

Journal *of the* American College *of* Dentists

Codes of
Ethics

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excellence, ethics, professionalism,
and leadership in dentistry

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It is the communication policy of the American College of Dentists to identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the College. The College is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in College publications do not necessarily represent those of the American College of Dentists or its Fellows.

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- A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
- B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
- C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate, and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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FROM THE EDITOR

Would You Mind If I Twisted Your Arm Just a Little?

Unless every patient says or implies “Well, I am thinking,” the dentist should stop and consider whether elements of coercion have crept into the office routine.

The values of a dental practice can be read more accurately in the office policy and structure of work flow than by what anyone says on the website. Dentists are choice architects, designing the experience so it is easy for others to pick the right thing to do.

Sometimes patients are very strongly guided. The dentist announces “You need root planing” or “I’m making an appointment for a cone beam diagnostic radiograph for you.” In most cases, any reasonable person, given a full and lay-understandable explanation of all plausible alternatives, would make the same choice the dentist believes is appropriate. The dentist is just saving a little time by assuming that the patient is reasonable and has the same values the dentist does. This is the “Golden Rule” scenario: treat every patient as you would your mother. The part of the rule about being even-handed and treating everyone the same is laudable. The part about a private standard for what everyone else should value is a little presumptuous. I have never met your mother—and I am sure she is a nice person—but neither do you know mine.

There is an old Jack Benny gag that is relevant here. The mugger sticks a gun in his face and demands “Your money or your life.” Benny hesitates, and the

annoyed mugger expresses frustration. Finally Benny says, “Well, I’m thinking.”

But this is not a simple matter. Sometimes the dentist or office manager just announces the treatment, or in the extreme but not unheard of case, proceeds with the treatment without even informing the patient. Standing orders for bite-wings prior to an oral inspection, for example, or letting the office manager decide the perio recall schedule are borderline malpractice. This is known technically as coercion. The term does not mean using physical force or the threat of force to get one’s way. It means restricting what others might choose for one’s own benefit.

The most common way for individuals in positions of power to coerce others is just failing to mention that they have a choice. When we do not tell others about an option open to them we are using coercion. Some dentists find the Jack Benny patient annoying. Such folks disrupt the routine, they seem to be demanding special attention, they slow things down unnecessarily, and they even seem to be questioning the dentist’s judgment. Unless every patient says or implies “Well, I am thinking,” the dentist should stop and consider whether elements of coercion have crept into the office routine. The technical term here is respect for autonomy. If your personal financial advisor expressed annoyance at your saying, “Well, I’m thinking,” it might be time to consider getting another financial advisor.

Dentists and corporations design choice routines, and they do so to achieve

many objectives. There are two noble optima: the autonomy of others and best oral health. There are numerous other goals, such as profit maximization, personal convenience and sense of control, responsiveness to external regulatory and commercial interests, or just plain confusion, for example. There are many practice management gurus, trade associations providing “member benefits,” and CE courses selling advice on designing systems for ignoble goals. And I have to say that many of them are very effective, primarily because they hide their interests under a veil of non-transparency.

The Gordian Knot for healthcare ethicists has traditionally been the conflict between autonomy and beneficence. A common solution is paternalism, deciding for patients based on the dentist’s oral health or other criteria. The ADA Code actually states that this tension is endemic in practice without offering guidance for harmonizing such conflicting goals. Leading bioethicists such as Beauchamp and Childress advise that professionals should “use their best judgment to achieve a workable balance.”

Here is one alternative that deserves consideration for managing the conflict between beneficence and autonomy. Richard Thaler and Cass Sunstein, in their book titled *Nudge*, propose this way forward: It is appropriate for powerful, knowable, caring individuals

to design choice situations for others to maximize the benefits the choice designers believe are in the best interests of others (paternalism) *provided that* others are adequately informed of the consequences of all their choices and have the opportunity to freely decline. It is fine to design choices so the default is presumed to be in the choosers’ best interests (even when they may not think so to begin with), as long as there is an “informed opt-out provision.” Thaler and Sunstein call this “nudging” folks into making the right choice. The default position is what wise and caring heads believe is in the public’s best interests. There are no neutral choice architectures. But there are sneaky ones.

Obamacare is a nudge, as are social security and workers’ compensation. So are subsidies for agribusiness and the oil industry. We generally welcome the concept of government intervention in practices where human nature is weak or uninformed, such as sex trafficking, drunk driving, corruption, false advertising, and scams. Naturally, each of us has opinions about designing nudges that are better customized to our personal interests, and we do opt out on occasion and welcome calls for more transparency (information that better informs our opt-out options). Count on it: patients feel the same way.

Thaler and Sunstein discuss in detail cases where changing the default to one that makes it easier to serve decision makers’ own best interests. Making organ donation the default on drivers’

license applications saved lives in New Jersey. Requiring an opt-out of employee contributions to employer-sponsored retirement plans increased net worth of those working in companies that went this way. (Even a nudge of agreeing to nothing this year but starting the process of automatic withdrawals in two years’ time was effective—a technique retailers are now using to their great advantage.) Medicare Part D, prescription drugs, has over 90% eligibility enrollment. This is not a function of offering multiple choices to seniors, but of constricting choices and automating enrollment, with informed opt-out rather than opt-in.

Nudging is responsible paternalism.



LET US BE LEADERS

Steven D. Chan. DDS, FACD

ACD PRESIDENT-ELECT'S ADDRESS

November 5, 2015
Washington, D.C.

Good morning. My name is Steve Chan. I am the incoming president of the College, and I bring you greetings.

I can't believe I'm here. I used to be scared of those guys on the podium. Now I am one of them.

This is a homecoming for me to be here in Washington. I graduated from Georgetown Dental School. It has since been closed, but Georgetown was a very traditional dental school. At Georgetown we wore white, high collar tunics, just like in the barber shops of old. But we also wore white pants, white shoes, and white lab coats. We looked like something out of the history books.

When I went back home to take the California licensure boards, I had to show them a copy of my diploma. They asked "What country did you come from?" I firmly told them, "I am a third generation Californian." They persisted: "Did you go to school in this country?" Biting my tongue, I answered "Georgetown is one of the oldest universities (1789) in this country." But then it dawned on me why the questions. My diploma from Georgetown is very traditional. It's written in Latin! I had to find someone to translate my diploma!

SOMEONE HELPED YOU GET HERE

Let's begin this morning with a short tale. It's a story of discovery. My journey to this podium began with my grandfather who sailed to this country in the 1880s. My grandmother followed by

steamer ship 90 years ago. She came with only one suitcase and the clothes on her back. She didn't understand what people were saying to her. There were few who looked like her.

I did some research at the National Archives on her early immigration. She came aboard the USS Howard Taft in 1924. It was a month-long voyage on the high seas.

I found that she was likely on the last ship that allowed Asian women to come into this country. The Immigration Act of 1924 effectively barred Asian females from immigrating until 1943.

If she hadn't gotten on that ship I wouldn't be here. So here today, some nine decades later after my grandmother touched these shores, her grandson has been given the honor of standing before you.

On behalf of the officers and regents of the American College of Dentists, I welcome you to the 2015 Annual Meeting of the oldest honorary organization for dentistry in America. The American College of Dentists is a mighty 95 years old!

When I was inducted, all I knew of the college were some initials behind the



Dr. Chan has recently retired from his practice of pediatric dentistry in Fremont, California; justkids1895@gmail.com.

names of my dental school professors. At my convocation I was unprepared for the experience. I was in my 30s. I saw admirals and generals. There were deans of schools and famous scientists whom I had read about. The man who invented the high-speed handpiece was being recognized that day. I had a lump in my throat that wouldn't go away. After the ceremony, I ran downstairs to copy the certificate—just in case there was another Steve Chan.

I wrote a letter to the executive director to thank the college for the honor. I was awestruck. I was standing next to people who were legendary. But in my letter I apologized. I was clearly out of my league. I wasn't even in the same class of people as those in that room. The executive director wrote back. What he said haunted me.

"Someone believed in you." That has been pretty hard to live up to.

And we see what many of you have done for the profession. So it is our honor to thank you. But this is more than just a single celebration in time. For most of you your work is not yet done.

Something made you different.

Someone saw something in you.

Someone saw something in you that could touch the lives of others.

Someone saw something in you that could move the profession.

It is said true leadership is tested and revealed in times of crisis. I hope you'll come back next year to the 2016 Convocation in Denver. You will hear a

story of leadership. The 2016 Convocation speaker will be the Honorable Norman Mineta.

He was the United States Secretary of Transportation when 9-11 struck the heart of our country: when this country didn't understand what was happening to us, when the planes were crashing into the Twin Towers, when they were crashing into the Pentagon, and when they were crashing into that Pennsylvania countryside.

There were no "higher ups" to turn to or manuals to look up what to do next. Thousands were being killed. At that moment in time, history thrust a test of leadership in our faces. Our country was changed.

Incoming fellows: this year, you will cross that stage. You will be changed. You have moved a bit of history to get here. The mountains you moved were formidable. Now the greater work begins. Those who follow you in their journeys are watching you. Move them. Teach them. Inspire them. They are your legacies.

THE COLLEGE HAS SOME WORK FOR LEADERS IN THE PROFESSION

It is our custom for the incoming president to address "What's ahead for the College."

"Someone believed in you."

As the ACA unfolds, dentists on the front line are framing "This is what oral health care should look like."

Ethics

The college is known as “the conscience of the profession.” In a way the college is to the profession what Walt Disney’s character Jiminy Cricket was to Pinocchio. In times when Pinocchio’s moral compass was dazzled and tempted, his companion Jiminy Cricket whispered into Pinocchio’s ear “Let your conscience be your guide.” (It’s okay. I can talk like that. I’m a pediatric dentist!)

Among the drivers for the founders to create the college was to raise the dignity of the profession. That was an era of American dentistry where hucksters preyed on the unsuspecting. Dentistry was struggling. Were we just another street trade or were we an honorable profession?

Ninety years ago ACD Pioneer William Gies led a turning point in the profession. He managed the construction of a major treatise on education that transformed American dentistry. Ninety years later this country has changed. The college recognizes that the challenge has returned. The regents have authorized a three-year ACD Gies Ethics Project that will lead to a major report on improving the ethical foundation vital to our profession. The college stands ready, side by side with the profession, to look at ourselves in the mirror. How does our profession “fit” with these new things we have yet to understand.

THE AFFORDABLE CARE ACT

This initiative will change the landscape of dentistry in this country. No matter what your politics, it is supposed to be about care for those who do not have care. As the ACA unfolds, dentists on the front line are framing “This is what oral health care should look like.” Meanwhile, nondentists are telling us what we can or cannot do. The greatest test posed by the ACA will be: “How is dentistry valued by the American consumer?”

The marketplace will go through a period of discovery. It will learn from the good and from the bad. The marketplace can demand what it wants. We remember the first role of the doctor is to teach what can be. The ACA will affect us on many levels. The ACA will affect what kind of care patients get. They will only remember whose hands delivered that care. How will dentistry “fit” in the Affordable Care Act?

CORPORATE DENTISTRY

The business of American dentistry is evolving. Considering the national dental care expenditures in this country, dentistry is a \$111 billion industry. But also consider America is often driven for bigger is better.

Once upon a time you “hung out your shingle” and you were in business. And once upon a time corporate dentistry meant a way for a doctor to protect his or her financial assets. But running a practice is getting more complicated. Competition surrounds us. Regulations are strangling us. Outsiders want control. Risk comes in many disguises.

There’s a signpost up ahead. In the drive to be leaner and more competitive and profitable—in the drive to be big—we must not forget that when we first came we professed to help a bit

of humanity. But along the way we may lose our own humanity and some will lose their souls.

We are given the power of the “laying on of hands.” We decide what our hands do to create one smile at a time. How will corporate dentistry “fit” in the marketplace?

SOCIAL MEDIA

We talk differently now. How will dentistry “fit” in the universe of social media?

The Internet is the new power tool. Yet, like any tool its impact depends on how it is used. A mallet can create and it can destroy.

Social media can create relationships. It can destroy relationships. A single online comment can crush a reputation that took a lifetime to build. The doctor may be the operator of the tool and he or she may sometimes be the target. In the goldfish bowl of social media we only have control of our own conduct. A doctor must be a doctor 24/7. This new “word of mouth” will remember how you carried yourself. It is about your good name.

OUR NEW FACE

The faces of American dentistry are changing. We, the members of the college will have to work through some significant challenges here. The implications are far reaching. The effects are here and now. For whom does the college exist?

Consider: our bylaws require membership in the ADA to be nominated for the college. The measure of admission is demonstrated leadership. Yet in today’s reality there are leaders who are not members of the ADA. We cannot recognize them and bring them into the

college. They share the same profession. They make their part of society better.

We struggle. The pool of leaders not found in the market share of the American Dental Association is expanding. The numbers may vary from year to year, but the trend line is clear. Depending on the report, market share may be dropping below 60%. As the ADA market share shrinks, the other wedges of the pie expand and occupy more of that marketplace.

In 2015 the face of dentistry in this country just looks different. And this is an additional demographic factor. The problem is the inability of the college to reach the other parts of this profession. Where are the missed opportunities to influence the fabric of the profession?

What of those from different ethnic or racial backgrounds who speak the language of their people or who share common stories where we just don't understand?

What of those who are in the military and serve our country?

What of those in public health who treat those who otherwise have no care?

And then there are the young. Within the first five to ten years of graduation, it is the money. "How do I pay this monstrous debt from school? How do I make a living doing this thing called dentistry?" Some things are just more important at that time.

And what of those who choose not to join the ADA, but who one day will inherit parts of profession untouched by the college?

Let me clearly state we are not forsaking our core values. We are not sacrificing any of our standards. We must reach out and share them with more of our colleagues.

But in today's reality leadership exists not only within the sphere of the ADA.

We in the college exist for the common good for the greater whole of the profession, not just a part of it. No matter what you look like, no matter what manner of dress you wear, no matter what language you speak, no matter the model of practice.

We believe in inclusiveness. America is built on the principle inclusiveness.

Several years ago I was invited to a graduation at the University of Pacific, Arthur A. Dugoni School of Dentistry. At the graduation we heard the same stories. "It's time to get on with our lives. It's time to start our families." "We look forward to starting our residencies." "We look forward to making a living. We owe nearly half a million dollars in educational loans."

I met one of these new grads. He had the same debt. He had a new baby to care for. He proudly told me, "I am going back to the reservation. I am going back to be the dentist for the Cherokee Nation. I am going back to help my people." This is leadership.

A few years ago, I went to another graduation for a pilot program that helps students from underserved populations prepare for dental school. They weren't only Black or Hispanic. Some came from the war-torn Middle East or the broken Soviet Union. What about Latinos? El Salvador is not Cuba is not Guatemala and certainly not Mexico. These immigrants are different—as different as the English and the Americans.

At this graduation the stories were the same. "I have to go back to help my people." Five years later, 100% remained in practice in federally identified shortage areas. Among their own people

In the drive to be leaner and more competitive and profitable—in the drive to be big—we must not forget that when we first came we professed to help a bit of humanity. But along the way we may lose our own humanity and some will lose their souls.

Let me clearly state we are not forsaking our core values. We are not sacrificing any of our standards. We must reach out and share them with more of our colleagues.

they are still healers. Do we still not have a place for them in the American College of Dentists?

The final story is about a Diversity Summit, an outreach by the ADA to ethnic and racial based organizations. Because of our own restrictions we could only invite three of those many leaders into the college. Consider: in their kingdoms, they are king, they are queen. Recognition of leadership begins with respect. We have chasms where we cannot reach. American dentistry is shifting. I believe the greater whole of the profession will be in a better place by bringing us together under the tent of the American College of Dentists.

How Do We Extend the Hand of the College?

Our mission is to advance excellence, ethics, professionalism, and leadership. Ethics and professionalism are about the here and now. Excellence is what you can see before you. Yet leadership is seeing what can be.

Leadership fascinates me. What makes a leader tick? How do they see possibilities we have yet to see? How do they inspire an audience? How do they send chills up our backs and move us on our own personal journeys long after they've left us?

I propose that the college build a Leadership Institute. Create a structured curriculum based on the social science of leadership. Study the skills. Study the art forms. Learn the craft. Build better leaders and we build better organizations.

Build better leaders and we build a better profession. Build better leaders and we build better images of who we are in the communities we live in.

How Did We Come to Be Here?

Leadership is to touch the lives of others. Leadership is to touch the future. We can build the "pipeline of hope" for the profession.

We began this morning with my grandmother. I lost her two years ago. She was 108. I see this tiny woman hunched over at the end of the day. She could barely stand. She was hurting. I saw her come home one late evening literally bleeding from her hands, a woman who came to this country, who couldn't speak English, who had no skills. All she wanted was honest work to feed and shelter her babies. She was a woman who taught me all I needed to know about faith and hard work by the simple eloquence of her example.

One hundred and thirty-five years ago my grandfather left a distant shore. He went to search for a place his countrymen called "Gold Mountain." One hundred and thirty-five years later, here at this podium, I believe I have found that Gold Mountain.

Gold Mountain is seated here before me. In my culture the Dragon is a noble creature. The dragons guard the heavens. I thank you for allowing me to fly with dragons.

May the gods of good fortune smile upon you and your families. May you live interesting lives. We are the American College of Dentists. ■

2015 ACD AWARDS

ETHICS AND PROFESSIONALISM AWARD



The Ethics and Professionalism Award recognizes exceptional contributions by individuals or organizations for effectively promoting ethics and professionalism in dentistry through leadership, education, training, journalism, or research. It is the highest honor given by the college in the area of ethics. The American College of Dentists recognizes Dental Lifeline Network as the recipient of the 2015 Ethics and Professionalism Award.

Dental Lifeline Network is a Denver-based national humanitarian organization incorporated in 1974. Its initial program, Bridge, focused on providing preventive dental outreach services specifically for developmentally disabled individuals in special education schools, workshops, and group homes. A dental house call program was also established enabling homebound individuals and long-term care residents in Denver and Chicago to receive a full-range of dental therapies. As congregate educational, vocational, and residential services for developmentally disabled individuals evolved into less restrictive environments, opportunities decreased for providing cost

effective and efficient preventive outreach services. Functionally, the Bridge program is essentially moribund. Yet Dental Lifeline Network's commitment to preventive outreach for vulnerable populations is resolute and the motivation for Bridge Renaissance, as summarized below.

Donated Dental Services (DDS) is a product of the Bridge program. Many developmentally disabled individuals screened through the outreach activities had rampant dental diseases and required extensive, but unaffordable and uncovered dental care. There was an ethical imperative to arrange pro bono dental therapies for such individuals. Neglect is bad, but supervising neglect by not assuring needed treatment was unconscionable!

Over time, however, it became obvious that the need extended to many individuals disadvantaged by other disabilities. Consequently, from a nucleus of need among developmentally disabled people, the DDS program has evolved as a national humanitarian initiative assisting individuals unable to afford dental care because of financial limitations related to medical, physical, mental, and age-related challenges. Since its launch as a pilot project in Colorado during the mid-1980s, DDS has expanded nationally with the collaborative assistance of many prominent and respected dental organizations. People are assisted in all states and Washington, DC. The 15,000 volunteer dentists (general practitioners and specialists), assisted by 3,800 dental laboratories, have provided \$280 million

in comprehensive, pain-relieving, dignity-restoring, function-enhancing and, frequently, medically-essential pro bono dental therapies for more than 100,000 people. Notwithstanding the scope of such benevolence, it is tragically dwarfed by the volume of need. Volunteerism is not a solution from a broad social perspective. The progress realized through DDS is therefore being leveraged to advance several related complementary initiatives:

- **Medical Triage.** To help assure that individuals requiring medically essential dental care are prioritized for assistance, a procedure has been developed for obtaining related feedback from physicians as part of the DDS application process.
- **Pharmacy Project.** The most frequent reason for prioritization is the increased risk of septicemias from serious dental infections among people immunosuppressed by disease or immunosuppressive pharmaceuticals. While "Information For Use" (IFU) materials for immunosuppressant and cytotoxic drugs include advisories regarding cautionary use if there is infection, reference is not included that dental caries and periodontal diseases are bacterial infections. Collaboration is underway with Loma Linda University to address this omission. The adverse dental consequences of xerostomia is another omission being addressed in the collaboration.

- **Bridge Renaissance.** Medical triage and the pharmacy project underscore the importance of bridging the gap that has historically segregated dental from other healthcare disciplines. There is a compelling ethical imperative to help medically compromised individuals understand the relevance of oral health to their overall healthcare management and well-being. To advance such progress, Dental Lifeline Network is endeavoring to build meaningful collaborative relationships with national medical organizations and national voluntary health organizations. For example, many people facing kidney problems are referred to the DDS program by dialysis centers since they require extensive, but unaffordable and uncovered dental care. It would be appropriate, and hopefully at some time it will seem intuitive, that through collaborative relationships with such groups as the Renal Physicians Association and the National Kidney Foundation, materials about the importance of preventive dental health care will be distributed by nephrologists. Just as DDS was a product of the original Bridge program, Bridge Renaissance is evolving from DDS. Thereby, beneficiaries of DDS will ultimately be a significant multiple of those directly assisted through the program.

Accepting the award for Dental Lifeline Network is Mr. Fred J. Leviton, president. The Ethics and Professionalism Award is made possible through the generosity of The Jerome B. Miller Family Foundation to which we are extremely grateful.

OUTSTANDING SERVICE AWARD



The Outstanding Service Award recognizes Fellows for specific efforts that embody the service ideal; emphasize compassion,

beneficence, and unselfish behavior; and have significant impact on the profession, the community, or humanity. The recipient of the Outstanding Service Award is **Dr. James D. Hudson.**

Dr. Hudson has served dentistry in numerous high-level capacities for many years. He has given unselfishly of himself to a number of worthy causes, setting an outstanding example of service for others. He has made a significant positive impact on his patients, colleagues, and students. His record of service and accomplishments include:

- Founder, La Romana Oral Health Initiative, Dominican Republic, and involved in needs assessment and yearly service outreaches.
- Past president and member, Board of Education, Bronxville, New York; elected to two 3-year terms and one additional year by appointment
- Deputy chief forensic dentist, Office of Chief Medical Examiner, City of New York
- Member, Special Operations Response Team and OCME Dental Identification Team
- Tour Commander, 9/11 World Trade Center Disaster
- Clinical assistant professor, New York University College of Dentistry
- Course director, postgraduate prosthodontics course on professional ethics
- Past president, Dental Clinics of the Boys Club Inc., Boys Clubs of New York
- Volunteer, Donated Dental Services, established Medical/Dental Triage Program

- Past president, New York Academy of Dentistry
- President, American Prosthodontic Society
- Past chair, New York Section, American College of Dentists
- Past secretary, Greater New York Academy of Prosthodontics
- Board of Directors, William J. Gies Foundation for the Advancement of Dentistry, later merged with American Dental Education Association
- Certificate of Recognition, U.S. House of Representatives, "To Honor Your Unsung Efforts and Unselfish Dedication to our City and Nation During its Time of Need After the Events of 9/11/01"
- Recipient, Gosta Gustafson Award, German Society of Dental, Oral and Craniomandibular Sciences, "In recognition of efforts in the identification of the victims of 9/11/01 and for the advancement of forensic dentistry in the United States"
- Recipient, Chief of Detectives Appreciation Award, "In appreciation of your outstanding contribution to the Chief of Detectives Homicide Investigator's Course"

HONORARY FELLOWSHIP

Honorary fellowship is a means to bestow fellowship on deserving non-dentists. This status is awarded to individuals who would otherwise be candidates for fellowship by virtue of demonstrated leadership and achievements in dentistry or the community except that they are not dentists. Honorary fellows have all the rights and privileges of fellowship except they cannot vote or hold elected office. This year there are four recipients of Honorary Fellowship.



