990; Rutkowski, 2012; Payant et al., 1994; Chancellor, 2002; Brown, 2012)

Potential future dental specialties include sleep dentistry, special care dentistry, geriatric dentistry, and even general dentistry. Sleep dentistry focuses upon the diagnosis and treatment of sleep apnea, bruxism, and silent gastric reflux; while special care dentistry focuses upon the dental treatment of disabled and medically complex patients. Geriatric dentistry focuses on the diagnosis and treatment of oral and dental disease of the aged (Bailey & Attanasio, 2012; Subar et al., 2012; Levy et al., 2013; Ganzberg et al., and Crandall, 2012). All of these dental disciplines have contributed to education

and research. The Academy of General Dentistry has run residency programs for many years to encourage expertise in vast field of general dentistry (Glassman, 1995). Obviously, general dentistry is not a focused field, but a case can be made for general dentists with advanced training to obtain diplomate status after successfully completing a proper examination process. Indeed, because of the breadth of general dentistry education, such certification is difficult to attain. In this case, the certification would allow the public information concerning advanced education and training. General dentistry may be compared to such medical specialties as family medicine and internal medicine, in which additional education and training is required after the physician receives his or her MD degree and successfully challenges the required certification examinations (Osman et al., 2015).

Finally, there is the possibility of placing emerging dental specialties into already established dental specialties. Currently the specialty of prosthetic dentistry has three subsets which include, fixed prosthodontics, removable prosthodontics, and maxillofacial prosthodontics. As such, one diagnostic specialty could be established which combines oral and maxillofacial pathology, oral and maxillofacial radiology, and oral medicine. Furthermore, such dental disciplines as sleep dentistry could be combined within the emerging dental specialty of orofacial pain. The main issue is this: Does the emerging specialty provide education and training beyond a dental undergraduate degree which can be certified through psychometric testing, and does the emerging specialty contribute to clinical research and clinical expertise that is beneficial for the public?

A PATH FORWARD

Recently the ABDS was formed with the objective of becoming an oversight board for dental specialty certification and to provide a pathway for the recognition of new dental specialties. The founders of the ABDS are the American Dental Board of Anesthesia (ADBA), the American Board of Orofacial Pain (ABOP), the American Board of Oral Medicine (ABOM), and the American Board of Oral Implantology (ABOI) (Orr, 2014). The ABOM was formed in 1956; the ABOP was formed in 1993; the ADBA was formed in 1994; and the ABOI was chartered in 1969. Dental anesthesiology, orofacial pain, oral medicine, and implant dentistry all have established two-year (or more), full-time residency programs at CODA accredited institutions. All four have applied unsuccessfully for dental specialty recognition through the ADA on multiple occasions. These applications were supported with a great deal of evidence, and all were unsuccessful (Leyman et al., 1999; Miller et al., 2001; Schiffman et al., 1990; Miller et al., 1997). The ABDS provides certifying process mechanisms to aid in ensuring that specialty boards provide appropriate psychometric evaluations of board qualified applicants and specialists requiring certification and recertification (Orr, 2014).

Clearly, there are important ethical issues related to dental specialization. There are concerns regarding certification, recertification, and specialty recognition. It is our opinion that it is necessary to establish unbiased equitable processes to ensure ethical standards in order to benefit education, residency training, certification, recertification, and patient care. Overall, we

believe that increasing the number of recognized dental specialties through a consistent and sensible process would improve oral health care for the public and be consistent with the best ethics of the dental profession. ■

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The courts have ruled that allowing a trade organization—the ADA—to make sole determinations of who may advertise diplomate credentials is a violation state and federal law.

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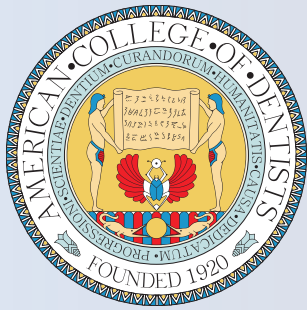
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