The first recipient of Honorary Fellowship is **John C. Kornitzer**. Mr. Kornitzer is founder and CEO of Kornitzer Capital

Management (KCM) and the Buffalo Funds, KCM's mutual fund group. His astute financial management and advice for over 15 years has enabled both the American College of Dentists and the American College of Dentists Foundation to optimize and advance their missions by greatly enhancing their financial sustainability. His accomplishments, credentials, and service include:

- He is a strong and enthusiastic supporter of ethics and professionalism, he has been an extremely important ally in helping the college accomplish its mission of advancing excellence, ethics, professionalism, and leadership in dentistry; he is and has been an ardent supporter of the college and its mission
- His extensive experience includes eleven years on Wall Street, seven years with Merrill Lynch, Pierce, Fenner & Smith Inc., and four years as vice president and managing partner of Butcher & Singer's New York region
- His firm (KCM) manages customized financial portfolios for private clients, institutions, pension funds, corporations, and foundations
- KCM founded Great Plains Trust Company in 1994, which provides trust and investment services for over 2,000 pension plans, personal trust customers, and IRA holders
- He has presented numerous high-level financial presentations on the global economy around the world, including to the college and its members; he is quoted often and regularly in the financial press
- Past chair and president, Kansas City Securities Association

- Past member, Board of Directors, Heart of America Shakespeare Festival
- Past member, Board of Directors, The American Royal, a nonprofit group supporting youth and education since 1899
- Past member, Board of Directors, American Academy of Pediatric Dentists Foundation
- Past Member, Board of Directors, Nelson Atkins Museum of Art Business Council
- Member, Board of Trustees, WWI Museum
- Member, Board of Trustees, University of St. Mary



The second recipient of Honorary Fellowship is **Mr. Frank J. Pokorny II**. Mr. Pokorny is the senior manager, dental codes

maintenance and development, for the American Dental Association. He has over 20 years of leadership, management, and policy experience across a wide spectrum of healthcare venues. He is widely recognized for his expertise and contributions. Highlights of his accomplishments and credentials include:

- BA in anthropology, Columbia College, Columbia University
- MBA, Michigan State University
- Senior manager, dental codes maintenance and development, ADA; ongoing maintenance and implementation, ADA code sets, e.g., Codes on Dental Procedures and claim formats used by members of the dental profession, third-party payers, and other sectors of the dental community. Duties in this capacity include: representing ADA and the profession's interests with national agencies that define or select national standards for dental and other health care administrative transactions and code sets; conceiving and

leading ongoing development of fee-based models for provider and dental practice staff training on procedure coding, claim submission; prepares technical content for biennial publication of "Current Dental Terminology" manual; developing and maintaining operating protocols for the ADA Dental Content Committee and the Code Revision Committee; preparing and delivering recommendation reports on emerging issues for action by ADA agencies and the Board of Trustees; testifying on ADA positions at hearings of the National Committee on Vital and Health Statistics; and representing the ADA and casts its ballot on standards for electronic healthcare transactions crafted by the American National Standards Institute Accredited Subcommittee X12

- Past client implementation specialist, CNA; engaged in the development and growth of an "inside the company" initiative to penetrate the new and growing market of PHOs, the physician and hospital response to HMOs owned by insurance companies or other for-profit organizations
- Past managing representative, electronic commerce and national standards, Blue Cross Blue Shield Association; established and led the Blue Cross Blue Shield Association's electronic commerce and national standards unit
- Board of directors, Workgroup for Electronic Data Interchange (WEDI)
- Founder and co-chair, ANSI ASC X12N Implementation Coordination Work Group
- Co-chair, X12N Provider Caucus
- Chair, Designated Standards Maintenance Organization (DSMO) Steering Committee
- ADA liaison, SNOMED International Editorial Board
- Editorial Board, "IT Health Care Strategist"



The third recipient of Honorary Fellowship is **Elizabeth A. Price**. Ms. Price is the executive director, Metro Denver

Dental Society. She has worked diligently in association management for over 15 years, and eight of those years were specifically in organized dentistry. Her leadership has significantly benefited dentistry and oral health care in a variety of important ways. She is highly respected by her peers and colleagues. Ms. Price's record of accomplishments include:

- MBA in marketing, Anderson School of Management, University of New Mexico
- Executive director, Metro Denver Dental Society; oversees the society, the Rocky Mountain Dental Convention, and the Mountain West Dental Institute (a hands-on continuing education dental clinic and event space which she established for the Metro Denver Dental Society); raised over \$1.3 million in cash and high-tech equipment contributions for the creation of the \$3.5 million facility, and led the project from development through its fruition
- Member, American Society of Association Executives and Colorado Society of Association Executives
- Member, Nominations Committee, Colorado Society of Association Executives
- Vice president, American Component Society Executives, ADA
- Member, Executive Director's Advisory Committee, ADA
- Honorary fellow, Pierre Fauchard Academy
- Established a partnership with Kids in Need of Dentistry enabling low income children to be served every Monday at the MWDI clinic
- Implemented the very first Give Kids A Smile Day in New Mexico, which

became an annual event serving hundreds of kids in need

- Led the charge in revamping the Rocky Mountain Dental Convention, turning it into the most highly attended, top quality, and highly profitable convention in the region
- Revitalized the *New Mexico Dental Journal* and the *MDDS Articulator News* into award-winning, self-supporting, and widely read membership publications



The fourth recipient of Honorary Fellowship is **Mr. Billy W. Tarpley**.

Mr. Tarpley is executive director, Arkansas State

Dental Association, and he has directed the day-to-day operations of the Association for 18 years. His leadership has been responsible for numerous important accomplishments of the association, and he is well-known and recognized by his peers for his expertise, vision, and leadership. Mr. Tarpley's record of accomplishments include:

- Executive director, Arkansas State Dental Association
- Over 33 years of experience working in the areas of nonprofit association management, public relations, communications, development, and governmental relations
- Registered lobbyist and past president, Arkansas Society of Professional Lobbyists
- Past president, Arkansas Society of Association Executives
- Past chair, Arkansas Health Care Provider's Forum
- Treasurer, Delta Dental of Arkansas Foundation
- Member, Board of Directors, Council for Advancement and Support of Education (CASE), Region IV (Texas, Oklahoma, Louisiana, Arkansas)
- Chair of the board, Henderson State University Foundation

- Past president, Gurdon Rotary Club, two terms
- Vice president, local school board, ten years.
- Past president, Gurdon Chamber of Commerce

SECTION NEWSLETTER AWARD

Effective communication is a prerequisite for a healthy Section. The Section Newsletter Award is presented to an ACD Section in recognition of outstanding achievement in the publication of a section newsletter. The award is based on overall quality, design, content, and technical excellence of the newsletter. The **Tennessee Section** is the winner of the Section Newsletter Award for 2015.

MODEL SECTION DESIGNATION

The purpose of the Model Section program is to encourage section improvement by recognizing sections that meet specific standards of performance in four areas: membership, section projects, ACD Foundation support, and commitment and communication. This year the **Arkansas Section** and the **British Columbia Section** earned the Model Section designation.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to fellows who have been a member of the college for 50 years. This recognition is supported by the Dr. Samuel D. Harris Fund of the ACD Foundation. Congratulations to the following recipients:

Ashur G. Chavoor
Ignatius Quartararo
John M. Faust
J. Marvin Reynolds
Donald Giddon
Richard V. Tucker
Alfred C. Long

2015 ACD Fellowship Class

New Fellows Sorted by Regency and Section

REGENCY 1

ATLANTIC PROVINCES SECTION

Doyle, Ian M.
Sydney, NS
Gillies, Stewart
St. John's, NL
Snelgrove, Keith D.E.
St. Johns, NL

HUDSON MOHAWK SECTION

Baim, Loren C.
Glens Falls, NY
DeMarco, Stephen
Albany, NY
DeSanti, Michael M.
Albany, NY
Gamache, Geoffrey
Averill Park, NY
Walsh, Christopher R.
Albany, NY

NEW ENGLAND SECTION

Kochhar, Puneet
Dover, NH
Lee, William
Boston, MA
Maguire, Robert M
Wolfboro, NH
Novy, Brian B.
North Crafton, MA

NEW YORK SECTION

Berkman, Charlene
Port Washington, NY

Ciccio, Joseph A.
Bronxville, NY
De Bartolo, Angela M.
Brooklyn, NY
Duvalsaint, Suzanne
New York, NY
Edwards, Maurice
New York, NY
Greenberg, Mitchell S.
Kew Gardens, NY
Guariglia, John L.
East Setauket, NY

Kilimitzoglou, Dimitrios
Smithtown, NY
Kim, Sahng Gyoong
New York, NY
Lane, Kerry J.
Southampton, NY
Ledner, Jay A.
Douglaston, NY
Lee, Jenny M.
New York, NY
Nicolay, Olivier
New York, NY
Rubinstein, Mitchell
New York, NY
Truhlar, Mary R.
Stony Brook, NY
Vazquez, Ivan A.
Hauppauge, NY

QUEBEC SECTION

Gaucher, Hubert B.
Quebec, QC
Lavigne, Gilles J.
Montreal, QC

WESTERN NEW YORK SECTION

Keating, Michael K.
Auburn, NY
Romano, Paul R.
Rochester, NY

REGENCY 2

EUROPEAN SECTION

Dewe-Mathews, James
London, England

MARYLAND SECTION

Kimbers, Ricardo C.
Baltimore, MD
Pincus, Harold J.
Potomac, MD

METRO WASHINGTON SECTION

Allick, Harrold David
Rockville, MD
Fassihi, Ali R.
Washington, DC
Frieder, Adam J.
Frederick, MD
Grant-Mills, Donna
Washington, DC
Jafine, Brian
Scarborough, ON
Krantz, Stacia M.
Rockville, MD
Progebin, Keith
Washington, DC
Ross, David S.
Bethesda, MD
Siegel, Victor R.
Rockville, MD

Thomas, Alonzo T.
Silver Spring, MD

Will, Michael J.
Ijamsville, MD

NEW JERSEY SECTION

Alberto, Pamela
Kinnelon, NJ
Elson, Howard M.
Pittsburgh, PA
Ritter, Brian K.
San Diego, CA
Roshong, Bryon E.
Dumont, NJ
Schachman, Mark A.,
Florham Park, NJ
Velazquez, Elisa J.
Rumson, NJ
Weddle, Michelle S.
Watchung, NJ

PHILADELPHIA-DELAWARE VALLEY SECTION

Barnett, Frederic
Penn Valley, PA
Brady, Tamara
Exton, PA
Burrell, Joanne
Abington, PA
Fetter, Kenneth A.
St. Davids, PA
Gradwell, Scott
Allentown, PA
Heleniak, Stanley
Lansdale, PA
Kessler, Lon
Phoenixville, PA

Knowlton, Richard D.
Elizabethtown, PA

Logan, Bernadette A.
Paoli, PA

Nordone, Thomas P.
Chadds Ford, PA

Wright, Kimberly R.
West Linn, OR

VIRGINIA SECTION

Brickhouse, Tegwyn H.
Richmond, VA

Lee, Edwin
Falls Church, VA

Southern, Cynthia M.
Pulaski, VA

Sullivan, Kit T.
Richmond, VA

Wilson, Lori S.
Petersburg, VA

WESTERN PENNSYLVANIA SECTION

Davenport, Judith
Pittsburgh, PA

Effort, Edmund
Pittsburgh, PA

Freedman, Matthew D.
Lancaster, PA

Gans, Michael J.
Pittsburgh, PA

Regan, Thomas L.
Quarryville, PA

Schuler, Cynthia L.
Washington, PA

REGENCY 3

ALABAMA SECTION

Kent, Leigh W.
Birmingham, AL

Mitchell, Stephen
Birmingham, AL

Mitchell, Sonya
Birmingham, AL

Tilashalski, Kenneth R.
Birmingham, AL

Willis, Thomas
Decatur, AL

CAROLINAS SECTION

Alves, Loren D.
Greenville, NC

Bayme, Jeffrey B.
Charleston, SC

Bocklet, Raymond C.
Charleston, SC

Brown, Carrie B.
Myrtle Beach, SC

Bumgardner, Charles G.
Lexington, SC

Buttler, Thomas K.
Raleigh, NC

Davis, Betsy
Charleston, SC

Fulcher, Roland
Summerville, SC

Graham, Richard
Spartanburg, SC

Hamrick, John F.
Greenville, SC

Hart, Stephen
Chapel Hill, NC

Heymann, Gavin
Durham, NC

Kleive, Mark
Black Mountain, NC

Pabst, Mark D.
Greenville, NC

Renne, Walter G.
Charleston, SC

Tyson, Chester J.
Wilmington, NC

FLORIDA SECTION

Abdoney, Mark Allen
Tampa, FL

Albert, Jeffrey S.
Delray Beach, FL

Anderson, Amy F.
St. Petersburg, FL

Cordoba, John X.
Lake Mary, FL

Godet, Yvette M.A.
Gainesville, FL

Kelner, Steven M.
Hollywood, FL

Mandelaris, George A.
Oakbrook Terrace, IL

Pileggi, Roberta
Gainesville, FL

Sadow, Pamela
Gainesville, FL

Thiems-Heflin, Suzanne
Gainesville, FL

GEORGIA SECTION

Neiva, Rodrigo F.
Gainesville, FL

Pannes, Dianne
Richmond Hills, GA

PUERTO RICO SECTION

Buitrago-Huertas, Edlin S.
San Juan, PR

Gonzalez, Ramon
Guaynabo, PR

Matos, Jose R.
Guaynabo, PR

REGENCY 4

FEDERAL SERVICES SECTION

Pachuta, Stephen
Alexandria, VA

INDIANA SECTION

Bagnoli, Diane D.
Lafayette, IN

Bagnoli, Michael L.
Lafayette, IN

Baumgartner, Joe A.
Nappanee, IN

Bennett, Jeffrey
Kokomo, IN

Celis, Lorraine
South Bend, IN

Derrow, Caroline W.
Auburn, IN

Ellinwood, Steven P.
Fort Wayne, IN

Herd, Sarah
Indianapolis, IN

McGue, Brian C.
Chesterton, IN

Valliere, Brenda M.
Fort Wayne, IN

Valliere, Roger P.
Fort Wayne, IN

KENTUCKY SECTION

Bobrowski, Garth D.
Greensburg, KY

Ford, Jason E.
Nicholasville, KY

German, Daniel S.
Dayton, OH

Jacobi, Joseph
Louisville, KY

Lowdenback, Clifford J.
Lexington, KY

McCarty, Joseph S.
Hartford, KY

Piontek, Dennis G.
Louisville, KY

Price, Dennis R.
Louisville, KY

Ransdell, James E.
Louisville, KY

MICHIGAN SECTION

Bander, Samuel T.
Grand Rapids, MI

Bartoszewicz, Leonard J.
Grand Rapids, MI

Conlon, Steven M.
Grand Rapids, MI

Fontana, Margherita R.
Ann Arbor, MI

Halk, Gerald
Sterling Heights, MI

Hoelscher, Diane C.
Detroit, MI

Kashani, Nahid
Detroit, MI

Maxson, Gregory M.
Lansing, MI

Monroy, Phillip G.
Port Huron, MI

Peters, Michael K.
East Lansing, MI

Soto, Lisandra
Portage, MI

Taichman, Russell S.
Ann Arbor, MI

Tremblay, Robert L.
Huntington Woods, MI

Vruggink, Seth A.
Grand Haven, MI

OHIO SECTION

Halasz, Michael H.
Kettering, OH

Kimberly, David R.
Akron, OH

Mueller, Elizabeth S.
Mason, OH

ONTARIO SECTION

Abbaszadeh, Keyvan
London, ON

Caldwell, Rick
New Liskeard, ON

Goren, Steve A.
Toronto, ON

Hornyak, Michael J.
Strathroy, ON

Panomitros, Nicholas E.
Chicago, IL

Patrician, Michael W.,
Toronto, ON

Pynn, Bruce R.
Thunder Bay, ON

Quinonez, Carlos R.
Toronto, ON

Rayman, Richard
Toronto, ON

Selnes, J. Eric
Mississauga, ON

VanRyswyk, Karin
London, ON

Visconti, LouAnn
Timmins, ON

WEST VIRGINIA SECTION

Allen, Leonard
Charleston, WV

Anderson, Anissa M.
New Martinville, WV

Ghareeb, Steven
South Charleston, WV

Ghareeb, Mitri
Cross Lanes, WV

REGENCY 5

ILLINOIS SECTION

Amirsoltani, Shafa
Oak Park, IL

Beetstra, Stephen
Little Rock, AR

Fiandaca, Dante J.
Algonquin, IL

Gesko, David S.
Bloomington, MN

Milnarik, Ronald M.
Chicago, IL

Moon, Brenden D.
Quincy, IL

Pendleton, Darryl D.
Chicago, IL

Stornio, Salvatore A.
Arlington Heights, IL

Williams, David A.
Northbrook, IL

IOWA SECTION

Burnham, Frederick
Davenport, IA

Gagliardo, Kyle
Bettendorf, IA

KANSAS SECTION

Herzog, Mark
Ellsworth, KS

Raben, Lucynda J.
Wichita, KS

Rogers, Paul N.
Arkansas City, KS

Sams, Marquez J.
Wichita, KS

MISSOURI SECTION

Jacobson, Arnold
St. Louis, MO

Mahaffey, Darren W.
Springfield, MO

Mahaffey, Sarah L.
Springfield, MO

Riordan, Danielle M.
St. Peters, MO

Satheesh, Keerthana M.
Kansas City, MO

UPPER MIDWEST SECTION

Block, Susan E.M.
Prior Lake, MN

Dens, Kevin W.
Brainerd, MN

Foss, Jeanni R.
Baxter, MN

Mensing, Candace A.
Rochester, MN

Quick, Karin K.
Minneapolis, MN

Riggs, Sheila M.
Eagan, MN

Self, Karl D.
Minneapolis, MN

Stenberg, Donna J.
Stillwater, MN

Thierer, Todd E.
Minneapolis, MN

Zettler, Melissa S.
Savage, MN

WISCONSIN SECTION

Hagner, Richard J.
New Berlin, WI

Levine, Paul S.
Milwaukee, WI

Ruff, Jesley
Milwaukee, WI

REGENCY 6

ARKANSAS SECTION

Buffington, April
West Memphis, AR

Chase, Timothy
Monticello, AR

Hopper, Alisa
Monticello, AR

Isbell, Thomas
Mountain View, AR

Liggett, Charles
Fort Smith, AR

Tortorich, Anthony L.
Little Rock, AR

LOUISIANA SECTION

Bennett, Donald P.
New Orleans, LA

Cavallino, Claudia A.
New Orleans, LA

Dubroc, Glenn C.,
Harvey, LA

MISSISSIPPI SECTION

Brown, Eugene
Jackson, MS

Herrington, John Eric,
Meridian, MS

Hollingsworth, James W.
Newton, MS

Qaisi, Mohammad
Jackson, MS

Roberson, John B.
Hattiesburg, MS

Zakkak, Thomas
Biloxi, MS

Broermann, Jeffrey G.
Tulsa, OK

Bryan, Robert B.
Oklahoma City, OK

OKLAHOMA SECTION

Fox Broermann, Sarah
Tulsa, OK

Griffin, Shannon I.
Edmond, OK

Henry, Blake R.
Tulsa, OK

Hunter, Nicholas S.
Tulsa, OK

Littlefield, C. Wayne
Lawton, OK

Lopez, Juan R.
Lawton, OK

Masood, Farah
Oklahoma City, OK

Mullasseril, Paul M.
Oklahoma City, OK

Pierce, Jeffrey C.
Alva, OK

Wooten, Craig A.
Oklahoma City, OK

TENNESSEE SECTION

Chacko, Danny
Oneida, TN

Kennedy, Johnny D.
Athens, TN

Reynolds, John A.
Franklin, TN

Watson, Hope E.
Maryville, TN

Young, Stanley P.
Dyersburg, TN

TEXAS SECTION

Archer, Richard D.
Midlothian, VA

Bonner, David M.
Dumas, TX

Cohen, Donald
Houston, TX

DePeralta, Alex A.
San Antonio, TX

Elmore, Brooke L.
Belton, TX

Graves, Cody C.
Goldthwaite, TX

Graves, Tom
Goldthwaite, TX

Hayes, Leslie
Bozeman, MT

Hoskin, Eileen R.
South Orange, NJ

James, Misti P.
Austin, TX

Janik, Andrea K.
San Antonio, TX

Johnson, Janice R.
Mount Joy, PA

Owen, Glenda G.
Houston, TX

Smith, Carmen P.
Dallas, TX

REGENCY 7

ARIZONA SECTION

Rolf, David D.,
Glendale, AZ

Smith, P. Bradford
Glendale, AZ

CALIFORNIA SECTION

Call, Donald R.
Sunnyvale, CA

Casey, Diane E.
Sunnyvale, CA

Daft, Kent S.
Sacramento, CA

Gulabivala, Kishor
London, CA

McClurkin, Veronical
Corona, CA

NORTHERN CALIFORNIA SECTION

Patel, Hema D.
Fremont, CA

Pisacane, John M.
San Jose, CA

Rothman, David L.
San Francisco, CA

Santucci, Noelle M.
Redwood City, CA

Weatherholt, Carey B.
San Jose, CA

SOUTHERN CALIFORNIA SECTION

Allen, John M.
Pomona, CA

Arcan, Simona C.
Huntington Beach, CA

Goldasich, Cheryl D.
Torrance, CA

Gonzalez-Balut, Mauricio
Del Valle, CA

Green, Richard S.
Moorpark, CA

Hanlon, Robert J.
Escondido, CA

Hasse, Charles D.
Newport Coast, CA

Hochman, Mark N.
Great Neck, NY

Lee, Dora
Los Alamitos, CA

Lukacs, Linda A.
La Mesa, CA

Smith Norman, Ravipan I.
Seal Beach, CA

REGENCY 8

BRITISH COLUMBIA SECTION

Baird, David W.R.
Sydney, BC

Chang, Greg
Surrey, BC

Emanuels, Ingrid
Surrey, BC

Gould, Timothy
Vancouver, BC

Hung, John T.W.
Burnaby, BC

Lim, David D.
Langley, BC

Remtulla, Farah
Vancouver, BC

Tsang, Phoebe W.Y.
Richmond, BC

COLORADO SECTION

Fuller, Diane
Denver, CO

Morrow, Carol
Walsh, CO

MONTANA SECTION

Hirt, Christopher A.
Billings, MT

Nybo, Norman T.
Bozeman, MT

OREGON SECTION

Barnard, Peter D.
St. Leonards, NSW

Beck, Todd
Portland, OR

Bettger, Athena
Portland, OR

Magnuson, Norman D.
Eugene, OR

Reddicks, Jeffery E.
Tigard, OR

Sunseri, Frances A.
Happy Valley, OR

UTAH SECTION

Poulson, Daniel S.
Cottonwood Heights, UT

WASHINGTON SECTION

Block, Lisa A.
Gig Harbor, WA

Morris, Darcie L.
Mount Vernon, WA

Warner, Danny G.
Camas, WA

WESTERN CANADA SECTION

Hodinsky, Larry K.
St. Paul, AB

ABSENTIA

Goren, Steve A.
Toronto, ON

Ethics Codes

INTRODUCTION

2016 will be the 150th anniversary of the American Dental Association's first code of ethics.

Some of the essential elements of the 1865 code read as though they were written yesterday. The concerns for misleading advertising, avoiding unjustifiable criticism of colleagues, upholding the general dignity of the profession, and obligation to return patients who have been referred for consult have been sustained concerns in the profession. Some things have changed. It is no longer legal to engage in price-fixing, as recommended in the first code, and dentistry is no longer considered to be a branch of medicine. The relationship between senior and junior members of the profession is called out for special attention, with mutual responsibilities identified on both sides.

But there are some subtle differences in language that must be understood in the two different contexts, separated by a century and a half. We must be careful about assuming that common words have identical meanings. Dentists 150 years ago were expected to avoid the "spirit of empiricism." This will rest uncomfortably on twenty-first century ears. Empiricism, what we would call evidence-based practice today, was disdained by professionals generations ago. The fact that a method or material had been shown to work was a dubious compliment. On the other hand, "gentleman" and "scientist" were cognate. Today, students from all over the world vie to get into American

universities, especially in graduate programs. In the nineteenth century, one was set apart by means of a German education. *Wissenschaft*, which we translate as science, was the essence of higher education. It meant disciplined inquiry. Philosophers and those who translated the Bible, as well as physicists, were scientists.

In Cambridge, the student organization that hosts weekly lectures given by famous scholars is called the The Moral Sciences Club. They discuss much more than ethics and anything based on the observation of data would be considered queer—another term whose meaning has shifted dramatically.

Perhaps the most striking aspect of the first ethics code of the American Dental Association is the centrality of being a gentleman. Reputation counted for much. Virtually the only specific behaviors enjoined involve the relationship between one dentist and another, sometimes the public at large, and very rarely the patient. There was no particular admonition to treat the patient effectively. Today we assume that the medical arts are built on proven restorative and even preventive interventions. That is an accomplishment achieved in the past century, and largely attributable to partnerships between the professions and research and industry. Like most of medicine, dentistry in the year of the first ADA code of ethics was essentially palliative. Hence demeanor, including the advice to be "condescending to patients," played a critical function in identifying the true professional.

The code of 150 years ago urged that dentists exhibit "moral rectitude and purity of character." Compared with the pioneers of the profession, dentists today balance a vastly larger and more effective set of interventions for patients with elevated expectations from society, standards of care and clinical guidelines, and rules and regulations. Dentists literally are expected to do more. But the foundation was laid many years ago, not on what dentists do, but on who they are.

The current ADA Principles of Ethics and Code of Professional Conduct can be found at www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct.

The first code is followed in these pages by an address to the American Dental Association in 1865, the year before the code was adopted. In this presentation, Dr. John Allen of Brooklyn, New York, made the case for a code and provided some useful context.

Virtually every organization, including many for-profit businesses, have codes. There are scores of them in dentistry and the groups that the profession interacts with. A sample has been assembled here that includes the American College of Dentists, the American Student Dental Association, the American Dental Education Association, the American Dental Hygiene Association, the Association of Dental Service Organizations, and selections from the American Medical Association code. ■

Code of Dental Ethics (1866)

ARTICLE I.

THE DUTIES OF THE PROFESSION TO THEIR PATIENTS.

SECTION 1. The dentist should be ever ready to respond to the wants of his patrons, and should fully recognize the obligations involved in the discharge of his duties toward them. As they are, in most cases, unable to correctly estimate the character of his operations, his own sense of right must guarantee faithfulness in their performance. His manner should be firm, yet kind and sympathizing, so as to gain the respect and confidence of his patients; and even the simplest case committed to his care should receive that attention which is due to any operation performed on living, sensitive tissue.

SECT 2. It is not to be expected that the patient will possess a very extended or a very accurate knowledge of professional matters. The dentist should make due allowance for this, patiently explaining many things which may seem quite clear to himself, thus endeavoring to educate the public mind so that it will properly appreciate the beneficent efforts of our profession. He should encourage no false hopes, by promising success where, in the nature of the case, there is uncertainty.

SECT 3. The dentist should be temperate in all things, keeping both mind and body in the best possible health, that his patient may have the benefit of that clearness of judgment and skill which is their right.

ARTICLE II.

MAINTAINING PROFESSIONAL CHARACTER.

SECTION 1. A member of the dental profession is bound to maintain its honor, and to labor earnestly to extend its sphere of usefulness. He should avoid everything in language and conduct calculated to discredit or dishonor his profession, and should ever manifest a due respect for his brethren. The young should show special respect to their seniors; the aged special encouragement to their juniors.

SECT 2. The person and office arrangements of the dentist should indicate that he is a gentleman; and he should sustain a high-toned moral character.

SECT 3. It is unprofessional to resort to public advertisements, cards, handbills, posters, or signs calling attention to particular styles of work, lowness of prices, special modes of operating, or to claim superiority over neighboring practitioners, to publish reports of cases, or certificates in public print, to go from house to house to solicit or perform operations, to circulate or recommend nostrums, or to perform any other similar acts.

SECT 4. When consulted by the patient of another practitioner, the dentist should guard against inquiries or hints disparaging to the family dentist, or calculated to weaken the patient's confidence in him, and if the interests of the patient will not be endangered thereby, the case should be temporarily treated, and referred back to the family dentist.

SECT 5. When general rules shall have been adopted by members of the profession practicing in the same localities, in relation to fees, it is unprofessional and dishonorable to depart from these rules, except when variation of circumstances require it. And it is ever to be regarded as unprofessional to warrant operations or work as an inducement to patronage.

ARTICLE III.

THE RELATIVE DUTIES OF DENTIST AND PHYSICIANS.

Dental surgery is a specialty in medical science. Physicians and dentists should both bear this in mind. The dentist is professionally limited to diseases of the dental organs and the mouth. With these he should be more familiar than the general practitioner is expected to be; and while he recognizes the superiority of the physician, in regard to diseases of the general system, the latter is under equal obligations to respect his higher attainments in his specialty. Where this principle governs, there can be no conflict, or even diversity of professional interests.

ARTICLE IV.

THE MUTUAL DUTIES OF THE PROFESSION AND THE PUBLIC.

Dentists are frequently witnesses, and at the same time the best judges, of the impositions perpetrated by quacks, and it is their duty to enlighten and warn the public regarding them. For this and the many other benefits conferred by the competent and honorable dentists, the profession is entitled to the confidence and respect of the public, who should always discriminate in favor of the true man of science and integrity, and against the empiric and imposter. The public has no right to tax the time and talents of the profession in examinations, prescriptions, or in any way without proper remuneration.

A CODE OF DENTAL ETHICS FOR THE AMERICAN DENTAL ASSOCIATION

ADDRESS TO THE AMERICAN DENTAL ASSOCIATION ANNUAL MEETING, 1865

J. Allen, DDS

As a learned profession, the time has come when a more elevated position should be taken and maintained by its members than has heretofore been observed. As one of the means of accomplishing this object, we believe that by adopting for our guide a proper code of dental ethics, defining the position, rank, and duties of the dental profession, important interest to ourselves and to the community at large will be promoted.

1st.

As a body, dentists should take a high and honorable position, and do all in their power to maintain it.

Each member should consider himself an integral part of the profession, and endeavor as far as he can to extend its usefulness and sustain its dignity.

A truthful, respectful, and gentlemanly deportment should be strictly observed by each one towards all the other members; and in our intercourse with others, all remarks designed to reflect discredit upon our profession, as a body, should be carefully avoided. This deportment towards each other would command the respect and admiration of the community at large, and evoke that esteem which a generous public is ever ready to accord to true merit, whether in individuals or organized bodies. But if dentists themselves do not look upon their own profession with deference and respect, how can they expect others to do so?

We hold this matter in our own hands, and can either take a position so high that others will look up to it with commendation, or so low as to be looked down upon with contempt.

With reference to moral rectitude and purity of character, there is, perhaps, no profession in which a higher standard is required of its members than ours, for without these essential requisites a member cannot command the respect and confidence of other dentists, nor of the community in which he lives; for no other attainments can compensate for a want of gentlemanly deportment and correct moral principles. Each member should be strictly temperate in all things, for the dentist requires a clear head, a good eye, a steady hand, an acute perception, and sound judgment. These requisites, together with other commensurate qualification, constitute the basis for a practitioner of dental surgery. And those who stand upon this platform, and maintain their position, are justly entitled to the confidence, respect, and professional courtesies which are justly their due. Again, there are also those who are young in their pursuits earnestly striving to take their places among this class of dentists, to whom the utmost kindness and respect should be shown by the older members of the profession. This demeanor towards them by their seniors would tend to inspire them with ambition, and strengthen them in their efforts to ascend the hill of science.

2d.

Our duties to each other require that in all our social and professional gatherings we should observe strict decorum, and proper respect for each other. And in debate all personalities and sarcastic remarks should be avoided; each speaker should keep in view only the points

involved in the discussion, and speak of principles, not of men. We should cultivate a respectful regard for the opinions of others; and in replying to what may have been said in debate, let it be done in a gentle, courteous manner.

3d.

Dentists are sometimes dependent upon each other for professional aid; and when such occasions occur, no charge should be made except for the expense incurred.

If, however, an honorarium be offered by an affluent member it should not be declined, especially if the circumstances would seem to justify its acceptance.

4th.

A dentist sometimes finds it necessary to request some of his professional brethren to officiate for him temporarily. Compliance with this request is an act of courtesy which should be performed with due regard for the interests and character of the dentist employed. In such cases, pecuniary considerations should be awarded, either by the dentist requiring such service, or by the patient, as the circumstances may dictate.

5th.

In consultations, all due respect should be shown the dentist having charge of the case; and no rivalry or jealousy should be indulged. If the case involves obscurity or doubt, no discussion should be held before the patient or his friends; but those in consultation should retire for deliberation, and the result of such consultation should be communicated to the patient by the regular attending dentist. The consulting dentist should carefully avoid any extra attentions or apparent solicitude, beyond what he is called upon to extend to the patient, lest his manner should have the appearance of artifice or intrigue.

No insinuations should be thrown out, that would tend to prejudice the patient against the dentist in charge, for what may have been done; but the previous course pursued should be justified as far as candor and truth will permit, for it often happens that patients become dissatisfied when there is no cause for it. The want of immediate success, to the extent the patient may have expected, is no evidence of a lack of professional knowledge or skill on the part of the dentist.

6th.

With reference to pecuniary considerations for services rendered, there should be some general rules adopted by the State or local societies; and it should be deemed a point of honor to adhere to those rules with as much uniformity as varying circumstances will permit. And it shall be held derogatory to the dignity of a dentist to advertise to do work for half price, or in any way to underrate the value of good operations, for it betrays a spirit of empiricism which should not be tolerated by our profession.

In short, there are many little courtesies and marks of respect due to our patients, which should be observed, and which distinguish the gentleman from the low-bred man.

With reference to moral rectitude and purity of character, there is, perhaps, no profession in which a higher standard is required of its members than ours, for without these essential requisites a member cannot command the respect and confidence of other dentists, nor of the community in which he lives; for no other attainments can compensate for a want of gentlemanly deportment and correct moral principles.

7th.

We believe that experience has proven clearly that patents in the dental profession do not advance its best interests, nor the interest of those obtaining them; and that, as a body, we should adopt some other, more appropriate plan for the encouragement of those who are disposed to bring before the profession valuable improvements.

8th.

There are certain rules of deportment which dentists should observe toward their patients. They should unite gentleness with firmness, and condescension with decision, in such a manner as to secure the respect and confidence of their patrons. This will commend also a like respect from others.

Reasonable indulgence should be granted to patients who are capricious or nervous, and cannot control themselves while in the dental chair. The constitutional diathesis of many persons may be such that weakness and imbecility take the place of strength and firmness of purpose.

9th.

Dentists should refrain from speaking of operations they may have performed for the distinguished Mrs. C., the Honorable Mr. D., or the Right Rev. Mr. B., in a boastful manner, for it is unprofessional, and, besides, those persons may feel a delicate sensibility about such matters, and would rather reveal their own personal affairs (if need be), than have others do it for them.

In short, there are many little courtesies and marks of respect due to our patients, which should be observed, and which distinguish the gentleman from the low-bred man.

10th.

In return for the honorable discharge of our professional duties to each other, and to those who become the recipients of our best efforts to serve them, we are justly entitled to a due appreciation of dental qualifications from the public, and a proper discrimination between the truly scientific operator and the ignorant pretender; and we will also be entitled to aid and encouragement in building up institutions for dental education; for in this the public are mutually interested with the profession.

There are those to whom these rules will not apply; for they have no aspirations for eminence, but seem content to be drones; and they take their position outside of the profession, and persistently remain there. This class of men can claim only the respect and consideration due to their rank, for their career is generally derogatory to the character of gentlemen, and the profession proper are not under any fraternal obligations to them.

But those who are accredited members of our profession, will promote its interests, dignity and honor, by adopting as their guide a self-digested code of ethics.

AMERICAN College of DENTISTS

STANDARDS of ETHICAL CONDUCT

The dental profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of the profession, a Fellow must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The following are not laws but standards of conduct which define the essentials of honorable behavior for a Fellow in the American College of Dentists.

1. A Fellow shall be dedicated to providing competent oral health service with compassion and respect for human dignity.
2. A Fellow shall be honest with patients and colleagues and appropriately report those who are deemed to be incompetent or engaged in fraud or deception.
3. A Fellow shall respect the rights of patients, colleagues, other health professionals, and society.
4. A Fellow shall continue to study, apply, and seek truth in the advancement of scientific knowledge and to make relevant information available to patients, colleagues, and society.
5. A Fellow shall responsibly participate in activities contributing to an improved community, profession, and society.
6. A Fellow shall act in a fair, just, and equitable manner.
7. A Fellow shall possess personal and professional integrity and act as a trustworthy and responsible citizen.

CORE VALUES

The core values represent a guide for ethical behavior for Fellows of the ACD and are the foundation from which the principles are derived. The core values collectively reflect the character, charter, and mission of the ACD. The ACD identifies the following as core values (in alphabetical order):

AUTONOMY

Patients have the right to determine what should be done with their own bodies. Because patients are moral entities they are capable of autonomous decision-making. Respect for patient autonomy affirms this dynamic in the doctor-patient relationship and forms the foundation for informed consent, for protecting patient confidentiality, and for upholding veracity. The patient's right to self-determination is not, however, absolute. The dentist must also weigh benefits and harms and inform the patient of contemporary standards of oral health care.

BENEFICENCE

Beneficence, often cited as a fundamental principle of ethics, is the obligation to benefit others or to seek their good. While balancing harms and benefits, the dentist seeks to minimize harms and maximize benefits for the patient. The dentist refrains from harming the patient by referring to those with specialized expertise when the dentist's own skills are insufficient.

COMPASSION

Compassion requires caring and the ability to identify with the patient's overall well-being. Relieving pain and suffering is a common attribute of dental practice. Acts of kindness and a sympathetic ear for the patient are all qualities of a caring, compassionate dentist.

COMPETENCE

The competent dentist is able to diagnose and treat the patient's oral health needs and to refer when it is in the patient's best interest. Maintaining competence requires continual self-assessment about the outcome of patient care and involves a commitment to lifelong learning. Competence is the just expectation of the patient.

INTEGRITY

Integrity requires the dentist to behave with honor and decency. The dentist who practices with a sense of integrity affirms the core values and recognizes when words, actions, or intentions are in conflict with one's values and conscience. Professional integrity commits the dentist to upholding the professions' Codes of Ethics and to safeguarding, influencing, and promoting the highest professional standards.

JUSTICE

Justice is often associated with fairness or giving to each his or her own due. Issues of fairness are pervasive in dental practice and range from elemental procedural issues, such as who shall

receive treatment first, to complex questions of who shall receive treatment at all. The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice.

PROFESSIONALISM

Self-governance is a hallmark of a profession, and dentistry will thrive as long as its members are committed to actively support and promote the profession and its service to the public. The commitment to promoting oral health initiatives and protecting the public requires that the profession work together for the collective best interest of society.

TOLERANCE

Dentists are challenged to practice within an increasingly complex cultural and ethnically diverse community. Conventional attitudes regarding pain, appropriate function, and esthetics may be confounded by these differences. Tolerance to diversity requires dentists to recognize that these differences exist and challenges dentists to understand how these differences may affect patient choices and treatment.

VERACITY

Veracity, often known as honesty or truth telling, is the bedrock of a trusting doctor-patient relationship. The dentist relies on the honesty of the patient to gather the facts necessary to form a proper diagnosis. The patient relies on the dentist to be truthful so that truly informed decision-making can occur. Honesty in dealing with the public, colleagues and self are equally important.

ASPIRATIONAL STATEMENTS OF THE CORE VALUES

The central aspiration of the American College of Dentists is that all members practice their profession in an ethical manner. The American College of Dentists identifies the following as aspirational statements of the core values (in alphabetical order):

AUTONOMY

A Fellow of the ACD recognizes the dignity and intrinsic worth of individuals and their right to make personal choices.

BENEFICENCE

A Fellow of the ACD acts in the best interests of patients and society even when there is conflict with the dentist's personal self-interest.

COMPASSION

A Fellow of the ACD is sensitive to, and empathizes with, individual and societal needs for comfort and help.

COMPETENCE

A Fellow of the ACD strives to achieve the highest level of knowledge, skill, and ability within his or her capacity.

INTEGRITY

A Fellow of the ACD incorporates the core values as the basis for ethical practice and the foundation for honorable character.

JUSTICE

A Fellow of the ACD treats all individuals and groups in a fair and equitable manner and promotes justice in society.

PROFESSIONALISM

A Fellow of the ACD is committed to involvement in professional endeavors that enhance knowledge, skill, judgment, and intellectual development for the benefit of society.

TOLERANCE

A Fellow of the ACD respects the rights of individuals to hold disparate views in ethics discourse and dialogue and recognizes these views may arise from diverse personal, ethnic, or cultural norms.

VERACITY

A Fellow of the ACD values truthfulness as the basis for trust in personal and professional relationships.

AMERICAN STUDENT DENTAL ASSOCIATION

Code of Ethics

The right of a dentist to professional status rests in the knowledge, skill, and experience with which she/he serves her/his patients and society. Every dentist should strive to continuously improve his/her knowledge of ethics in order to help achieve higher levels of patient care. These foundational ethical values will serve as a guideline throughout the dentist's career, from predoctoral student to fully credentialed professional.

The American Student Dental Association (ASDA) recognizes the importance of high ethical standards in the dental school setting. Therefore, the association believes students should conduct themselves in a manner reflecting integrity and fairness in both the didactic and clinical learning environments. The code outlined below relates most directly to the dental school environment. To gain a more expansive understanding of ethics in practice, please see the ADA.

Code of Ethics

The following is the American Student Dental Association Code of Ethics:

I. Dental Student conduct

- A. All dental students are obligated to maintain high standards of moral and ethical behavior and to conduct themselves in a professional manner at all times. This applies to the classroom, clinic, laboratory, and other institutional facilities; externships, community service, or meetings of professional organizations.
- B. Ethical and professional behavior by dental students is characterized by honesty, fairness, and integrity in all professional circumstances; respect for the rights, differences, and property of others; concern for the welfare of patients, competence in the delivery of care, and preservation of confidentiality in all situations where this is warranted.
- C. All dental students are obligated to report unethical activity and violations of the honor code to the appropriate body at the school.

II. Patient Autonomy ("self-governance")

- A. Informed Consent and Refusal
 1. Students should conduct a thorough discussion with every patient. This must be repeated

whenever there are substantive changes or additions to the treatment plan. Discussion should include:

- a. Diagnoses
- b. Treatment plan
- c. Prognosis
- d. Risks/benefits
- e. Alternatives

The discussion should be in understandable terms and enable a reasonable person in the patient's position to make an informed decision regarding care, except in emergencies, when risks are unknown, commonly known or the patient waives the right to disclosure.

2. Students should inform the patient of the consequences of not accepting treatment. The patient has a right to an informed refusal which should be honored by the student.
3. The student should make sure to allow time to answer any and all questions the patient may have to the best of his/her ability.

B. Patient Confidentiality

1. Students should follow HIPAA guidelines.

III. Nonmaleficence (“do no harm”) and beneficence (“do good”)

- A. The student should conduct him/herself with veracity (truthfulness). He/she should always act in a manner that promotes the welfare of patients and avoids harm to the patient.
- B. Treatment plans should be determined according to patient needs as opposed to unmet requirements of the student.
- C. No procedures should be started without instructor authorization, and all procedures should be evaluated by the instructor upon completion.
- D. Referrals to residents, specialists, or staff members should be made when the complexity of the case exceeds the student’s ability to meet the standard of care. The referring student should inform the patient who will be responsible for dental maintenance and the reason for referral.

- E. Students should exercise discretion in treating family members due to problems associated with medical history disclosure, confidentiality, objectivity, and professionalism.
- F. Students are encouraged to participate in community outreach programs in order to improve the dental health of the public.
- G. Students should advocate access to care for patients who are unable to receive care due to physical or mental disability or financial hardship.

IV. Justice (“fairness”)

- A. Ethnicity, religion, sex, sexual orientation, age, national origin, disability, or infectious disease status should not influence whether or not a patient is accepted by a student to receive care. Furthermore, all patients should be treated with the same level of compassion, kindness, and respect.
- B. Students must not discriminate against patients in high-risk behavior groups.
- C. The student should not cheat, plagiarize, forge, or falsify official records, patient charts, or examinations.

- D. The student should not participate in activities involving theft and/or vandalism of school or student property.
- E. Sexual harassment between colleagues, between health care provider and patient, and between students and faculty or residents is unacceptable and must be reported.
- F. Students must report suspected abuse/neglect of patients to an appropriate instructor.
- G. Students should exercise respect when working with human cadavers.
- H. Controlled substances
 - 1. Students have the responsibility of protecting the integrity of the profession by reporting any suspicions of unethical behavior.
 - 2. Students must never perform dental procedures while in an impaired condition, regardless of the source of the impairment.

V. All members of the American Student Dental Association must comply with the ASDA Code of Ethics.

AMERICAN DENTAL EDUCATION ASSOCIATION

STATEMENT ON PROFESSIONALISM IN DENTAL EDUCATION

The American Dental Education Association (ADEA) is committed to developing and sustaining institutional environments within the allied, predoctoral, and postdoctoral dental education community that foster academic integrity and professionalism.

The ADEA Task Force on Professionalism in Dental Education was charged by the ADEA Board of Directors with the development of an ADEA Statement on Professionalism in Dental Education for the dental education community. All seven ADEA Councils endorsed this effort and were represented on the Task Force. Through its work, the Task Force sought to identify and clarify those personal and institutional values and behaviors that support academic integrity and professionalism in dental education and that are aligned with the existing values and codes of the dental, allied dental, and higher education professions.

The Task Force acknowledges and respects that each academic dental education institution has its own unique culture, institutional values, principles and processes, and in some cases, codes of conduct for institutional members. The ADEA Statement on Professionalism in Dental Education is not intended to replace or supersede these codes.

The Task Force hopes that this ADEA Statement on Professionalism in Dental Education stimulates broad discussions about professional behavior in dental education, provides guidance for individual and institutional behavior within dental education, and in so doing supports professionalism across the continuum of dental education and practice.

VALUES DEFINING PROFESSIONALISM IN DENTAL EDUCATION

The Task Force identified and developed the following six values-based statements defining professionalism in dental education:

Competence: Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

Fairness: Demonstrating consistency and even-handedness in dealings with others.

Integrity: Being honest and demonstrating congruence between one's values, words, and actions.

Responsibility: Being accountable for one's actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

Respect: Honoring the worth of others.

Service-mindedness: Acting for the benefit of the patients and the public we serve, and approaching those served with compassion.

A discussion of each of these values follows and includes a more full definition of each value and a description of the behaviors that enactment of the value requires and to which all members of the dental education community can aspire.

In developing the ADEA Statement on Professionalism in Dental Education, the Task Force sought to align the statement with existing codes of ethics and conduct within the allied, predoctoral, and postdoctoral dental communities. To illustrate the continuity of these values between the dental education community and the practicing community, the discussion of each value includes a reference to the ethical principles espoused by the American Dental Association (ADA Principles of Ethics and Code of Professional Conduct) and the American Student Dental Association (ASDA Student Code of Ethics), and the values expressed in the American Dental Hygienists' Association's Code of Ethics for Dental Hygienists.

Finally, examples of how the value applies to different constituencies within the dental education community are provided.

DETAILED DEFINITIONS OF THE SIX VALUES

COMPETENCE

Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

Expanded Definition: Encompasses knowledge of oral health care (having acquired the unique knowledge, skills, and abilities required for effective provision of clinical care to patients); knowledge about how people learn and skills for effective pedagogy (including developing curriculum and assessments); knowledge of ethical principles and professional values; lifelong commitment to maintain skills and knowledge; modeling appropriate values as both an educator and a dental professional; developing ability to communicate effectively with patients, peers, colleagues, and other professionals; recognizing the limits of one's own knowledge and skills (knowing when to refer); and recognizing and acting upon the need for collaboration with peers, colleagues, allied professionals, and other health professionals. Includes recognizing the need for new knowledge (supporting biomedical, behavioral, clinical, and educational research) and engaging in evidence-based practice.

Alignment with:

ADA Principles of Ethics: Beneficence and nonmaleficence

ADHA Code for Dental Hygienists: Beneficence and nonmaleficence

ASDA Student Code of Ethics: Nonmaleficence and beneficence

Examples:

1. For students: Learning oral health care is a top priority. Develop the habits and practices of lifelong learning, including self-assessment skills. Accept and respond to fair negative feedback about your performance (recognize when you need to learn). Learn and practice effective communication skills. Know the limits of your knowledge and skills and practice within them; learn when and how to refer.
2. For faculty: Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development in oral health care and pedagogy. Ensure curricular materials are current and relevant. Model effective interactions with patients, colleagues, and students; accept and respond to constructive criticism about your performance (recognize when you need to learn). Know the limits of your skills and practice within them; model how and when to refer; acknowledge and act on the need for collaboration.
3. For researchers: Generate new knowledge. Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development. Model effective interactions with patients, colleagues, and students; accept and respond to fair negative feedback about your performance (recognize when you need to learn).
4. For administrators and institutions: Set high standards. Learn and practice effective self-assessment skills; accept and respond to fair negative feedback (recognize the need for institutional learning and address it); acknowledge and act on the need for collaboration. Support the learning needs of all members

of the institution and encourage them to pursue lifelong learning.

FAIRNESS

Demonstrating consistency and evenhandedness in dealings with others.

Expanded Definition: Encompasses consideration of how to best distribute benefits and burdens (to each an equal share, to each according to need, to each according to effort, to each according to contribution, to each according to merit are some of the possible considerations); encompasses evenhandedness and consistency; includes setting process standards, striving for just consideration for all parties, ensuring consistency in application of process (following the rules) while recognizing that different outcomes are possible, transparency of process, and calibration; consistent, reliable, and unbiased evaluation systems; commitment to work for access to oral health care services for underserved populations.

Alignment with:

ADA Principles of Ethics: Justice, beneficence, nonmaleficence

ADHA Code for Dental Hygienists: Justice and fairness, beneficence, nonmaleficence

ASDA Student Code of Ethics: Justice, nonmaleficence and beneficence

Examples:

1. For students: Follow institutional rules and regulations. Promote equal access to learning materials for all students and equal access to care for the public.
2. For faculty: Use appropriate assessment and evaluation methods for students; view situations from multiple perspectives, especially those that require evaluation;

provide balanced feedback to students, colleagues, and the institution. Use evidence-based practices. Promote equal access to oral health care.

3. For researchers: Set high standards for the conduct of research and use unbiased processes to assess research outcomes. Generate data to support evidence-based practice and education.
4. For administrators and institutions: Set high standards and ensure fair, unbiased assessment and evaluation processes for all members of the institution, including applicants to educational programs. Ensure that institutional policies and procedures are unbiased and applied consistently; ensure transparency of process. Provide leadership in promoting equal access to care for the public.

INTEGRITY

Being honest and demonstrating congruence between one's values, words, and actions.

Expanded Definition: Encompasses concept of wholeness and unity; congruence between word and deed; representing one's knowledge, skills, abilities, and accomplishments honestly and truthfully; devotion to honesty and truthfulness, keeping one's word, meeting commitments; dedication to finding truth, including honesty with oneself; willingness to lead an examined life; willingness to engage in self-assessment and self-reflection; willingness to acknowledge mistakes; commitment to developing moral insight and moral reasoning skills; recognizing when words, actions, or intentions are in conflict with one's values and conscience and the willingness to take corrective action; dedication and commitment to

excellence (requires more than just meeting minimum standards), making a continual conscientious effort to exceed ordinary expectations; encompasses fortitude, the willingness to suffer personal discomfort, inconvenience, or harm for the sake of a moral good.

Alignment with:

ADA Principles of Ethics:

Beneficence, nonmaleficence, and veracity

ADHA Code for Dental Hygienists:

Beneficence, nonmaleficence, and veracity

ASDA Student Code of Ethics:

Nonmaleficence and beneficence, dental student conduct

Examples:

1. For students: Strive for personal and professional excellence. Take examinations honestly; make entries in patients' records honestly.
2. For faculty: Strive for personal and professional excellence in teaching, practice, research, or all of these. Represent your knowledge honestly.
3. For researchers: Strive for personal and professional excellence. Report research outcomes honestly.
4. For administrators and institutions: Strive for personal, professional, and institutional excellence. Use appropriate outcomes measures and acknowledge openly when improvements need to be made. Ensure institutional systems and structures are honest, open, and respectful and do not create undue conflicts.

Responsibility

Being accountable for one's actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

Expanded Definition: Encompasses the concepts of obligation, duty, and accountability; requires an appreciation of the fiduciary relationship (a special relationship of trust) between oral health professionals and patients, and the profession and society. Accountability requires fulfilling the implied contract governing the patient-provider relationship as well as the profession's relationship to society; includes standard setting and management of conflicts of interest or commitment as well as meeting one's commitments and being dependable. It requires striking a morally defensible balance between self-interest and the interest of those who place their trust in us, our patients and society; keeping one's skills and knowledge current and a commitment to lifelong learning; and embracing and engaging in self-regulation of the profession, including peer review and protecting from harm those who place their trust in us.

Alignment with:

ADA Principles of Ethics: Beneficence and nonmaleficence

ADHA Code for Dental Hygienists: Beneficence and nonmaleficence

ASDA Student Code of Ethics: Nonmaleficence and beneficence

Examples:

1. For students: Meet commitments; complete assignments on time; make your learning a top priority. Acknowledge and correct errors; report misconduct and participate in peer review.
2. For faculty: Continuously improve as a teacher; stay current; set high standards. Respect time

commitments to others; be available to students when assigned to teach; meet commitments. Acknowledge and correct errors; report and manage conflicts of interest or commitment. Ensure that all patient care provided is in the best interest of the patient; ensure that patient care provided is appropriate and complete; protect students, patients, and society from harm. Report misconduct and participate in peer review.

3. For researchers: Know and practice the rules and regulations for the responsible conduct of research; stay current. Meet commitments; report and manage conflicts of interest or commitment; report scientific misconduct and participate in peer review.
4. For administrators and institutions: Continuously improve as administrators. Use appropriate institutional outcomes assessments and continuously improve institutional systems and processes; acknowledge and correct errors. Report misconduct and support institutional peer review systems.

RESPECT

Honoring the worth of others.

Expanded Definition: Encompasses acknowledgment of the autonomy and worth of the individual human being and his/her belief and value system; sensitivity and responsiveness to diversity in patients' culture, age, gender, race, religion, disabilities, and sexual orientation; personal commitment to honor the rights and choices of patients regarding themselves and their oral

health care, including obtaining informed consent for care and maintaining patient confidentiality and privacy (derives from our fiduciary relationship with patients); and according the same to colleagues in oral health care and other health professions, students and other learners, institutions, systems, and processes. Includes valuing the contributions of others, inter-professional respect (other health care providers), and intraprofessional respect (allied health care providers); acknowledging the different ways students learn and appreciating developmental levels and differences among learners; includes temperance (maintaining vigilance about protecting persons from inappropriate over- or undertreatment, abandonment, or both) and tolerance.

Alignment with:

ADA Principles of Ethics: Autonomy, beneficence, and nonmaleficence

ADHA Code for Dental Hygienists: Individual autonomy and respect for human beings, beneficence, and nonmaleficence

ASDA Student Code of Ethics: Patient autonomy and nonmaleficence and beneficence

Examples:

1. For students: Develop a nuanced understanding of the rights and values of patients; protect patients from harm; support patient autonomy; be mindful of patients' time and ensure timeliness in the continuity of patient care. Keep confidences; accept and embrace cultural diversity; learn cross-cultural communication skills; accept and embrace differences. Acknowledge and support the contributions of peers and faculty.
2. For faculty: Model valuing others and their rights, particularly those of

patients; protect patients from harm; support patient autonomy. Accept and embrace diversity and difference; model effective cross-cultural communication skills. Acknowledge and support the work and contribution of colleagues; accept, understand, and address the developmental needs of learners. Maintain confidentiality of student records; maintain confidentiality of feedback to students, especially in the presence of patients and peers.

3. For researchers: Protect human research subjects from harm; protect patient autonomy. Accept, understand, and address the developmental needs of learners. Acknowledge and support the work and contributions of colleagues.
4. For administrators and institutions: Recognize and support the rights and values of all members of the institution; acknowledge the value of all members of the institution; accept and embrace cultural diversity and individual difference; model effective cross-cultural communication skills. Support patient autonomy, protect patients from harm, and safeguard privacy; protect vulnerable populations. Create and sustain healthy learning environments; ensure fair institutional processes.

SERVICE-MINDEDNESS

Acting for the benefit of the patients and the public we serve, and approaching those served with compassion.

Expanded Definition: Encompasses beneficence (the obligation to benefit others or to seek their good as well as the primacy of the needs of the patient

or the public, those who place their trust in us); the patient's welfare, not self-interest, should guide the actions of oral health care providers. Also includes compassion and empathy; providing compassionate care requires a sincere concern for and interest in humanity and a strong desire to relieve the suffering of others; empathic care requires the ability to understand and appreciate another person's perspectives without losing sight of one's professional role and responsibilities; extends to one's peers and co-workers. The expectation that oral health care providers serve patients and society is based on the autonomy granted to the profession by society. The orientation to service also extends to one's peers and to the profession. Commitment of oral health care providers to serve the profession is required in order for the profession to maintain its autonomy. The orientation to service also extends to encouraging and helping others learn, including patients, peers, and students. Dental education institutions are also expected to serve the oral health needs of society not only by educating oral health care providers, but also by being collaborators in solutions to problems of access to care.

Alignment with:

ADA Principles of Ethics: Beneficence and justice

ADHA Code for Dental Hygienists: Beneficence, justice, and fairness

ASDA Student Code of Ethics: Nonmaleficence and beneficence and justice

Examples:

1. For students: Contribute to and support the learning needs of peers and the dental profession. Recognize and act on the primacy of the well-being and the oral health needs of patients and society in all actions; provide compassionate care; support the values of the profession. Volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public.
2. For faculty: Model a sincere concern for students, patients, peers, and humanity in your interactions with all; volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public. Model recognition of the primacy of the needs of the patients and society in the oral health care setting and, at the same time, support the learning needs of students. Contribute to and support the knowledge base of the profession to improve the oral health of the public.
3. For researchers: Generate new knowledge to improve the oral health of the public; contribute to and support the learning needs of students, colleagues, and the dental profession. Model the values of and service to the dental profession and to relevant scientific and research associations; volunteer to serve the public and the profession; engage in peer review.
4. Administrators and institutions: Recognize and act on opportunities to provide oral health care for underserved populations. Encourage and support all members of the institution in their service activities; provide leadership in modeling service to the profession and the public.

AMERICAN DENTAL HYGIENE ASSOCIATION

CODE OF ETHICS FOR DENTAL HYGIENISTS

1. Preamble

As dental hygienists, we are a community of professionals devoted to the prevention of disease and the promotion and improvement of the public's health. We are preventive oral health professionals who provide educational, clinical, and therapeutic services to the public. We strive to live meaningful, productive, satisfying lives that simultaneously serve us, our profession, our society, and the world. Our actions, behaviors, and attitudes are consistent with our commitment to public service. We endorse and incorporate the code into our daily lives.

2. Purpose

The purpose of a professional code of ethics is to achieve high levels of ethical consciousness, decision making, and practice by the members of the profession. Specific objectives of the Dental Hygiene Code of Ethics are:

- To increase our professional and ethical consciousness and sense of ethical responsibility.
- To lead us to recognize ethical issues and choices and to guide us in making more informed ethical decisions.
- To establish a standard for professional judgment and conduct.
- To provide a statement of the ethical behavior the public can expect from us.

The Dental Hygiene Code of Ethics is meant to influence us throughout our careers. It stimulates our continuing study of ethical issues and challenges us

to explore our ethical responsibilities. The Code establishes concise standards of behavior to guide the public's expectations of our profession and supports dental hygiene practice, laws, and regulations. By holding ourselves accountable to meeting the standards stated in the code, we enhance the public's trust on which our professional privilege and status are founded.

3. Key Concepts

Our beliefs, principles, values, and ethics are concepts reflected in the code. They are the essential elements of our comprehensive and definitive code of ethics, and are interrelated and mutually dependent.

4. Basic Beliefs

We recognize the importance of the following beliefs that guide our practice and provide context for our ethics:

- The services we provide contribute to the health and wellbeing of society.
- Our education and licensure qualify us to serve the public by preventing and treating oral disease and helping individuals achieve and maintain optimal health.
- Individuals have intrinsic worth, are responsible for their own health, and are entitled to make choices regarding their health.
- Dental hygiene care is an essential component of overall health care and we function interdependently with other health care providers.
- All people should have access to health care, including oral health care.

- We are individually responsible for our actions and the quality of care we provide.

5. Fundamental Principles

These fundamental principles, universal concepts and general laws of conduct provide the foundation for our ethics.

Universality

The principle of universality expects that, if one individual judges an action to be right or wrong in a given situation, other people considering the same action in the same situation would make the same judgment.

Complementarity

The principle of complementarity recognizes the existence of an obligation to justice and basic human rights. In all relationships, it requires considering the values and perspectives of others before making decisions or taking actions affecting them.

Ethics

Ethics are the general standards of right and wrong that guide behavior within society. As generally accepted actions, they can be judged by determining the extent to which they promote good and minimize harm. Ethics compel us to engage in health promotion/disease prevention activities.

Community

This principle expresses our concern for the bond between individuals, the community, and society in general. It leads us to preserve natural resources and inspires us to show concern for the global environment.

Responsibility

Responsibility is central to our ethics. We recognize that there are guidelines for making ethical choices and accept responsibility for knowing and applying them. We accept the consequences of our actions or the failure to act and are willing to make ethical choices and publicly affirm them.

6. Core Values

We acknowledge these values as general for our choices and actions.

Individual Autonomy and Respect for Human Beings

People have the right to be treated with respect. They have the right to informed consent prior to treatment, and they have the right to full disclosure of all relevant information so that they can make informed choices about their care.

Confidentiality

We respect the confidentiality of client information and relationships as a demonstration of the value we place on individual autonomy. We acknowledge our obligation to justify any violation of a confidence.

Societal Trust

We value client trust and understand that public trust in our profession is based on our actions and behavior.

Nonmaleficence

We accept our fundamental obligation to provide services in a manner that protects all clients and minimizes harm to them and others involved in their treatment.

Beneficence

We have a primary role in promoting the wellbeing of individuals and the public by engaging in health promotion/disease prevention activities.

Justice and Fairness

We value justice and support the fair and equitable distribution of healthcare resources. We believe all people should have access to high-quality, affordable oral healthcare.

Veracity

We accept our obligation to tell the truth and expect that others will do the same. We value self-knowledge and seek truth and honesty in all relationships.

7. Standards of Professional Responsibility

We are obligated to practice our profession in a manner that supports our purpose, beliefs, and values in accordance with the fundamental principles that support our ethics. We acknowledge the following responsibilities:

To Ourselves as Individuals...

- Avoid self-deception, and continually strive for knowledge and personal growth.
- Establish and maintain a lifestyle that supports optimal health.
- Create a safe work environment.
- Assert our own interests in ways that are fair and equitable.
- Seek the advice and counsel of others when challenged with ethical dilemmas.
- Have realistic expectations of ourselves and recognize our limitations.

To Ourselves as Professionals...

- Enhance professional competencies through continuous learning in order to practice according to high standards of care.
- Support dental hygiene peer-review systems and quality-assurance measures.
- Develop collaborative professional relationships and exchange knowledge to enhance our own lifelong professional development.

To Family and Friends...

- Support the efforts of others to establish and maintain healthy lifestyles and respect the rights of friends and family.

To Clients...

- Provide oral health care utilizing high levels of professional knowledge, judgment, and skill.
- Maintain a work environment that minimizes the risk of harm.
- Serve all clients without discrimination and avoid action toward any individual or group that may be interpreted as discriminatory.
- Hold professional client relationships confidential.
- Communicate with clients in a respectful manner.
- Promote ethical behavior and high standards of care by all dental hygienists.
- Serve as an advocate for the welfare of clients.
- Provide clients with the information necessary to make informed decisions about their oral health and encourage their full participation in treatment decisions and goals.
- Refer clients to other healthcare providers when their needs are beyond our ability or scope of practice.
- Educate clients about high-quality oral health care.
- Recognize that cultural beliefs influence client decisions.

To Colleagues...

- Conduct professional activities and programs, and develop relationships in ways that are honest, responsible, and appropriately open and candid.
- Encourage a work environment that promotes individual professional growth and development.
- Collaborate with others to create a work environment that minimizes risk to the personal health and safety of our colleagues.

- Manage conflicts constructively.
- Support the efforts of other dental hygienists to communicate the dental hygiene philosophy and preventive oral care.
- Inform other healthcare professionals about the relationship between general and oral health.
- Promote human relationships that are mutually beneficial, including those with other health care professionals.

To Employees and Employers...

- Conduct professional activities and programs, and develop relationships in ways that are honest, responsible, open, and candid.
- Manage conflicts constructively.
- Support the right of our employees and employers to work in an environment that promotes wellness.
- Respect the employment rights of our employers and employees.

To the Dental Hygiene Profession...

- Participate in the development and advancement of our profession.
- Avoid conflicts of interest and declare them when they occur.
- Seek opportunities to increase public awareness and understanding of oral health practices.
- Act in ways that bring credit to our profession while demonstrating appropriate respect for colleagues in other professions.
- Contribute time, talent, and financial resources to support and promote our profession.
- Promote a positive image for our profession.
- Promote a framework for professional education that develops dental hygiene competencies to meet the oral and overall health needs of the public.

To the Community and Society...

- Recognize and uphold the laws and regulations governing our profession.
- Document and report inappropriate, inadequate, or substandard care and/or illegal activities by a health care provider, to the responsible authorities.
- Use peer review as a mechanism for identifying inappropriate, inadequate, or substandard care provided by dental hygienists.
- Comply with local, state, and federal statutes that promote public health and safety.
- Develop support systems and quality-assurance programs in the workplace to assist dental hygienists in providing the appropriate standard of care.
- Promote access to dental hygiene services for all, supporting justice and fairness in the distribution of healthcare resources.
- Act consistently with the ethics of the global scientific community of which our profession is a part.
- Create a healthful workplace ecosystem to support a healthy environment.
- Recognize and uphold our obligation to provide pro bono service.

To Scientific Investigation...

We accept responsibility for conducting research according to the fundamental principles underlying our ethical beliefs in compliance with universal codes, governmental standards, and professional guidelines for the care and management of experimental subjects. We acknowledge our ethical obligations to the scientific community:

- Conduct research that contributes knowledge that is valid and useful to our clients and society.
- Use research methods that meet accepted scientific standards.

- Use research resources appropriately.
- Systematically review and justify research in progress to insure the most favorable benefit-to-risk ratio to research subjects.
- Submit all proposals involving human subjects to an appropriate human subject review committee.
- Secure appropriate institutional committee approval for the conduct of research involving animals.
- Obtain informed consent from human subjects participating in research that is based on specification published in Title 21 Code of Federal Regulations Part 46.
- Respect the confidentiality and privacy of data.
- Seek opportunities to advance dental hygiene knowledge through research by providing financial, human, and technical resources whenever possible.
- Report research results in a timely manner.
- Report research findings completely and honestly, drawing only those conclusions that are supported by the data presented.
- Report the names of investigators fairly and accurately.
- Interpret the research and the research of others accurately and objectively, drawing conclusions that are supported by the data presented and seeking clarity when uncertain.
- Critically evaluate research methods and results before applying new theory and technology in practice.
- Be knowledgeable concerning currently accepted preventive and therapeutic methods, products, and technology and their application to our practice.

ASSOCIATION of DENTAL SUPPORT ORGANIZATIONS

Code of Ethics

PREAMBLE

America's dental services market is evolving to meet the dental needs of the nation's growing population. Dental support organizations (DSOs) help dental care professionals meet those needs by assisting dentists with non-clinical business and administrative functions of operating a dental office. Every year, an increasing number of practicing dentists maximize their professional potential by choosing to be supported by a DSO for nonclinical services, or deciding to work as an associate in a dental practice that has contracted for dental support services, so that they may focus on providing dental care to their patients.

The purpose of the Association of Dental Support Organizations (ADSO) Code of Ethics (the Code) is to serve as a standard of conduct for all member companies. Company compliance with the ADSO Code of Ethics is a requirement for membership in the ADSO. This Code of Ethics embodies ADSO's mission and confirms that member companies shall act with fairness, honesty, and the highest ethical standards in all business

activities; for ADSO member companies, upholding the highest ethical standards comes before everything else.

By abiding by the ADSO Code of Ethics, each ADSO member company affirms that its objective is to support dentists so that they may focus on improving the quality of dental care for their patients and the quality of life for themselves and their dental professional colleagues. ADSO member companies have an obligation to act in ways that will merit the trust, confidence, and respect of dental professionals and the general public. By engaging an ADSO member company, dental professionals can be sure they are dealing with an organization committed to providing quality business service and supporting ethical conduct at the highest levels.

Code of Ethics

I. Principles of Member Company Conduct

A. *ADSO Member Companies Act with Integrity:* ADSO member companies act with honesty, integrity, fairness, and respect towards all. It is important for ADSO member companies to act in a manner that supports the dental profession by performing administrative functions with the utmost care while refraining from engaging in activities that damage the credibility of the dental business support services industry. ADSO member companies will be truthful in all communications. All ADSO

member companies must comply in good faith with all material requirements of law in any city, county, and state in which they do business. Therefore, this Code does not restate all legal obligations.

- B. *ADSO Member Companies Focus on Meeting the Needs of Dentists:* As health professionals who dedicate their careers to meeting patients' oral health needs, dentists play a vital role in society. DSOs exist to provide nonclinical support services which enable dentists to serve their patients and communities as effectively and efficiently as possible and increase access to dental treatment.
- C. *ADSO Member Companies Never Interfere with Dentists' Clinical Decision-Making and Treatment Services:* ADSO member companies recognize and support the clinical autonomy of dentists and respect that only licensed medical professionals should engage in clinical decision-making and the delivery of dental treatment services. DSOs provide administrative support services for providers. ADSO member companies never set quotas or support dental practices that set quotas on providers based on the number of procedures or types of procedures. ADSO member companies will never

interfere with the efficient and effective access to patient records by a dentist or dental practice.

- D. *ADSO Member Companies Employ Qualified Staff and Use Proven Methods to Deliver Effective Support:* Thousands of dentists engage ADSO member companies to provide state-of-the-art nonclinical support services. ADSO member companies view this relationship as both a privilege and a responsibility. As a result, ADSO member companies endeavor to employ qualified, dedicated staff and deploy appropriate technologies, administrative methods, and supply-procurement and other processes and skills to enable their dentist-clients to operate supported practices as efficiently as possible.
- E. *DSO Member Companies Provide a Variety of Business Support Services to Meet the Needs of Dentists:* ADSO member companies meet the needs of dentists in a variety of practice settings. As such, ADSO member companies serve dentists operating as solo providers, in small dental groups, and in large dental group practices. ADSO member companies provide a variety of models to meet dentists' unique needs.
- F. *ADSO Member Companies Are Dedicated to Supporting Dentists as They Meet Needs at Home and Abroad:* ADSO member companies are privileged to support dentists who are committed to meeting critical societal needs. From charitable action in their communities, to addressing

America's dental care access, to making a difference around the world, dentists play a vital role.

ADSO member companies share this commitment and are proud to both support dentists in their charitable endeavors and engage directly in humanitarian action at home and abroad.

II. Member Company Governance

- A. *Self-Regulation:* This Code of Ethics is not law, but its obligations require a level of ethical behavior from its member companies. Nonobservance of this Code does not create any civil responsibility or liability whatsoever; however, suspension or termination of ADSO membership and the benefits thereto and the cessation of all references to or use of the ADSO name or logo may result.
- B. *ADSO Member Company Responsibilities and Duties:*
 - 1. ADSO Member Company Ethics Officer of the member's compliance with this Code.
 - 2. Internal Regulation
 - a. Each ADSO member company shall establish, within the member company complaint handling procedures to assist prompt resolution of complaints regarding an ADSO member company's relationship with its supported dentists.
 - b. In the event any individual or entity complains directly to an ADSO member company that it believes that the member company has engaged in any improper course of conduct pertaining to the services provided or offered to its DSO supported dentists, the ADSO member company shall promptly investigate the

complaint and shall take such corrective actions as it may find appropriate and necessary.

- c. The ADSO member companies subscribing to this Code recognize that its success will require diligence in creating awareness among supported dentists, contractors, employees, officers, directors, partners, and/or agents of the ADSO member companies' obligations under the Code. No ADSO member shall in any way attempt to persuade, induce, or coerce another ADSO member to breach this Code, and the ADSO members hereto agree that the inducing of the breach of this Code will be considered a violation of the Code.

C. ADSO Administration

- 1. Interpretation and Execution: The Board of Directors of the ADSO shall appoint an Ethics Committee to serve for a fixed term to be set by the board prior to appointment. The Ethics Committee will be responsible directly and solely to the board. The Board of Directors will establish all procedures necessary to administer the provisions of this Code.
- 2. Ethics Committee
 - a. The Ethics Committee shall be comprised of an odd number between five and nine members of the Board of Directors, or others appointed in the discretion of the Board of Directors, and shall be appointed for staggered three-year terms.

- b. The Ethics Committee shall review annually the Code of Ethics and make recommendations.
 - c. The Ethics Committee shall answer as promptly as possible all queries posed by member companies relating to the Code and its application, and, when appropriate, may suggest, for consideration by the Board of Directors, revisions to the Code to make it more effective.
 - d. The Ethics Committee shall participate in the new member application process by undertaking an ethics review of all applicant companies as directed by the Board of Directors.
3. Complaint Processing
- a. The Ethics Committee may establish, publish, and implement transparent complaint handling procedures to the ADSO member companies to ensure prompt resolution of all complaints regarding an ADSO member company's relationship with its supported dentists. In determining such complaint procedures, the Ethics Committee shall endeavor to ensure that the complaint handling procedures provide, in the Ethics Committee's opinion, fair notice to member companies of any complaints made against them, and are afforded due process in the complaint handling procedures.
 - b. The Ethics Committee, in accordance with the complaint handling procedures, shall hear and determine all charges against member companies, affording such member company an opportunity to understand all allegations against the member and to be heard fully in response to the allegations.
 - c. Upon receipt of a complaint, the Ethics Committee shall undertake to determine whether a violation of the Code has occurred.
 - d. Upon completion of its review, the Ethics Committee shall make a recommendation to the Board of Directors. The recommendation may include one or more of the following actions. If, in the judgment of the Ethics Committee, a complaint is beyond its scope of expertise or resources, the Ethics Committee may decline to exercise jurisdiction in the matter and may, in its discretion, recommend to the complainant another forum in which the complaint can be addressed.
 - ii. The Ethics Committee may determine that a complaint is invalid and dismiss it or may issue a "no finding" decision, if appropriate in the Ethics Committee's sole discretion.
 - iii. Require the accused member company to submit to the Ethics Committee a written commitment to abide by the ADSO Code of Ethics in future practices, behaviors and/or transactions and to exercise due diligence to assure there will be no recurrence of the practice leading to the subject Code complaint.
 - iv. Reprimand the member.
 - iv. Suspension of the member.
 - v. Termination of the member.
- III. Amendment**
- This Code may be amended by a two-thirds' vote of the Board of Directors.

AMERICAN MEDICAL ASSOCIATION

CODE OF ETHICS (SELECTIONS)

PREAMBLE

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Opinion 2.03—Allocation of Limited Medical Resources

A physician has a duty to do all that he or she can for the benefit of the individual patient. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients. Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources.

Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

Opinion 2.072—Ethically Sound Innovation in Medical Practice

Innovation in medicine can range from improving an existing intervention, to introducing an innovation in one's own clinical practice for the first time, to using an existing intervention in a novel way or translating knowledge from one clinical context into another. Innovation shares features with both research and patient care, but is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with

professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of techniques and interventions they offer to patients.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise;
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation;
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients;
- (d) Be sensitive to the cost implications of innovation; and
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

- (f) Base recommendations on patients' medical needs;
- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills;

- (h) Recognize that in this context informed decision making requires the physician to disclose: i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists; ii) why the physician is recommending the innovative modality; iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are; iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy; and v) what conflicts of interest the physician may have with respect to the recommended therapy.

- (i) Discontinue any innovative therapies that are not benefiting the patient; and
- (j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate and delayed positive and negative outcomes.

To promote responsible innovation, the medical profession should:

- (k) Require that physicians who adopt innovative treatment or diagnostic techniques into their practice have appropriate knowledge and skills;
- (l) Provide meaningful professional oversight of innovation in patient care; and

- (m) Encourage physician-innovators to collect and share information about the resources needed to implement their innovative therapies effectively. (V, VIII)

OPINION 2.095—THE PROVISION OF ADEQUATE HEALTH CARE

Because society has an obligation to make access to an adequate level of health care available to all of its members regardless of ability to pay, physicians should contribute their expertise at a policy-making level to help achieve this goal. In determining whether particular procedures or treatments should be included in the adequate level of health care, the following ethical principles should be considered:

- (1) degree of benefit (the difference in outcome between treatment and no treatment),
- (2) likelihood of benefit,
- (3) duration of benefit,
- (4) cost, and
- (5) number of people who will benefit (referring to the fact that a treatment may benefit the patient and others who come into contact with the patient, as with a vaccination or antimicrobial drug).

Ethical principles require that a just process be used to determine the adequate level of health care. To ensure justice, the process for determining the adequate level of health care should include the following considerations:

- (1) democratic decision making with broad public input at both the developmental and final approval stages,
- (2) monitoring for variations in care that cannot be explained on medical grounds with special attention to evidence of discriminatory impact on historically disadvantaged groups, and
- (3) adjustment of the adequate level over time to ensure continued and broad public acceptance.

Because of the risk that inappropriate biases will influence the content of the basic benefits package, it may be desirable to avoid rigid or precise formulas to define the specific components of the basic benefits package. After applying the five ethical values listed above, it will be possible to designate some kinds of care as either clearly basic or clearly discretionary. However, for care that is not clearly basic or discretionary, seemingly objective formulas may result in choices that are inappropriately biased. For that care, therefore, it may be desirable to give equal consideration (e.g., through a process of random selection) to the different kinds of care when deciding which will be included in the basic benefits package. The mechanism for providing an adequate level of health care should ensure that the health care benefits for the poor will not be eroded over time. (VII)

Opinion 2.30—Information from Unethical Experiments

All proposed experiments using human subjects should undergo proper ethical evaluation by a human studies review board before being undertaken.

Responsibility for revealing that the data are from unethical experiments lies

in the hands of authors, peer reviewers, and editors of medical texts that publish results of experimental studies. Each publication should adopt a standard regarding publication of data from unethical experiments.

If data from unethical experiments can be replaced by existing ethically sound data and achieve the same ends, then such must be done. If ethically tainted data that have been validated by rigorous scientific analysis are the only data of that nature available, and such data are necessary in order to save lives, then the utilization of such data by physicians and editors may be appropriate.

Should editors and/or authors decide to publish an experiment or data from an experiment that does not reach standards of contemporary ethical conduct, a disclaimer should be included. Such disclosure would by no means rectify unethical conduct or legitimize the methods of collection of data gathered from unethical experimentation. This disclaimer should:

- (1) clearly describe the unethical nature of the origin of any material being published;
- (2) clearly state that publication of the data is needed in order to save human lives;
- (3) pay respect to the victims;
- (4) avoid trivializing trauma suffered by the participants;
- (5) acknowledge the unacceptable nature of the experiments; and
- (6) endorse higher ethical standards.

Based on both scientific and moral grounds, data obtained from cruel and inhumane experiments, such as data collected from the Nazi experiments and data collected from the Tuskegee Study, should virtually never be published or cited. In the extremely rare case when no other data exist and human lives would certainly be lost without the knowledge obtained from use of such

data, publication or citation is permissible. In such a case, the disclosure should cite the specific reasons and clearly justify the necessity for citation.

Certain generally accepted historical data may be cited without a disclaimer, though a disclosure of the ethical issues would be valuable and desirable. (II, V, VII)

Opinion 3.01—

Nonscientific Practitioners

It is unethical to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care.

Physicians should also be mindful of state laws which prohibit a physician from aiding and abetting an unlicensed person in the practice of medicine, aiding or abetting a person with a limited license in providing services beyond the scope of his or her license, or undertaking the joint medical treatment of patients under the foregoing circumstances. Physicians are otherwise free to accept or decline to serve anyone who seeks their services, regardless of who has recommended that the individual see the physician. (III, VI)

Opinion 3.02—Nurses

The primary bond between the practices of medicine and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that

nurses follow orders contrary to standards of good medical and nursing practice. In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations. (IV, V)

Opinion 3.03—

Allied Health Professionals

Physicians often practice in concert with allied health professionals such as, but not limited to, optometrists, nurse anesthetists, nurse midwives, and physician assistants in the course of delivering appropriate medical care to their patients. In doing so, physicians should be guided by the following principles:

- (1) It is ethical for a physician to work in consultation with or employ allied health professionals, as long as they are appropriately trained and duly licensed to perform the activities being requested.
- (2) Physicians have an ethical obligation to the patients for whom they are responsible to ensure that medical and surgical conditions are appropriately evaluated and treated.
- (3) Physicians may teach in recognized schools for the allied health professionals for the purpose of improving the quality of their education. The scope of teaching may embrace subjects which are within the legitimate scope of the allied health profession and which are designed to prepare students to engage in the practice of the profession within the limits prescribed by law.
- (4) It is inappropriate to substitute the services of an allied health professional for those of a physician

when the allied health professional is not appropriately trained and duly licensed to provide the medical services being requested. (I, V, VII)

Opinion 3.04—

Referral of Patients

A physician may refer a patient for diagnostic or therapeutic services to another physician, limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever he or she believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless the physician is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements. (V, VI)

Opinion 3.05—

Physician Employment by a Nonphysician Supervisor

Physicians' relationships with midlevel practitioners must be based on mutual respect and trust as well as their shared commitment to patient well-being. Healthcare professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training and scope of practice. Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians.

When nonphysicians employ physicians to supervise the employer's

clinical practice, conditions are created that can lead to ethical dilemmas for the physician. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, a physician's personal and financial interests can be put at odds with patient care interests. Similarly, the administrative and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or her employer.

Physicians in such arrangements must give precedence to their ethical obligation to act in the patient's best interest by always exercising independent professional judgment, even if that puts the physician at odds with the employer/supervisee. (II, VI, VIII)

Opinion 5.02—

Advertising and Publicity

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive,

high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading. The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements

that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II)

OPINION 5.026—

THE USE OF ELECTRONIC MAIL

Electronic mail (e-mail) can be a useful tool in the practice of medicine and can facilitate communication within a patient-physician relationship. When communicating with patients via e-mail, physicians should take the same precautions used when sending faxes to patients. These precautions are presented in the following considerations:

- (1) E-mail correspondence should not be used to establish a patient-physician relationship. Rather, e-mail should supplement other, more personal, encounters.
- (2) When using e-mail communication, physicians hold the same ethical

responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies can provide specific guidance as to the appropriateness of offering specialty care or advice through e-mail communication.

- (3) Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
- (4) Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization. (I, IV, VI, VIII)

Opinion 5.027—

USE OF HEALTH-RELATED ONLINE SITES

As Internet prevalence and access rapidly increases, individuals turn to the Internet to find health-related information quickly and efficiently. Online users can access innumerable informational or interactive online sites, many of which are maintained by physicians or rely on their services. Physician involvement should be guided by the following considerations:

- (1) Physicians responsible for the health-related content of an online site should ensure that the information is accurate, timely, reliable, and scientifically sound, and includes appropriate scientific references.
- (2) The provision of diagnostic or therapeutic services through interactive online sites, including advice to online users with whom the physician does not have a pre-existing relationship or the use of decision-support programs that generate personalized information directly transmitted to users, should be consistent with general and specialty-specific standards. General standards include truthfulness, protection of privacy, principles of informed consent, and disclosures such as limitations inherent in the technology.
- (3) When participating in interactive online sites that offer e-mail communication, physicians should follow guidelines established in Opinion 5.026, "The Use of Electronic Mail."
- (4) Physicians who establish or are involved in health-related online sites must minimize conflicts of interest and commercial biases. This can be achieved through safeguards for disclosure and honesty in funding and advertising. It also requires that physicians not place commercial

interests ahead of patient health; therefore, physicians must not use health-related online sites to promote unnecessary services, refer patients to entities in which they have ownership interests, or sell products outside of established ethical guidelines. (See Opinions 2.19, "Unnecessary Services;" 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician;" 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices;" and 8.063, "Sale of Health-Related Products from Physicians' Offices"). Promotional claims on online sites must conform to Opinion 5.02, "Advertising and Publicity."

- (5) Physicians who establish or are involved in health-related online sites that use patient-specific information must provide high-level security protections, as well as privacy and confidentiality safeguards. (I, II, IV, V, VI)

Opinion 6.02—FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical.

A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source.

In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (II)

Opinion 6.12—FORGIVENESS OR WAIVER OF INSURANCE COPAYMENTS

Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the copayment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates Opinion 2.19, "Unnecessary Services," and is unethical.

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers. (II)

Opinion 6.13— Professional Courtesy

Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient copayments may violate Opinion 6.12, “Forgiveness or Waiver of Insurance Copayments.” (II, IV)

Opinion 8.03—Conflicts of Interest: Guidelines

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician’s financial benefit is unethical. If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit. (II)

Opinion 8.0321— Physicians’ Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for

self-referral in which patients’ medical interests can be in tension with physicians’ financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

- (1) Ensure that referrals are based on objective, medically relevant criteria.
- (2) Ensure that the arrangement:
 - (a) is structured to enhance access to appropriate, high quality health care services or products; and
 - (b) within the constraints of applicable law: (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation; (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and (iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (3) Take steps to mitigate conflicts of interest, including:

- (a) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products;
- (b) establishing mechanisms for utilization review to monitor referral practices; and,
- (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. (II, III, VIII)

Opinion 8.061—

Gifts to Physicians from Industry

The previous Opinion 8.061, also entitled “Gifts to Physicians from Industry,” issued June 1992, updated June 1996 and June 1998, was replaced by the current Opinion 8.061, “Gifts to Physicians from Industry.”

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

- (a) Decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations.
- (b) Decline any gifts for which reciprocity is expected or implied.
- (c) Accept an in-kind gift for the physician's practice only when the gift: (i) will directly benefit patients, including patient education; and (ii) is of minimal value.
- (d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided: (i) the program identifies recipients based on independent institutional criteria; and (ii) funds are distributed to recipients without specific attribution to sponsors. (II)

Opinion 8.062—

SALE OF NON-HEALTH-RELATED GOODS FROM PHYSICIANS' OFFICES

The sale of non-health-related goods by physicians presents a conflict of interest and threatens to erode the primary obligation of physicians to serve the interests of their patients before their own. Furthermore, this activity risks placing undue pressure on the patient and risks demeaning the practice of medicine.

Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below.

Physicians may sell low-cost non-health-related goods from their offices for the benefit of community organizations, provided that (1) the goods in question are low-cost; (2) the physician takes no share in profit from their sale; (3) such sales are not a regular part of the physician's business; (4) sales are conducted in a dignified manner; and (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases. (I, II)

Opinion 8.075—HEALTH

PROMOTION AND PREVENTIVE CARE

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when

recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

- (a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
- (b) Educate patients about relevant modifiable risk factors.
- (c) Recommend and encourage patients to have appropriate vaccinations and screenings.
- (d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
- (e) Collaborate with the patient to develop recommendations that are most likely to be effective.
- (f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
- (g) Consider the health of the community when treating their

own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

- (h) Recognize that modeling health behaviors can help patients make changes in their own lives.
- Collectively, physicians should:
- (i) Promote training in health promotion and disease prevention during medical school, residency, and in continuing medical education.
 - (j) Advocate for healthier schools, workplaces, and communities.
 - (k) Create or promote healthier work and training environments for physicians.
 - (l) Advocate for community resources designed to promote health and provide access to preventive services.
 - (m) Support research to improve the evidence for disease prevention and health promotion. (V, VII)

OPINION 8.08—INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from

failure to treat is imminent. In special circumstances, it may be appropriate to postpone disclosure of information, (see Opinion E-8.122, "Withholding Information from Patients").

Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients. Physicians need not communicate all information at one time, but should assess the amount of information that patients are capable of receiving at a given time and present the remainder when appropriate. (I, II, V, VIII)

OPINION 8.11—NEGLECT OF PATIENT

Physicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient. (I, VI)

OPINION 8.115—TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured. (I, VI)

OPINION 8.121—ETHICAL RESPONSIBILITY TO STUDY AND PREVENT ERROR AND HARM

In the context of health care, an error is an unintended act or omission, or a flawed system or plan, that harms or has the potential to harm a patient. Patient safety can be enhanced by studying the circumstances surrounding health care errors. This can best be

achieved through a legally protected review process, which is essential for reducing health care errors and preventing patient harm.

- (1) Because they are uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing health care errors. This responsibility exists even in the absence of a patient-physician relationship.
- (2) Physicians should participate in the development of reporting mechanisms that emphasize education and systems change, thereby providing a substantive opportunity for all members of the health care team to learn. Specifically, physicians should work with other relevant health care professionals to:
 - (a) Establish and participate fully in an effective, confidential, and protected error-reporting mechanism
 - (b) Develop means for objective review and analysis of reports regarding errors, and to conduct appropriate investigations into the causes of harm to a patient
 - (c) Ensure that the investigation of causes of harm, and the review and study of error reports result in preventive measures that are conveyed to all relevant individuals
 - (d) Identify and promptly report impaired and/or incompetent colleagues so that rehabilitation, retraining or disciplinary action can occur in order to prevent harm to patients
- (3) Physicians must offer professional and compassionate concern toward

patients who have been harmed, regardless of whether the harm was caused by a health care error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlies the patient-physician relationship, and may help reduce the risk of liability.

- (4) Physicians have a responsibility to provide for continuity of care to patients who may have been harmed during the course of their health care. If, because of the harm suffered under the care of a physician, a patient loses trust in that physician, the obligation may best be fulfilled by facilitating the transfer of the patient to the care of another physician.
- (5) Physicians should seek changes to the current legal system to ensure that all errors in health care can be safely and securely reported and studied as a learning experience for all participants in the health care system, without threat of discoverability, legal liability, or punitive action. (I, II, III, IV, VIII)

Opinion 8.131—PROFESSIONALISM IN HEALTH CARE SYSTEMS

Containing costs, promoting high quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage under treatment and over treatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations have an ethical responsibility to ensure that practices for financing and organizing the delivery of care:

- (a) Are transparent.
- (b) Reflect input from key stakeholders, including physicians and patients.
- (c) Recognize that over reliance on financial incentives may undermine physician professionalism.
- (d) Ensure ethically acceptable incentives that: (i) Are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data, and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with

ethical guidelines. (ii) Are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities. (iii) Are implemented in conjunction with the infrastructure and resources needed to support high value care and physician professionalism. (iv) Mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

- (e) Encourage, rather than discourage, physicians (and others) to:
 - (i) provide care for patients with difficult to manage medical conditions; (ii) practice at their full capacity, but not beyond.
- (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
- (g) Are routinely monitored to:
 - (i) identify and address adverse consequences; (ii) identify and encourage dissemination of positive outcomes.

All physicians have an ethical responsibility to:

- (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
- (i) Advocate for changes in health care payment and delivery models to promote access to high quality care for all patients. (I, II, III, V)

Opinion 8.14—SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE

Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.

If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship. (I, II, IV)

Opinion 8.145—SEXUAL OR ROMANTIC RELATIONS BETWEEN PHYSICIANS AND KEY THIRD PARTIES

Patients are often accompanied by third parties who play an integral role in the patient-physician relationship. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the more troubling

sexual or romantic contact with the physician would be. This is especially true for the individual whose decisions directly impact on the health and welfare of the patient. Key third parties include, but are not limited to, spouses or partners, parents, guardians, and proxies.

Physicians should refrain from sexual or romantic interactions with key third parties when it is based on the use or exploitation of trust, knowledge, influence, or emotions derived from a professional relationship. The following factors should be considered when considering whether a relationship is appropriate: the nature of the patient's medical problem, the length of the professional relationship, the degree of the third party's emotional dependence on the physician, and the importance of the clinical encounter to the third party and the patient. (I, II)

Opinion 8.20—INVALID MEDICAL TREATMENT

The following general guidelines are offered to serve physicians when they are called upon to decide among treatments:

- (1) Treatments which have no medical indication and offer no possible benefit to the patient should not be used (Opinion 2.035, "Futile Care").
- (2) Treatments which have been determined scientifically to be invalid should not be used (Opinion 3.01, "Nonscientific Practitioners").
- (3) Among the treatments that are scientifically valid, medically indicated, and offer a reasonable chance of benefit for patients, some are regulated or prohibited by law; physicians should comply with these laws. If physicians disagree with such laws, they should seek to change them.
- (4) Among the various treatments that are scientifically valid, medically indicated, legal, and offer a

reasonable chance of benefit for patients, the decision of which treatment to use should be made between the physician and patient. (I, III, IV)

Opinion 9.0115—FINANCIAL RELATIONSHIPS WITH INDUSTRY IN CME

In an environment of rapidly changing information and emerging technology, physicians must maintain the knowledge, skills, and values central to a healing profession. They must protect the independence and commitment to fidelity and service that define the medical profession.

Financial or in-kind support from pharmaceutical, biotechnology or medical device companies that have a direct interest in physicians' recommendations creates conditions in which external interests could influence the availability and/or content of continuing medical education (CME). Financial relationships between such sources and individual physicians who organize CME, teach in CME, or have other roles in continuing professional education can carry similar potential to influence CME in undesired ways.

CME that is independent of funding or in-kind support from sources that have financial interests in physicians' recommendations promotes confidence in the independence and integrity of professional education, as does CME in which organizers, teachers, and others involved in educating physicians do not have financial relationships with industry that could influence their participation. When possible, CME should be provided without such support or the participation of individuals who have financial interests in the educational subject matter.

In some circumstances, support from industry or participation by individuals who have financial interests in the

subject matter may be needed to enable access to appropriate, high-quality CME. In these circumstances, physician-learners should be confident that vigorous efforts will be made to maintain the independence and integrity of educational activities.

Individually and collectively physicians must ensure that the profession independently defines the goals of physician education, determines educational needs, and sets its own priorities for CME. Physicians who attend CME activities should expect that, in addition to complying with all applicable professional standards for accreditation and certification, their colleagues who organize, teach, or have other roles in CME will:

- (a) be transparent about financial relationships that could potentially influence educational activities.
- (b) provide the information physician-learners need to make critical judgments about an educational activity, including: (i) the source(s) and nature of commercial support for the activity; and/or (ii) the source(s) and nature of any individual financial relationships with industry related to the subject matter of the activity; and (iii) what steps have been taken to mitigate the potential influence of financial relationships.
- (c) protect the independence of educational activities by: (i) ensuring independent, prospective assessment of educational needs and priorities; (ii) adhering to a transparent process for prospectively determining when industry support is needed; (iii) giving preference in selecting faculty or content developers to similarly qualified experts who do not have financial interests in the educational subject matter; (iv) ensuring a transparent process for making decisions about participation

by physicians who may have a financial interest in the educational subject matter; (v) permitting individuals who have a substantial financial interest in the educational subject matter to participate in CME only when their participation is central to the success of the educational activity; the activity meets a demonstrated need in the professional community; and the source, nature, and magnitude of the individual's specific financial interest is disclosed; and (vi) taking steps to mitigate potential influence commensurate with the nature of the financial interest(s) at issue, such as prospective peer review. (I, V)

Opinion 9.031—

REPORTING IMPAIRED, INCOMPETENT, OR UNETHICAL COLLEAGUES

Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (see Opinion E-9.0305, "Physician Health and Wellness"). Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority.

Incompetence. Initial reports of incompetence should be made to the

appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence that poses an immediate threat to the health and safety of patients should be reported directly to the state licensing board.

Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines and, considering, as necessary, the right to privacy of any patients involved:

- Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization.
- When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted

anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved. (II)

Opinion 9.04— Discipline and Medicine

Incompetence, corruption, or dishonest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or loss of favor, incompetent or corrupt, dishonest, or unethical conduct on the part of members of the profession. Questions of such conduct should be reported and reviewed in accordance with Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues."

Violation of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates the ethical standards involving a breach of moral duty or principle. However, medical societies have a civic and professional obligation to report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

Although a physician charged with allegedly illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is credible evidence tending to establish unethical conduct.

The Council cannot pass judgment in advance on a situation that may later come before it on appeal. The Council cannot be an attorney for a society or a member thereof and later judge in the same factual situation. The local medical society has the initial obligation of determining all the facts and whether or not disciplinary action is indicated. Questions asking for a review of a proposed course of action or an evaluation of an existing factual situation should be presented to the appropriate official of the physician's local society. (II, III, VII)

Opinion 9.045— Physicians with Disruptive Behavior

This Opinion is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy."

- (1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.
- (2) Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations

where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness—or equivalent—committee.

- (3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements:
 - (a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.
 - (b) Describing the behavior or types of behavior that will prompt intervention
 - (c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.
 - (d) Establishing a process to review or verify reports of disruptive behavior.
 - (e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
 - (f) Including means of monitoring whether a physician's disruptive conduct improves after intervention.
 - (g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities

or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.

- (h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
- (i) Providing clear guidelines for the protection of confidentiality.
- (j) Ensuring that individuals who report physicians with disruptive behavior are duly protected. (I, II, VIII)

Opinion 9.08— NEW MEDICAL PROCEDURES

In the ethical tradition expressed by Hippocrates and continuously affirmed thereafter, the role of the physician has been that of a healer who serves patients, a teacher who imparts knowledge of skills and techniques to colleagues, and a student who constantly seeks to keep abreast of new medical knowledge.

Physicians have an obligation to share their knowledge and skills and to report the results of clinical and laboratory research. Both positive and negative studies should be included even though they may not support the author's hypothesis. This tradition enhances patient care, leads to the early evaluation of new technologies, and permits the rapid dissemination of improved techniques.

The intentional withholding of new medical knowledge, skills, and techniques from colleagues for reasons of personal

gain is detrimental to the medical profession and to society and is to be condemned.

Prompt presentation before scientific organizations and timely publication of clinical and laboratory research in scientific journals are essential elements in the foundation of good medical care. (I, II, V, VII)

Opinion 9.065— CARING FOR THE POOR

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician's practice schedule.

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.

Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, know-

ledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (I, VII)

Opinion 9.0651—FINANCIAL BARRIERS TO HEALTH CARE ACCESS

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation:

- (1) Individual physicians should take steps to promote access to care for individual patients.
- (2) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
- (3) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
- (4) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
- (5) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people. (VI, IX)

Opinion 9.0652—

Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

- (a) base recommendations and decisions on patients' medical needs;
- (b) use scientifically grounded evidence to inform professional decisions when available;
- (c) help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals;
- (d) endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals;
- (e) choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient, but require different levels of resources;

- (f) be transparent about alternatives, including disclosing when resource constraints play a role in decision making; and
- (g) participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

- (h) encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship;
- (i) ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending; and
- (j) advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship. (I, V, VII, VII, IX)

Opinion 9.10—Peer Review

Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of

peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary, and committees performing such work act ethically as long as principles of due process (Opinion 9.05, "Due Process") are observed. They balance the physician's right to exercise medical judgment freely with the obligation to do so wisely and temperately. (II, III, VII)

Opinion 9.11—Ethics Committees in Health Care Institutions

The following guidelines have been developed to aid in the establishment and functioning of ethics committees in hospitals and other health care institutions that may choose to form such committees.

- (1) Ethics committees in health care institutions should be educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution. Recommendations of the ethics committee should impose no obligation for acceptance on the part of the institution, its governing board, medical staff, attending physician, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers.
- (2) The size of the committee should be consistent with the needs of the institution but not so large as to be unwieldy. Committee members should be selected on the basis of their concern for the welfare of the sick and infirm, their interest in

ethical matters, and their reputation in the community and among their peers for integrity and mature judgment. Experience as a member of hospital or medical society committees concerned with ethical conduct or quality assurance should be considered in selecting ethics committee members. Committee members should not have other responsibilities that are likely to prove incompatible with their duties as members of the ethics committee. Preferably, a majority of the committee should consist of physicians, nurses, and other health care providers. In hospitals, medical staff bylaws should delineate the functions of the committee, general qualifications for membership, and manner of selection of members, in accordance with these guidelines.

- (3) The functions of the ethics committee should be confined exclusively to ethical matters. The Code of Medical Ethics of the American Medical Association is recommended for the guidance of ethics committees in making their own recommendations. The matters to be considered by the committee should consist of ethical subjects that a majority of its members may choose to discuss on its own initiative, matters referred to it by the executive committee of the organized medical staff or by the governing board of the institution, or appropriate requests from patients, families, or health care providers.
- (4) In denominational health care institutions or those operated by religious orders, the recommendations of the ethics committee may be anticipated to be consistent with published religious tenets and principles. Where particular religious beliefs are to be taken into consideration in the

committee's recommendations, this fact should be publicized to physicians, patients, and others concerned with the committee's recommendations.

- (5) In its deliberations and communication of recommendations, the procedures followed by the ethics committee should comply with institutional and ethical policies for preserving the confidentiality of information regarding patients.
- (6) Committee members should be prepared to meet on short notice and to render their recommendations in a timely and prompt fashion in accordance with the demands of the situation and the issues involved. (II, IV, VII)

OPINION 9.115—

ETHICS CONSULTATIONS

Ethics consultations may be called to clarify ethical issues without reference to a particular case, facilitate discussion of an ethical dilemma in a particular case, or resolve an ethical dispute. The consultation mechanism may be through an ethics committee, a subset of the committee, individual consultants, or consultation teams. The following guidelines are offered with respect to these services:

- (1) All hospitals and other health care institutions should provide access to ethics consultation services. Health care facilities without ethics committees or consultation services should develop flexible, efficient mechanisms of ethics review that divide the burden of committee functioning among collaborating health care facilities.
- (2) Institutions offering ethics consultation services must appreciate the complexity of the

task, recognizing the potential for harm as well as benefit, and act responsibly. This includes true institutional support for the service.

- (3) Ethics consultation services require a serious investment of time and effort by the individuals involved. Members should include either individuals with extensive formal training and experience in clinical ethics or individuals who have made a substantial commitment over several years to gain sufficient knowledge, skills, and understanding of the complexity of clinical ethics. A wide variety of background training is preferable, including such fields as philosophy, religion, medicine, and law.
- (4) Explicit structural standards should be developed and consistently followed. These should include developing a clear description of the consultation service's role and determining which types of cases will be addressed, how the cases will be referred to the service, whether the service will provide recommendations or simply function as a forum for discussion, and whether recommendations are binding or advisory.
- (5) Explicit procedural standards should be developed and consistently followed. These should include establishing who must be involved in the consultation process and how notification, informed consent, confidentiality and case write-ups will be handled.
- (6) In general, patient and staff informed consent may be presumed for ethics consultation. However,

patients and families should be given the opportunity, not to participate in discussions either formally, through the institutional process, or informally.

- (7) In those cases where the patient or family has chosen not to participate in the consultation process, the final recommendations of the consultant(s) should be tempered.
- (8) In general, ethics consultation services, like social services, should be financed by the institution.
- (9) A consultation service should be careful not to take on more than it can handle, ie, the complexity of the role should correspond to the level of sophistication of the service and the resources it has available. As a result, some services may offer only information and education, others a forum for discussion but not advice, others might serve a mediation role, and some might handle even administrative or organizational ethics issues. (IV, V)

Opinion 9.12—

**PATIENT-PHYSICIAN Relationship:
RESPECT FOR LAW AND HUMAN RIGHTS**
The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious

discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI)

Opinion 9.121—RACIAL AND ETHNIC HEALTH CARE DISPARITIES

Differences in treatment that are not directly attributable to variances in clinical needs or patient preferences constitute disparities in health care. Among racial and ethnic minority populations, such disparities may contribute to health outcomes that are considerably worse than those of majority populations. This represents a significant challenge for physicians who ethically are called upon to serve patients without regard to medically irrelevant personal characteristics. The following guidelines are intended to help reduce racial and ethnic disparities in health care.

- (1) Physicians must strive to offer the same quality of care to all their patients irrespective of personal characteristics such as race or ethnicity. The provision of care should be customized to meet patient needs and preferences.
- (2) Physicians must learn to recognize racial and ethnic health care disparities and should examine their own practices to ensure that inappropriate considerations do not affect clinical judgment.
- (3) Physicians should work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients. Inappropriate discrimination toward any patient or group of patients must not be permitted.
- (4) Participatory decision making should be encouraged with all patients. This requires trust, which in turn requires effective communication. Physicians should

seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' health care decisions. Physicians should not rely upon stereotypes; they should customize care to meet the needs and preferences of individual patients.

- (5) Physicians should recognize and take into account linguistic factors that affect patients' understanding of medical information. In particular, language barriers should be minimized so that information is exchanged in a manner that both parties can understand.
- (6) Increasing the diversity of the physician workforce may be an important step in reducing racial and ethnic health care disparities. Physicians should therefore participate in efforts to encourage diversity in the profession
- (7) Physicians should help increase awareness of health care disparities by engaging in open and broad discussions about the issue in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities. Research should continue to investigate health care disparities, including the development of quality measures. (I, VII, VIII, IX)

Opinion 9.122—

GENDER DISPARITIES IN HEALTH CARE

A patient's gender plays an appropriate role in medical decision making when biological differences between the sexes are considered. However, some data suggest that gender bias may be playing a role in medical decision making. Social attitudes, including stereotypes, prejudices, and other evaluations based on gender role expectations, may play

themselves out in a variety of subtle ways. Physicians must ensure that gender is not used inappropriately as a consideration in clinical decision making. Physicians should examine their practices and attitudes for influence of social or cultural biases which could be inadvertently affecting the delivery of medical care.

Research on health problems that affect both genders should include male and female subjects, and results of medical research done solely on males should not be generalized to females without evidence that results apply to both sexes. Medicine and society in general should ensure that resources for medical research should be distributed in a manner which promotes the health of both sexes to the greatest extent possible. (I, IV)

Opinion 9.123—DISRESPECT AND DEROGATORY CONDUCT IN THE PATIENT-PHYSICIAN RELATIONSHIP

The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting their dignity and rights. Trust can be established and maintained only when there is mutual respect.

Derogatory language or actions on the part of physicians can cause psychological harm to those they target. Also, such language or actions can cause reluctance in members of targeted groups to seek or to trust medical care and thus create an environment that strains relationships among patients, physicians, and the health care team. Therefore, any such conduct is profoundly antithetical to the Principles of Medical Ethics.

Patients who use derogatory language or otherwise act in a prejudicial manner toward physicians, other health care professionals, or others in the health care setting, seriously undermine the integrity of the patient-

physician relationship. Such behavior, if unmodified, may constitute sufficient justification for the physician to arrange for the transfer of care. (I, II, VI, IX)

Opinion 9.124—PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship.

Physicians should weigh a number of considerations when maintaining a presence online:

- (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- (b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional

information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

- (c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines, just as they would in any other context.
- (d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
- (e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
- (f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)

Opinion 9.132—
HEALTH CARE FRAUD AND ABUSE
The following guidelines encourage physicians to play a key role in identifying and preventing fraud:

- (1) Physicians must renew their commitment to Principle II of the American Medical Association's Principles of Medical Ethics which states that "a physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character, competence, or who engage in fraud or deception."
- (2) Physicians should make no intentional misrepresentations to increase the level of payment they receive or to secure non-covered health benefits for their patients. (II)

Opinion 9.14—Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable. While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- (1) Keeping current with best care practices and maintaining professional competence.
- (2) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (3) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

- (4) Demonstrating a commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
- (5) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession. (I, V, VII, VIII)

Opinion 10.01— Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

- (1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.
- (2) The patient has the right to make decisions regarding the health care

that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

- (3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
- (4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
- (5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
- (6) The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. (I, IV, V, VIII, IX)

Opinion 10.015—

THE PATIENT-PHYSICIAN RELATIONSHIP

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient (or surrogate). In some instances the agreement is implied, such as in emergency care or when physicians provide services at the request of the treating physician. In rare instances, treatment without consent may be provided under court order (see Opinion 2.065, "Court-Initiated Medical Treatments in Criminal Cases"). Nevertheless, the physician's obligations to the patient remain intact.

The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.

Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. (I, II, VI, VIII)

Opinion 10.017—

GIFT FROM PATIENTS

Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship.

Some gifts signal psychological needs that require the physician's attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts

or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that gifts given to secure preferential treatment compromise their obligation to provide services in a fair manner.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient; however, the gift's value relative to the patient's or the physician's means should not be disproportionately or inappropriately large. One criterion is whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient's medical care.

If, after a patient's death, a physician should learn that he or she has been bequeathed a gift, the physician should consider declining the gift if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family. The interaction of these various factors is complex and requires the physician to consider them sensitively. (I, II)

Opinion 10.02—

PATIENT RESPONSIBILITIES

It has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process. Such a partnership does not imply that both partners have identical responsibilities or equal power. While physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate

openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program.

Like patients' rights, patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.

- (1) Good communication is essential to a successful patient-physician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physicians.
- (2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.
- (3) Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
- (4) Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with physician

instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

- (5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.
- (6) Patients should discuss end-of-life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.
- (7) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.
- (8) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.
- (9) Participation in medical education is to the mutual benefit of patients and the health care system. Patients are

encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.

- (10) Patients should discuss organ donation with their physicians and, if donation is desired, make applicable provisions. Patients who are part of an organ allocation system and await needed transplant should not try to go outside of or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources.
- (11) Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by physicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities. (I, IV, VI)

OPINION 10.03—

PATIENT-PHYSICIAN RELATIONSHIP IN THE CONTEXT OF WORK-RELATED AND INDEPENDENT MEDICAL EXAMINATIONS

When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist. Both "Industry Employed Physicians" (IEPs), who are employed by businesses or insurance companies for the purpose of conducting medical examinations, and Independent Medical Examiners" (IMEs), who are independent contractors providing medical examinations within the realm of their specialty, may perform such medical examinations.

Despite their ties to a third party, the responsibilities of IEPs and IMEs are in some basic respects very similar to those of other physicians. IEPs and IMEs have the same obligations as physicians in other contexts to:

- (1) Evaluate objectively the patient's health or disability. In order to maintain objectivity, IEPs and IMEs should not be influenced by the preferences of the patient-employee, employer, or insurance company when making a diagnosis during a work-related or independent medical examination.
- (2) Maintain patient confidentiality as outlined by Opinion 5.09, "Industry Employed Physicians and Independent Medical Examiners."
- (3) Disclose fully potential or perceived conflicts of interest. The physician should inform the patient about the terms of the agreement between himself or herself and the third party as well as the fact that he or she is acting as an agent of that entity. This should be done at the outset of the examination, before health information is gathered from the patient-employee. Before the physician proceeds with the exam, he or she should ensure to the extent possible that the patient understands the physician's unaltered ethical obligations, as well as the differences that exist between the physician's role in this context and the physician's traditional fiduciary role.

IEPs and IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians. Consequently, a limited patient-physician relationship should be

considered to exist during isolated assessments of an individual's health or disability for an employer, business, or insurer.

The physician has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination. In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care. (I)

Opinion 10.06—

Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have

considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on

interventions or services a patient might otherwise reasonably expect the practice to offer.

- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethical guidelines. (I, II, IV, VI, VIII, IX).

MORAL COMMUNITIES AND MORAL LEADERSHIP

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

ABSTRACT

The American College of Dentists is embarking on a multiyear project to improve ethics in dentistry. Early indications are that the focus will be on actual moral behavior rather than theory, that we will include organizations as ethical units, and that we will focus on building moral leadership. There is little evidence that the “telling individuals how to behave” approach to ethics is having the hoped for effect. As a profession, dentistry is based on shared trust. The public level of trust in practitioners is acceptable, but could be improved, and will need to be strengthened to reduce the risk of increasing regulation. While feedback from the way dentists and patients view ethics is generally reassuring, dentists are often at odds with patients and their colleagues over how the profession manages itself. Individuals are an inconsistent mix of good and bad behavior, and it may be more helpful to make small improvements in the habits of all dentists than to try to take a few certifiably dishonest ones off the street. A computer simulation model of dentistry as a moral community suggests that the profession will always have the proportion of bad actors it will tolerate, that moral leadership is a difficult posture to maintain, that massive interventions to correct imbalances through education

or other means will be wasted unless the system as a whole is modified, and that most dentists see no compelling benefit in changing the ethical climate of the profession because they are doing just fine. Considering organizations as loci of moral behavior reveals questionable practices that otherwise remain undetected, including moral distress, fragmentation, fictitious dentists, moral fading, decoupling, responsibility shifting, and moral priming. What is most needed is not philosophy or principles, but moral leadership.

The American College of Dentists Gies Ethics Project began in the summer of 2015. We identify this project with the landmark publication by William Gies in 1926 of the 500-page *Carnegie Foundation for the Advancement of Teaching Bulletin Number Nineteen: Dental Education in the United States and Canada*. Among other recommendations stemming from that study were that dentistry should be a separate profession from medicine but of equal standing, and in order to achieve that and Gies’s fond hope of finding a cure for or strong preventive measures in oral health, dental education should be housed in research-intensive universities. The hallmark of Gies’s work was getting close to the actual situation on the ground at the time (Shulman, 2010). As the prep school headmaster, Abraham Flexner, had done 20 years earlier in medicine, the biochemist Gies visited every school in the United States

and Canada, and his report is very long on evidence and short on advice.

The American College of Dentists wants to follow the methodological lead of Gies. Our focus is ethics in the oral health professions. Our goal is to determine the extent to which the profession can be elevated by focusing on the way we treat each other. We will generally leave aside considerations of legal safe play, political power, and economic advantage. These are alternative means individual and organizations use to influence others, but they have their own logics and their own advocates. At our best as human beings, we can leverage the extensive training, technical skills, and organizational wisdom of the profession to do better for all concerned by ethical means. And we should.

We have made progress in the past 20 years since ethics became a central concern for the college. It is now fine to talk about ethics in detail, and we are building a common vocabulary for having those conversations. Since 1997, accreditation standards have required that dental schools demonstrate that students are competent in applying ethical principles. 2016 marks the 150th anniversary of the American Dental Association’s Code of Ethics. Most



Dr. Chambers is the editor of the college.

This paper is a more formal reworking of a Fellows Forum presentation at the ACD Convocation in Washington, DC, November 4, 2015.

professions have several peer-reviewed journals with the term ethics in the title. Until a few years ago, that was not the case for dentistry. Now we have one, although it is published in India.

The American College of Dentists has a rich array of resources in ethics, including free, online continuing education credit courses that have been taken by 80,000 individuals; an online dental ethics resource textbook; programs in ethics that have been presented to a thousand dentists in both large lecture and all-day, hands-on seminar formats; a 50-hour active participation program for dental offices; presentations in dental schools by fellows of the college; and scholarships for practitioners pursuing advanced training in ethics.

The ACD Gies Ethics Project is beginning what will likely be a three-year activity. We will be working closely with four representative states—California, Ohio, Oklahoma, and North Carolina—to see what ethics means at the level of individual dentists, organized dentistry, and the public. The first research study on “Do Patients and Dentists See Ethics the Same Way?” was published in the second number of this journal this year (Chambers 2015a). A dozen other empirical studies are under way.

Although it is still early in the process, several very broad generalizations are bringing to take shape. They will be refined as we go, of course, but right now they are guiding what data are to be gathered and how it is best organized.

Morality is about the way we treat each other and the effects our decisions have on the quality of life for ourselves and others. *Ethics* is how we talk about it; it is theory. The ACD Gies Ethics Project will be about morality (although we will also retain the more familiar term).

The traditional view that one is ethical unless one steps over the line often or conspicuously needs to be replaced with a three-category system. It is better to be one who refrains from hurting others (neutrals) than to make others worse off (detractors). But it is preferable still in very important ways to help others, including helping others to be more ethical (leaders). At the moment, we are in great need of ethical leadership—not leaders in the political sense who are ethically neutral, but those who can show the way to making others more ethical even if they do not have high political visibility.

Morality is not a private matter. It cannot be done when one is alone. Making morality purely personal will limit the good that can be done, often to nothing more than theoretical considerations. Morality is a group activity, in community. The way an individual acts when alone may not be predictive of

Breaking the ethical rules is more predictive of generating more rules than existing rules are for preventing misconduct.

how that same individual will act as part of group. Organizations strongly influence how individuals act.

Think of this as the “good barrels” approach to ethics rather than the “bad apples” approach.

OTHERS CARE ABOUT WHAT WE DO

In their “Jerusalem to Jericho” study, Darley and Bateson (1973) conducted a now-famous demonstration showing how hollow ethical talk can be. Their subjects were graduate students who were told to complete a questionnaire and then report to another building where they would be videotaped making a short presentation on the importance of helping others. Half of the subjects were told they were expected immediately, and half were told they had a little slack time. On the way to the taping, all students encountered a rough-looking man planted in a doorway, groaning and complaining of pain. He seemed to be hurt, and he called out for help. Some graduate students stopped to at least ask whether they could do anything; most did not.

The questionnaire completed immediately before the incident had covered topics such as the ethical obligation to assist others. There was no relationship between the attitudes expressed on the questionnaire and actual willingness to assist the man in seeming distress. Morality (good action) and ethics (good theory) seemed to live parallel lives. Less than two-thirds of those students who had time before giving their speeches tried to help. For those who thought they might be late, the helping rate was 10%.

The students were enrolled in Princeton University’s Theological Seminary and the title of the talk they were to give was “The Good Samaritan.”

CODES AND RULES

Codes belong in the category of ethical theory rather than being examples of moral behavior. Every organization has one, but they can be imperfect guides and even mislead the public about what to expect from the organization. The evidence suggests that organizations that have codes are more likely to engage in deceptive practices (Matthews, 1988). The most impressive one I have found was 64 pages long, grounded in ethical principles, and very specific about the penalties for those who stepped over the line. It was even signed by the chairman of the board, whose name, Ken Lay, might be familiar. For a short time after Enron folded, former employees were selling this ethics code on eBay. Now it can be downloaded free from the Internet. (See Beenen & Pinto, 2009 for an interview with Sherron Watkins, one of the principal whistleblowers at Enron).

Here is the really sad part of the story. A major consequence of the scandals such as Enron was passage by Congress of the Sarbanes-Oxley Act. That was essentially a code on codes. CEOs at big firms are now required to sign their codes and other policies (apparently no problem for Mr. Lay). The penalties under the new United States Sentencing Guidelines (www.ussc.gov/guidelines-manual/2014/2014-ussc-guidelines-manual) allow for reduced fines for abusive firms if there is a mechanism in place to inform employees and the public about their codes of ethics, among other things. Breaking the ethical rules is more predictive of generating additional rules than existing rules are for preventing misconduct. Later in this

paper I will report on how much the public trusts legislators who make these kinds of rules.

WHAT I SAY...

In dentistry we have opportunities for training students in ethics while they are in professional school. Many graduate business programs (Hanson & Moore, 2014; Giacalone, 2007), almost all medical schools (Hafferty 2006), but all dental schools teach ethics (Commission on Dental Accreditation, predoctoral standards). In 2010, United States dental schools offered 26.5 hours of instruction in ethics on average and more than three-quarters of schools identified this as their greatest unmet curricular need (Lantz et al, 2011). The most commonly taught topics were central values of the profession and codes, and liberal use was made of small group discussion of cases (dilemmas).

It has proven easier to document effort in the direction of professional ethics education than outcomes. The rate of unacceptable academic integrity (better known as cheating) is well over 50% across professional programs generally (McCabe et al, 2006) and may be as high as 80% in dental schools (Andrews 2007). This is not a recent phenomenon, as Fuller and Killip in 1979 reported cheating in dental schools at 94%. As in most health professionals education, dental students become more cynical as they spend more time in the system, especially as they enter the clinical setting (Hutton, 1968). Chambers (2007) provides a summary.

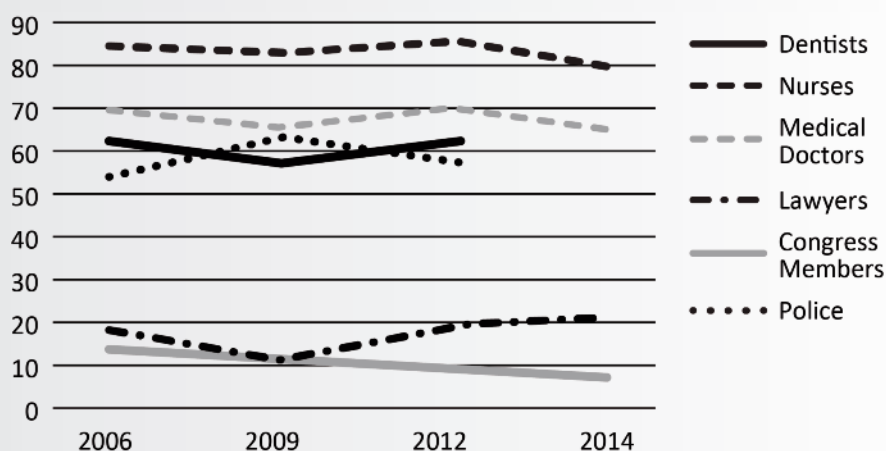
Soft standards, lightly enforced are not a problem unique to dentistry. Surveys of students at the University of Chicago Medical School (Humphrey et al, 2007), for example, report a slight

positive increase in answering the question “Do you know what professionalism is?” as students go through the program. At the same time, they are significantly less likely to report a classmate known to be cheating or approach a colleague who cheats or acts unprofessionally. They are blunt about the project of trying to talk students into being professional: “Get over it...this is just the new ‘in’ topic. Quite honestly, I feel harassed by all this professionalism talk.” In the 2014 Survey of Seniors graduating from dental schools (Wanchek et al, 2015), the most commonly reported curricular areas students felt were taught to excess were the basic sciences (at 20%) and ethics (14%). (See Sharp & Kuthy, 2008.) Judging from the chronically low attendance at CE programs on ethics and even their almost total absence at state and large national dental conventions, this attitude of taking a pass on formal instruction in ethics carries over to practice. The average age of physicians who have their licenses disciplines for the first time is 54 (Papadakis et al, 2004)—closer to retirement than to beginning practice.

These data should not be used to make a case for diminishing the attention to ethics in dental education. And we should certainly get serious about bringing this discussion to those in practice. We may be going about it in the wrong manner (Bertolami, 2004). Right concern; not exactly the right approach.

The number one reason people cheat, in school (McCabe, 2001) and in life (Callahan 2004) is that others cheat. Andrews and colleagues (2007) report that dental students cheat because they do not respect a system that allows others to bend or break the rules with no consequences. The right unit of analysis is probably not the individual but the organization. The method of

FIGURE 1: GALLUP SURVEY of HONESTY/ETHICS in PROFESSIONS.



change is probably not high talk but a system of rewards and punishments. Professionals adapt their behavior to what is modeled in the education system and then in practice (Fischman et al, 2004). They learn what is allowable. Codes, pledges, and lectures and seminars saying that there is, in theory, a better way carry little weight if they are inconsistent with what young professionals see around them.

WHAT THE PUBLIC THINKS

The public is also concerned with the integrity of the dental profession. Each November, the Gallup organization surveys Americans concerning trust in various professions. The question posed is “Tell me how you would rate the honesty and ethical standards of people in these field...” Results are reported in terms of the percentage of respondents who answer “Very High” or “High” on a five-point scale. Figure 1 shows some historic trends.

The number one reason people cheat, in school and in life, is that others cheat.

Nurses have been the most trusted profession for years, with medical doctors, pharmacists, and others in the health fields being in a comfortable position. Dentistry is only surveyed every few years. It is on the low end of the health professions group and took a small hit in 2009 but has rebounded. It is neck-and-neck with law enforcement officers.

By comparison, lawyers have benefited from a sustained growth of public trust over the past ten years, but they started from a weak position. The clergy and the media generally poll in the 30% to 40% trust range. The most conspicuous sustained decline is the U.S. House of Representatives at 8%. The president's approval rating is sampled on a monthly basis, and as of December 2015 stood at 46%.

Dentistry is a fiduciary profession. That means it is based on trust. Patients, the public, and policy makers have no way of knowing in accurate detail whether the claims made by all individuals with the title "dentist" are believable. Certainly the motives and knowledge of the vast majority of dentists are solid. It is just that the public has to depend on general impressions. Trust is a shared asset among professionals. The solid practitioner and the shady dealer are equal beneficiaries in the positive reputation the profession enjoys (Paruchuri & Misangyi, 2015). As the trend grows for large group practices where a patient may see several different dentists on subsequent visits to the same office, the importance of fiducial relationship becomes more significant.

OBLIGATION TO PROTECT THE PROFESSION'S REPUTATION

The public has given the professions first opportunity to manage the trustworthiness of their members. The American Dental Hygiene Association, the American Medical Association, the American Nursing Associations, and other professional groups have named trust as an essential element of their codes. The American Dental Association has not.

It is likely that there is a direct, inverse relationship between general trust in a profession and amount of regulation (Lange, 2008). What cannot be assumed on faith must be governed by rules, filings, inspections, and penalties. The insurance industry has made this argument for years. Dentistry will have to decide whether it wishes to take the position (as it apparently has) that all dentists are to be regarded by others as equally trustworthy. There are two other possible positions: Vigorously self-police or allow a free-market, and presumably transparent, system with each dentist making his or her own case directly to the public.

DENTISTRY AS A COMMUNITY OF PROFESSIONALS

It has been taken for granted by many that the functional unit in ethics is the individual. Ethics is regarded as a personal choice, folks are classified as ethical or unethical, and it is believed that the moral tone of a group can be expressed as the average performance of those in the group. It is assumed that dentists will practice close enough to the publically announced standards that we need not be concerned. This leads naturally to an approach based on educating individuals and faith that once they have been told how to behave, the problem has been handled. The natural

consequence of this view is to shift attention away from communities as moral agents and to blame individuals when there are untoward events. Indeed, one of the predictable aspects of license remediation is to require ethics training. This has the unfortunate effects of absolving organizations of moral responsibility and casting ethics training as a punishment for bad acting without diagnosing or correcting the circumstances that promoted that behavior.

One of the studies that has already been completed in the ACD Gies Ethics Project (Chambers, 2015a) surveyed 54 patients and 91 dentists regarding eight ethics cases. Both groups were asked to indicate the appropriateness of various courses of action and the reasons they would use to justify these actions. The issue of concern here is whether patients and dentists interpret ambiguous moral situations the same way. In a great many cases there is reassuring consistency.

But not always. In one of the cases, a dentist is presented with compelling evidence that a colleague has engaged in continuous and gross faulty treatment. The question is whether the dentist who has such information should bring it to the attention of the component dental society. As shown in Figure 2, patients overwhelmingly expect that this is happening. Dentists are of a more mixed opinion. Three points bear emphasis here. First, the ADA Code of Professional Conduct C.4 (justifiable criticism) is clear that this should be done. Second, practitioners who take no action will be acting contrary to the expectations of most of their patients. Third, whatever the practitioner decides to do, he or she will be at odds with many colleagues. Treviño and Victor (1992) found in several business contexts that colleagues expect others will report misconduct at

the same time they display negative attitudes toward those who actually do. That is a formula for hypocrisy. It is a tender topic; but it is not one that is likely to get better by being ignored. We already have clear policy, but we do not have consistent, positive behavior.

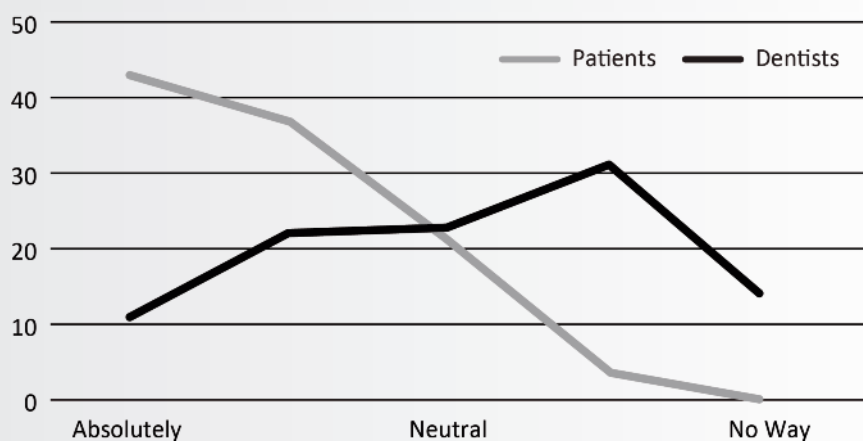
GOOD OR BAD IS NOT THE RIGHT WAY TO LOOK AT PEOPLE

Ethical concern seems to come in various strengths and in two flavors (Reynolds, 2006). Ethical *awareness* is a trait of those who are sensitive to the wrong that is occurring around them in the world. This has been investigated in dentistry (Bebeau & Brabeck, 1987). Not everyone is sensitive, and those who are oblivious cannot be counted on to

lift up those around them. But ethical awareness can also be a curse, leading to depression and making one an annoyance to others who hear constantly how bad the world is. Those high in ethical awareness sometimes act as though outing the failings of others is the goal of ethics. Moral *attentiveness* is different. It requires a person to recognize opportunities for them to participate in making the world better. Research shows that moral attentiveness is a better predictor of positive behavior than is ethical awareness.

It has been known since the classic studies by Hugh Hartshorne and Mark May nearly a hundred years ago (1928) that the distinction between ethical and unethical individuals is a clumsy view. Hartshorne and May used direct

FIGURE 2: SHOULD THE DENTIST WHO IS AWARE OF PATIENT MISTREATMENT BY A COLLEAGUE MAKE A REPORT?



observation over time rather than opinion surveys and found marked inconsistency within principles across contexts. One child would steal school supplies but not a friend's lunch, while his buddy would do the opposite. Which has an "honest" character? Some dentists cheat insurance companies by upcoding but would not cheat on their spouse. Sometimes it is the other way. It is not uncommon that upcoding is engaged in selectively, and about 40% of physicians do it (Wynia et al, 2000). The United States Internal Revenue Service website reports that about one in five tax filings is believed to be underreported, the average amount being approximately \$4,000. Recent research (Ariely, 2009) makes a case that cheating is most common among individuals who regard themselves as "ethical" in general and that it is justified as "being owed to them."

The point of this argument is that dividing individuals into ethical and unethical groups is too blunt a categorization to be useful. We should focus on ethical behaviors rather than "ethical individuals." It is reasonable to expect that we can achieve very significant improvements in the ethical tone of the profession without focusing on a few bad actors (although that certainly should be considered). Our biggest opportunity is likely to be small changes in the daily behavior of the vast majority of dentists who are regarded by their colleagues and the public as being good dentists. But it may be especially difficult to improve ethical behavior one dentist at a time.

I carry with me a story that defies much of the theory of professional ethics experts. An individual I respect told me about applying for orthodontic residence positions. In his final year of dental school, classmates told him about some bootlegged unreleased copies of National Board test questions. Despite National Board scores being lousy predictors of success in graduate programs and the National Commission on National Dental Board Examination's vigorous polemics to stop the practice, residency directors place great weight on these scores. My friend knew that classmates who had marginal grades were using these pirated questions to boost their competitiveness. What should he do? Using the unauthorized questions seemed devious; letting less qualified individuals get into graduate programs seemed unjust. We cannot solve this problem at the individual level, or by theory and principles. It is a fault built into the system. The technical term for forcing others into a situation where they must make unethical decisions is "moral distress."

ETHICAL COMMUNITIES EVOLVE OVER TIME

An earlier investigation in the ACD Gies Ethics Project (Chambers 2014a) explored how communities evolve ethically over time. I will describe this study in some detail here because there are several lessons in it.

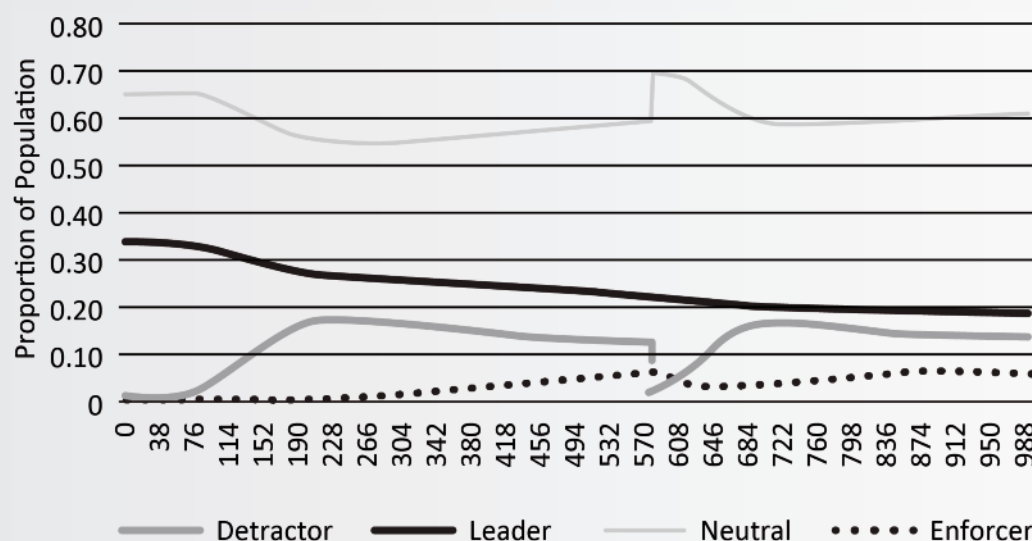
I started with two assumptions: (a) individuals can change—or better, individuals can modify the proportion of acts that positively affect others—and (b) these changes over time are a function of the relationships they have with others. This is a bit complicated as behavior is both the result of others' actions and the cause of their behavior. That means that such complex interactions have to be studied by means of computer simulations. The approach I used is a Markov replicator model, such

as those used by evolutionary biologists and ecologists.

There are four types of agents in the system: (a) Leaders—dentists who for the most part act ethically and help others to do so as well; (b) Neutrals—those who fail to rise to anyone's attention based on the way they treat others; (c) Detractors—those who damage the profession by taking advantage of the public or their colleagues; and (d) Enforcers—dental boards, state agents, or others indemnified for disciplining the Detractors. Although it is natural to label these as "individuals," it is more accurate to think in terms of bundles of behavior that might be classified as belonging to each category.

The key to the system is to ask, for example, what typically happens when a Detractor interacts with a Neutral? It is essential for Detractors to be embedded among a community of Neutrals who provide reputational cover so the interaction is positive from the Detractor's point of view. But it is just a little to the disadvantage of the Neutral. Over the long run and in small increments, the level of public trust in the profession is damaged in professions that harbor bad actors. The interaction between a moral Leader and a Detractor is more exciting. The Detractor suffers because the Leader is willing to confront the Detractor directly or even bring the bad behavior to the attention of the appropriate Enforcers. (It is apparent that I am modeling the kind of relationship described above in the study where eight cases were reviewed by dentists and patients.) It costs the Detractor more than the interaction with the Neutral does, but it also costs the Leader something. The interaction of a Detractor with an Enforcer is more dramatic still. It may cost the Detractor

FIGURE 3. COMPUTER SIMULATION OF DENTISTRY AS A MORAL COMMUNITY INVOLVING FOUR TYPES OF AGENTS: LEADERS, NEUTRALS, DETRACTORS, AND ENFORCERS.



his or her license, but it helps the Enforcers. If there were no Detractors to go after, the Enforcers would be out of their jobs. There are 16 such relationships in all. Each can be given a value, with 1.0 meaning nothing of interest is taking place one way or the other. Numbers less than 1.0 indicate that the interaction is negative, and values higher than 1.0 signal benefits. Interactions less than 1.0 at Time 1 means that type of behavior is less likely at Time 2. All of this can be put in a computer and shaken up for various periods of time.

To start a computer simulation such as this, some initial values are necessary for the matrix of 16 possible interactions and an estimate of the starting proportion of various types of agents. These estimates were provided by the regents and officers of the American College of Dentists. The results of working such a model over time are shown in Figure 3.

The proportions were set at two-thirds Neutrals, Leaders at one-third, and Enforcers at 1%. Although the regents and officers thought the proportion of Detractors might be as high as 20%, I overrode their judgment and started the

simulation by allowing only 0.01% Detractors. I have run hundreds of variations on this simulation, adjusting the starting proportions and the matrix that describes the interactions. The pattern shown here is representative.

The first thing to note is that the proportions change over time even when the starting point and the interaction matrix remain constant. Systems like this—moral communities—have an internal dynamic that emerges with repeated iterations, eventually becoming stable.

The next thing that draws attention is that the Detractors reach a steady state of around 20%, despite being only a tiny fraction of the original population and being vastly outnumbered at the beginning by Enforcers. The system “produces” Detractors. The regents and officers of the college were right after all. Neutrals go through some changes, but remain essentially stable as the

Leaders become neutralized and a proportion of the Neutrals defect until the system has absorbed all it can handle.

It is likely that there is a direct, inverse relationship between general trust in a profession and amount of regulation. What cannot be assumed on faith must be governed by rules, filings, inspections, and penalties.

dominant types in such a system. They avoid the costs of getting whacked if they are found to be Detractors and of the costs of Leadership. The losers in the system are the ethical Leaders. These experience a steady decline; the system is unfriendly to them. Note what is happening is not that Leaders are becoming Detractors; Leaders become neutralized and a proportion of the Neutrals defect until the system has absorbed all it can handle.

There is a bump in the middle of the graph. This represents “the miracle of continuing education.” At a point where the system was approaching stability, I inserted a line of code in the program that converted 80% of the Detractors to Neutral status. One could think of this as a massive and very effective ethics education intervention. At a single point, a hugely successful correction was made *to the individuals who needed it*. But the system very quickly overwhelmed this intervention, even with a bit of spiteful backlash. This affirms a traditional saying in management theory that every organization is perfectly designed to produce exactly the amount of bad performance it will tolerate.

This simulation supports the following general conclusions:

1. Moral behavior is a complex interaction within a community of individuals, each with different reward structures.
2. Systems that tolerate Detractors have a predictable number of them.
3. Interventions that are not supported by changes in the fundamental relationships among the members of the community will be a waste of time.

4. Systems such as this with a majority of Neutrals and a minority of Detractors are stable, and the majority of participants (Neutrals) have no incentive to disrupt the status quo.

Further work needs to be done with models such as this, but it is at least a plausible starting point to assume there is little current energy behind improving the ethical tone in such a system by either moving Neutrals to Leaders or Detractors to Neutrals. It is just not worth the effort of the Neutrals. The longer the dysfunctional system is allowed to remain in place, the more difficult it is to exercise leadership.

The model does offer a surprising perspective on the matter of cost and benefit to the majority. The system is stable with regard to the relationship between Neutrals and Detractors, so there is no advantage in going after the few bad apples. The key leverage point is the relationship between Leaders and Neutrals. Very small changes in these nearly even and very common exchanges actually promote substantial improvements. Even casual and informal adjustments at this interface lead to sharp declines in the proportion of Detractors.

Consider this conversation, the likes of which I have heard several times. A Neutral dentist brings up his or her last visit to an online chat room where practitioners share methods for “getting a little more from the insurance companies if one is willing to kind of imagine that what one is doing is ethical.” The Detractor-in-training will want to know more and may share additional strategies. The other Neutrals in the conversation will feel proud of themselves for not saying much of anything. The ethical Leader will say, “I am bothered by practices such as this. I doubt that this is ethical, and I imagine insurance companies will take steps to

block it. Because the insurance companies or even state agencies cannot easily control a few targeted practitioners, they will add new layers of regulation that I and all ethical dentists will have to comply with, even though we would never consider behaving this way. You are calling my integrity into question and increasing my practice burden for your own benefit.”

Notice that this extended example has involved two matters that hold new promise for study in the ACD Gies Ethics Project: a morality as a community (professional) rather than individual activity, and (b) a three-type classification of moral actions as being a leader, being neutral, or detracting from the profession.

Ethics in Community

I have redeemed my promise to look at the way we treat each other rather than what we say about it, to envision the individual as part of a professional community, and to highlight the need for moral leaders who take an active role in improving the ethics of others. Looking at moral behavior in a different light or at the practices in the profession in new ways should make us aware of problems that have been discussed before. We will see more and perhaps better be able to address long-standing issues that have been hiding in plain sight. The rest of this paper will give examples of some of the kinds of moral issues that emerge in this new perspective.

There is a deep literature in the business field that starts from the perspective that organizations establish the context in which members function (Ashforth & Anand, 2003; Phillips and Margolis, 1999; Victor & Cullen, 1988;

Treviño et al, 2006).

There is an overwhelming body of evidence that organizations that have a strong moral foundation flourish (start with Simha & Cullen 2012 or Treviño et al, 2006). Communities that have a reputation for being ethical and where members report being treated with dignity make more money, have more positive impact on those they serve, enjoy customer loyalty, have lower turnover and higher morale, experience less employee theft and embezzlement, and have fewer workers' compensation claims and legal actions. Leaving aside the fact that “it is the right thing to do,” ethics pays. The opposite is also true. Organizations that are morally soft have a long-term toxic effect on everyone. We can even say that ethically neutral organizations are leaving a lot on the table.

In all the examples that follow, it is impossible to isolate the moral behavior of an individual from the context of communities in which he or she behave. In most, there is no face-to-face interaction between the moral agent and the person he or she helps or harms. Often the individual is unaware or helpless in the face of moral manipulations by groups. In most, it is the community itself that drives the ethics.

MORAL DISTRESS

One especially pernicious form of group ethical effect is called moral distress (Epstein & Delgado, 2010). Those in power, or at least those who have a loud voice in setting up the rules, sometimes force others into positions where they are morally compromised no matter what they do. William Styron's novel *Sophie's Choice*—where the protagonists is asked “which of your children do you want to send to the gas chamber?”—is an extreme example. Should the hygienist

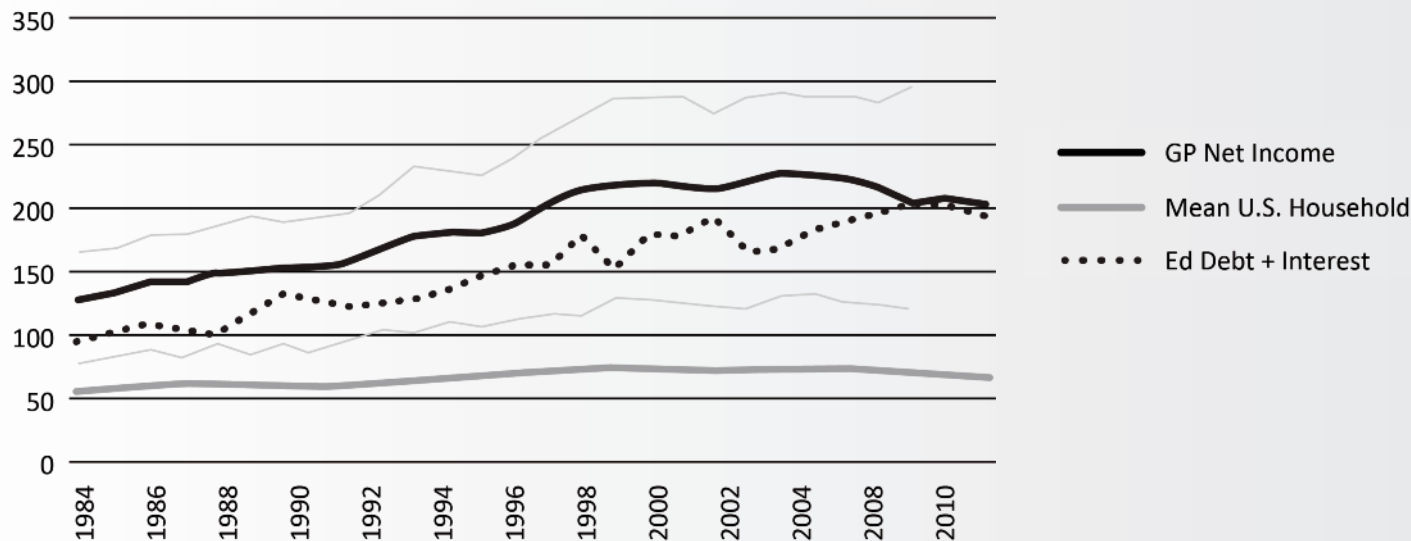
demonstrate concern for the patient by noting that a “required” procedure is of questionable value or demonstrate loyalty to the practice by remaining quiet? It is misleading to consider this an ethical dilemma for the individual. The fault is at the system level. What about incentive plans in large practices that make it attractive to cut corners on patient care? It is moral turpitude on the part of the system that forces others into decisions they should not have to make.

The example above of a student forced to choose between using bootlegged National Boards or diminishing his chances of getting into a graduate program despite his outstanding academic record is moral distress. So are some of the arrangements created by one-shot initial licensure testing that promote treatment planning that is not in the patient's best interest and firms that traffic in “ideal” board patients for a fee. Of course, testing agencies have ethical codes frowning on those practices, but not on their creating such incentives. The pressures on graduates today are not the same as those existing when the rule makers were entering practice. One officer in a regional testing agency recently wrote to advise his young colleagues that he had employed the patient-recruiting services of Jack Daniels.

FRAGMENTATION

Historically, one of the strengths of organized dentistry is that it can speak to the public on policy matters “with one

FIGURE 4: ECONOMIC TRENDS IN DENTISTRY (IN THOUSANDS OF DOLLARS ADJUSTED FOR INFLATION).



voice.” Dentistry has been based on common values so that it makes sense that what is good and right for one dentist will be very close to what is good and right for many of them. Differences always exist, but in the past it would be unusual for dentists not to share substantial common ground and to agree with each other on what is ethical and what is pushing the boundaries too far.

The ACD Gies Ethics Project will measure the values of the profession and of its constituencies, very likely employing a modification of a widely used and well-validated instrument known as the Moral Factors Questionnaire (Haidt, 2012). It is hoped that there will be large overlap among dentists and the public on basic values. If it should happen that there are gaps and camps; if these divergences are associated with demographic characteristic such as age, part of the

country, or practice style; and if these differences seem to be growing, that would be evidence that the profession is fragmenting at the most basic level.

One sign of potential fragmentation can be noted already (Chambers, 2014b). Figure 4 shows historical trends in dentists’ incomes. Several things are obvious, even without a statistical analysis. First, incomes for dentists in general practice—in real, CPI-adjusted dollars—have been going up dramatically over the last third of a century. Whereas the amount of money the public has to spend on all necessities has remained flat, dentists are roughly in the top ninety-seventh percentile. This means that dentistry is costing more of the average American’s money than it did formerly.

The much-commented-on rise in dental school education debt may be a bit more nuanced than is thought. Educational debt throughout most of this period was a constant fraction of the average annual income of dentists in general practice. This relationship between debt and earnings changed in about 2006. That was partially a

reflection of educational costs, but primarily a function of dentists’ incomes leveling off. Personal characteristics such as sex and background appear to be better predictors of practice plans than is educational debt. The most recent Survey of Seniors reported that 44% of graduates say that debt has no effect or only a slight one on practice plans (Wanchek et al, 2014), while another quarter said it had only a moderate effect (Wanchek et al, 2015).

What is more concerning in Figure 4 is the two thin lines that look like sleeves on the line for dentists’ income. These are the standard deviations for what dentists take home. Approximately 16% of general dentists earned more than the amount indicated by the top line and 16% earned below the bottom line. There are dentists who are doing better and better in recent years and those who are losing ground in real dollars. But the danger signal is that the gap has increased by about 150% in the past ten years while average incomes have been

flat. The profession is being pulled apart into those who are doing well financially and those who are less successful. It is possible that this spread reflects a divergence in values (or at least differential acceptance of an economic orientation). It is also reasonable to accept this as *prima facie* evidence for fragmentation in the profession.

FICTITIOUS DENTISTS

Some dentistry is delivered by entities with an ambiguous legal standing. Like companies that enjoy both the status of persons and the status of fictitious legal entities, increasingly dentists are LLCs—limited liability corporations. That means they have protection from crippling damages should they break the law or even make foolish business decisions. Corporate owners of dental practices would like to restrict the definition of dentistry to only the surgical delivery of a billable procedure. That would give them the most freedom from regulation under state dental practice acts. Currently the debate in some states is whether treatment planning is covered in states' practice acts. Where the line is drawn will be perhaps the greatest single issue faced by organized dentistry in the next decade.

Here is a cautionary tale. In John Steinbeck's masterpiece, *The Grapes of Wrath*, the situation of Oklahoma tenant farmers in the 1930s is described. They work the land, but they do not own it. By the law of random fluctuation, farmers are bound to encounter bad years when it is necessary to borrow money, although perhaps not as much as current dental students borrow. Most of them cannot pay back the debt, and they end up working for the banks. That is fine until the banks are squeezed economically as they were during the Depression. They realize they can do much better by farming large plots in a

standardized and mechanized fashion. So they evict the tenants and hire back a few to work for the company. Steinbeck describes a conversation between a tenant farmer and the "company man" sent out to give him a few hours notice that his farm and all around him will be leveled to make way for a more productive and better managed system. The women and children watch as the farmer draws idle circles in the dust and then promises to be at the window with his rifle when the bulldozers come.

"Times are changing, mister, don't you know. Can't make a living on the land unless you've got two, five, ten thousand acres and a tractor." "But let a man get property he doesn't see, or can't take time to get his fingers in, or can't be there to walk on it—why, then the property is the man. The property is the man, stronger than he is." "It's not me. There's nothing I can do. I'll lose my job if I don't do it. And look—suppose you kill me? They'll just hang you, but long before you're hung there'll be another guy on the tractor, and he'll bump the house down. You're not killing the right guy." "That's so," the tenant said. "Who gave you orders? I'll go after him. He's the one to kill." "You're wrong, he got his orders from the bank." "Well, there's a president of the bank. There's a board of directors. I'll fill up the magazine of the rifle and go into the bank." The company man said. "Fellow was telling me the bank gets orders from the East. The orders were, 'Make the land show a profit or we'll close you up.'" "But where does it stop? Who can we shoot? I don't aim to starve to death before I kill the man that's starving me." "I don't know. Maybe there's nobody to shoot. Maybe the thing isn't men at all. Anyway I told you my orders."

A chestnut in the first management course in MBA programs is that authority can be delegated, but responsibility cannot.

Moral fading is essentially obtaining an ethical pass by making it a legal matter and then buying off the verdict.

Several years ago I examined every ad for dentists in the San Francisco phone book—there were about 1,200 of them (Chambers, 2010). Just over 10% listed a fictitious business name and not the name of any person. Of these, only 54% were registered with the department of consumer affairs as per state regulations and the country as required. Those practices with fictitious names were statistically more likely to have multiple practice locations, have a disciplined dental license, place large ads in the Yellow Pages, and mention price and products by name (i.e., Zoom and Invisalign) in their ads. Older dentists were more likely to use fictitious names, to advertise, and to have disciplined licenses and less likely to be members of the San Francisco Dental Society.

MORAL FADING

Although individuals do this, it is much more common among organizations (Tenbrunsel & Messick, 2004). The term “moral bleaching” is also used and may be more descriptive. The practice is simple: Move moral issues out of the domain of right and wrong or good and bad into the legal or economic areas. A consent decree is a typical example. The company agrees to pay a “large” government fine or the city agrees to pay the parents of a shooting victim a settlement out of tax dollars, as long as there is no admission of guilt and usually no legal record. On the national news we hear that a company is initiating a recall in the face of several deaths and violation of government safety regulations. The story predictably concludes with something like this: “Spokesmen for X Company declined to be interviewed for this story, but provided a statement saying that X Company is strongly

committed to the highest standards of customer safety consistent with their rich tradition of providing the ultimate in driving luxury.” That, of course is just an advertisement, probably an expensive one given the size of the fine, but certainly an ethical dodge.

Moral fading is essentially obtaining an ethical pass by making it a legal matter and then buying off the verdict. Criminals do it under the cloak of plea bargaining. It has been a common enough annoyance for rich families whose sons could not restrain their amorous appetites. There are a number of stories in circulation in the dental board community where moral reprobates hired lawyers to redefine patient ethical abuse as partially questionable commercial practices, paid the fine without its going on their record, and moved to another state with a clean slate.

DECOUPLING

I have already shown that individuals can agree in principle and diverge in practice. When organizations do this, it is known as “decoupling” (Crilly et al, 2012; Weaver et al, 1999; Butterfield et al, 2000; MacLean & Behnam, 2010). It is common that organizations invest substantially in public relations messages touting high ethical principles. Some trade associations even club to create a small fund and give a prize to the one of its members who was “most ethical” last year. It is generally the case that organizations decouple in the direction of protecting the interests of internal stakeholders compared to customers or regulatory agencies and that tangible assets and interests are enhanced while professing adherence to principles.

Individuals naturally “decouple” from codes and professional norms, with the focus being on doing well in local, practical settings (Terlaak, 2007).

Responsibility Shifting

A chestnut in the first management course in MBA programs is that authority can be delegated, but responsibility cannot. That makes it a questionable practice to pay others to assume one's moral responsibility. Consider "pay to delay" drug marketing settlements. A large and successful pharmaceutical manufacturer faces revenue losses when the patent on one of its drugs expires. A smaller manufacturer announces plans to market a generic version, which typically sells for about one-sixth the cost. The larger firm threatens legal action over patent infringement. Although the case is recognized as having no merit, introduction of the generic will be delayed while the suit is pending. The large company continues to make a profit since high-priced sales minus legal costs are greater than no sales or sales at the generic price. The smaller firm will eventually prevail if it has deep enough pockets, but then only at an increasing net minus cash position the longer the legal action lasts. The lawyers on both sides benefit the longer the matter is in the courts regardless of outcome. Courts generally frown on this kind of maneuvering and attempt to expedite resolutions. This can produce settlements where the generic manufacturer agrees to delay introduction of the competitive product for a period of say seven years in exchange for several millions in cash payments from the larger firm each year. This is a case where the legal system is used as a shield for immoral behavior.

Drug manufacturers also partner with consumers in a scheme to extract money from insurance companies. When patients select a brand name drug they are often charged a co-pay on their insurance plan because the insurance company has to pay the pharmaceutical firm a large amount for such products.

If an equally effective generic is available, the insurance company will not charge the co-pay. Drug makers now advertise programs where they subsidize the co-payment on behalf of patients if the patient will request the more expensive brand-name alternative. It is a wash to the patient (a bit of paperwork for a marketed brand name). The pharmaceutical firm takes a small loss on each sale (co-pay), but receives much more by selling the brand name product (larger profit margin). The insurance company must pay for brand drugs at a high cost (with a slight discount from the makers of the brand drugs) under contracts stipulating that the patients are free to choose. They pass the increased costs on to patients generally, and primarily to employers, in the form of higher insurance premiums.

It appears there is potential for moral shifting in the kind of corporate dental practice where those other than at chairside can decide office hours, material and procedures, and who is employed (as opposed to true DSOs where the dentist can fire the service provider) (Chambers 2015b). In the corporate model, dentists are responsible for any untoward dental outcome while the corporate interests share in the benefits of the effective care others provide.

PRIMING

The final example of community moral behavior is priming. It is natural to play a variety of ethical roles. We have personal templates of ethical standards and behavior patterns appropriate to multiple situations, and we customize our responses based on which "self" is supposed to show up in each situation (Aquino & Reed, 2002; Welsh & Ordóñez 2014). A familiar example is conflict of

interest. It is fine to be in the pay of a firm that sells dental products, and it is fine to lecture on differences between products. In the United States, it is not okay to do both without also alerting one's audience that a potential conflict exists. In Canada, there is at present no single code of ethics for the entire dental profession. There are provincial codes, as in states in this country. Virtually all Canadian codes of ethics prohibit a dentist from publicly endorsing dental products even with disclosures. The ADA code is silent on this topic.

Ethical priming consists of promoting the likelihood of one pattern of ethical response over another. In a famous study (Mazar et al, 2008), now repeated many times, subjects are asked to solve a number of puzzles, such as finding sequences of numbers that total to ten. The puzzles are self-scored from a key and participants in the project report their scores to an attendant and are given small rewards based on how well they say they have done. The amount of self-promotion per subject is measured by retrieving the answer sheets from the conveniently located trash can, since each answer sheet contains an embedded code. Minor self-promotion is widespread.

The priming part of this kind of project comes in the preliminary procedure. Some subjects are asked to engagement in a neutral task such as listing favorite songs in high school. Others are asked to write down as many of the Ten Commandments as they can recall. We learn two things from such studies: First, people cannot recall many

of the Ten Commandments. Second, just trying to do so reduces cheating. What a simple and effective way of boosting morality—all it takes is highlighting the culture of a community that expects the ethical self to be present. This is one of the points that emerged in the computer simulation of the ethical community described above.

Another example of priming was a recent study of Army medics (Leavitt et al, 2012). These individuals have two identities: military and health care. At issue was a choice in an ethical ambiguous decision fixing the dollar amount of compensation to families of soldiers killed in combat. In one condition, medics completed the ethics questionnaire wearing their uniforms in a room decorated with military insignia. In the other, they were primed by reporting in scrubs to a room filled with medical equipment. Those encouraged to activate their medical moral template did in fact demonstrate more moral opinions than the same individuals who thought they were soldiers.

If priming can be demonstrated in dentistry, we will have a strong case that practitioners who are both businessmen and businesswomen and healthcare professions will behave based on which background music is playing loudest. We should raise our voices for ethics. ■

REFERENCES

- Andrews, K. G., Smith, L. A., Henzi, D., & Demps, E. (2007). Faculty and student perceptions of academic integrity at U. S. and Canadian dental schools. *Journal of Dental Education*, 71 (8), 1027-1039.
- Aquino, K., & Reed, A., II (2002). The self-importance of moral identity. *Journal of Personality and Social Psychology*, 83, 1423-1440.
- Ariely, D. (2009). *Predictably irrational: The hidden forces that shape our decisions*. New York, NY: Harper.
- Ashforth, B. E., & Anand, V. (2003). The normalization of corruption in organizations. *Research in Organizational Behavior*, 5, 1-52.
- Bebeau, M. J., & Brabeck, M. (1987). Ethical sensitivity and moral reasoning among men and women in the professions. In M. Brabeck (Ed.), *Who cares? Theory, research, and educational implications of the ethic of care*. New York, NY: Praeger, pp. 144-163.
- Beenen, G., & Pinto, J. (2009). Resisting organizational-level corruption: An interview with Sherron Watkins. *Academy of Management Learning & Education*, 8 (2), 275-289.
- Bertolami, C. M. (2004). Why our ethics curricula don't work. *Journal of Dental Education*, 68 (4), 414-425.
- Butterfield, K. D., Treviño, L. K., & Weaver, G. R. (2000). Moral awareness in business organizations: Influences of issue-related and social context factors. *Human Relations*, 53 (7), 981-1018.
- Chambers, D. W. (2007). A primer on dental ethics: Part II. Moral behavior [leadership essay]. *Journal of the American College of Dentists*, 74 (4), 38-51.
- Chambers, D. W. (2010). Dentistry from the perspective of the San Francisco phone book. *CDA Journal*, 38 (11), 801-808.
- Chambers, D. W. (2014a). Computer simulation of dental professionals as a moral community. *Medicine Health Care and Philosophy*, 17, 467-476.
- Chambers, D. W. (2014b). Factors driving recent changes in dentists' incomes. *Journal of the California Dental Association*, 42 (5), 331-337.
- Chambers, D. W. (2015a). Do patients and dentists see ethics the same way? *Journal of the American College of Dentists*, 82 (2), 31-47.
- Chambers, D. W. (2015b). The separation of treatment from management. Editorial. *Journal of the American College of Dentists*, 82 (1), 2-5.
- Crilly, D., Zollo, M., & Hansen, M. T. (2012). Faking it or muddling through? Understanding decoupling in response to stakeholder pressures. *Academy of Management Journal*, 55 (6), 1429-1448.
- Darley, J. M., & Bateson, C. D. (1973). From Jerusalem to Jericho: A study of situational and dispositional variables in helping behavior. *Journal of Personality and Social Psychology*, 27, 100-119.
- Epstein, E.G., Delgado, S., (2010) Understanding and addressing moral distress. *OJIN: The Online Journal of Issues in Nursing*, 15 (3), Manuscript 1.
- Fischman, W., Solomon, B., Greenspan, D., & Gardener, H. (2004). *Making good: How young people cope with moral dilemmas at work*. Cambridge, MA: Harvard University Press.
- Fuller, J. L., & Killip, D. E. (1979). Do dental students cheat? *Journal of Dental Education*, 43 (3), 666-669.
- Giacalone, R. A. (2007). Taking a red pill to disempower unethical students: Creating ethical sentinels in business schools. *Academy of Management Learning & Education*, 6 (4), 534-542.
- Gies, W. J. (1926). *Dental education in the United States and Canada: A report to the Carnegie Foundation for the Advancement of Teaching*. New York, NY: The Carnegie Foundation for the Advancement of Teaching.
- Hafferty, F. W. (2006). The elephant in the medical professionalism kitchen. *Academic Medicine*, 81, 906-914.
- Haidt, J. (2012). *The righteous mind: Why good people are divided by politics and religion*. New York, NY: Vintage.
- Hanson W. R., & Moore J. R. (2014). Business student moral influencers: Unseen opportunities for development? *Academy of Management Learning & Education*, 13 (4), 525-546.
- Hartshorne, H., & May, M. W. (1928). *Studies in the nature of character*. New York, NY: Macmillan.
- Humphrey, H. J., Smith, K., Reddy, S., Scott, D., Madara, J. L., & Arora, V. M. (2007). Promoting an environment of professionalism: The University of Chicago "Roadmap." *Academic Medicine*, 82 (11), 1098-1107.
- Hutton, J. G., Jr. (1968). Attitudes of dental students toward dental education and the profession. *Journal of Dental Education*, 32 (3), 296-305.
- Lange, D. (2008). A multidimensional conceptualization of organizational corruption control. *Academy of Management Review*, 33 (3), 710-729.
- Lantz, M. S., Bebeau, M. J., & Zarkowski, P. (2011). The status of ethics teaching and learning in U. S. dental schools. *Journal of Dental Education*, 75 (1), 1295-1309.

- Leavitt, K., Reynolds, S. J., Barnes, C. M., Schilpzand, P., & Hannah, S. T. (2012). Different hats, different obligations: Plural occupational identities and situated moral judgment. *Academy of Management Journal*, 55(6), 1316-1333.
- MacLean, T. L., & Behnam, M. (2010). The dangers of decoupling: The relationship between compliance programs, legitimacy perceptions, and institutionalized misconduct. *Academy of Management Journal*, 53(6), 1499-1520.
- Matthews, M. C. (1988). *Strategic intervention in organizations: Resolving ethical dilemmas*. Newbury Park, CA: Sage.
- Mazar, N., Amir, O., & Ariely D. (2008). The dishonesty of honest people: A theory of self-concept maintenance. *Journal of Marketing Research*, 45, 633-644.
- McCabe, D. L. (2001). Cheating: Why students do it and how we can help them stop. *American Educator*, Winter, 1-7.
- McCabe, D. L., Butterfield, K. D., and Treviño, L. K. (2006). Academic dishonesty in graduate programs: Prevalence, causes, and proposed action. *Academy of Management Learning & Education* 5(3), 294-305.
- Papadakis, M. A., Hodgson, C. S., Teherani, A., & Kohatsu, N. D. (2004). Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Academic Medicine*, 79(3), 244-249.
- Paruchuri, S., & Misangyi, V. F. (2015). Investor perceptions of financial misconduct: The heterogeneous contamination of bystander firms. *Academy of Management Journal*, 58(1), 169-194.
- Phillips, R. A., & Margolis, J. D. (1999). Toward an ethics of organizations. *Business Ethics Quarterly*, 9(4), 619-638.
- Reynolds, S.J. (2006). Moral awareness and ethical predispositions: Investigating the role of individual differences in the recognition of moral issues. *Journal of Applied Psychology*, 91(4), 737-748.
- Sharp, H. M., & Kuthy, R. A. (2008). What do dental students learn in an ethics course? An analysis of student-reported learning outcomes. *Journal of Dental Education*, 72(12), 1450-1457.
- Shulman, L. (2011). Forward: On the shoulders of Flexner. In M. Cooke, D. M. Irby, & B. C. O'Brien (Eds.), *Educating physicians: A call for reform of medical school and residency*. San Francisco, CA: Jossey-Bass, pp. v-xii.
- Simha, A., & Cullen, J. B. (2012). Ethical climates and their effects on organizational outcomes: Implications from the past and prophecies for the future. *Academy of Management Perspectives*, 26(5), 20-34.
- Tenbrunsel, A. E., & Messick, D. M. (2004). Ethical fading: The role of self-deception in unethical behavior. *Social Justice Research*, 17(2), 223-236.
- Terlaak, A. (2007). Order without law? The role of certified management standards in shaping socially desired firm behavior. *Academy of Management Review*, 32(3), 968-985.
- Treviño, L. K., Weaver, G. R., & Reynolds, S. J. (2006). Behavioral ethics in organizations: A review. *Journal of Management*, 32(6), 951-990.
- Treviño, L. K., & Victor, B. (1992). Peer reporting of unethical behavior: A social context perspective. *Academy of Management Journal*, 35(1), 38-64.
- Victor, B., & Cullen, J. B. (1988). The organizational bases of ethical work climates. *Administrative Science Quarterly*, 33, 101-125.
- Wanchek, T., Nicholson, S., Vujicic, M., Menezes, A., & Ziebert A. (2014). Educational debt and intended employment choice among dental school seniors. *Journal of the American Dental Association*, 145(5), 428-434.
- Wanchek, T., Cook, B. J., Anderson, E. L., and Valachovic, R. W. (2015). Annual ADEA Survey of Dental School Seniors: 2014 graduating class. *Journal of Dental Education* 79(9), 1108-1128.
- Weaver, G. R., Treviño, L. K., & Cochran, P. L. (1999). Integrated and decoupled corporate social performance: Management commitments, external pressures, and corporate ethics practices. *Academy of Management Journal*, 42(5), 539-552.
- Welsh, D. T., & Ordóñez, L. D. (2014). Conscience without cognition: The effects of subconscious priming on ethical behavior. *Academy of Management Journal*, 57(3), 723-742.
- Wynia, M. K., Cummings, D. S., VanGeest, J. M., & Wilson, I. B. (2000). Physicians manipulation of reimbursement rules for patient: Between a rock and a hard place. *Journal of the American Medical Association*, 283, 1858-1865.

Ethical priming consists of promoting the likelihood of one pattern of ethical response over another.

2015 MANUSCRIPT REVIEW PROCESS

In addition to the 24 published theme papers and three articles reviewed by the American Society for Dental Ethics, seven unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentists* during 2015. Two manuscripts were accepted for publication with minor revisions. Two remain under review. Three were determined by the reviewers as not meeting publication standards, one without review because the content did not match the mission of the *Journal*.

Sixteen reviews were received for the four manuscripts for which reviews have been complete, for an average of 4.0 reviews per manuscript. Consistency of reviews was determined using the phi coefficient, a measure of association between review recommendations and the ultimate publication decision. The phi was 0.830, where 0.00 represents chance agreement and 1.00 represents perfect agreement. The college feels that authors are entitled to know the consistency of the review process. The editor also follows the practice of sharing all reviews among the reviewers as a means of improving calibration.

Instructions for authors and instructions for reviewers can be found on the website of the college. Journal reviewers are encouraged to use a sequential set of standards in evaluating manuscripts. The first concern is that the manuscript presents a topic of significant interest to our readers. Those that meet this criterion are evaluated for absence of bias in the presentation. The third standard is clarity of presentation.

The editor is aware of three requests from others to republish articles appearing in the journal received and granted during the year. This is a 13% republication rate.

The college thanks the following professionals for their contributions, sometimes multiple efforts, to the dental literature as reviewers for the *Journal of the American College of Dentists* during 2015.

Rickland G. Asai, DMD, FACD
Portland, OR

David F. Boden, DDS, FACD
Port St. Lucie, FL

Herb H. Borsuk, DDS, FACD
Montreal, QC

Steven D. Chan, DDS, FACD
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Milton Essig, DDS, FACD
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William A. van Dyk, DDS, FACD
San Pablo, CA

James Willey, DDS, FACD
Chicago, IL

Submitting Manuscripts for Potential Publication in JACD

Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of *JACD*. These can be found on the ACD web page under “publications.” In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not publish clinical case reports or articles that describe dental techniques. The communication policy of the College is to “identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of

public policy and personal leadership to advance the purpose and objectives of the College.”

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A “desk review” is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer review process typically takes four to five weeks.

Authors whose submissions are peer-reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on the ACD website under “How to Review a Manuscript for the *Journal of the American College of Dentists*.” An annual report of the peer review process for *JACD* is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts

reviewed and the consistency of the reviewers is in the phi = .60 to .80 range.

Letters from readers concerning any material appearing in this journal are welcome at dchambers@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. [The editor reserves the right to refer submitted letters to the editorial board for review.]

This journal has a regular section devoted to papers in ethical and professional aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of the Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.

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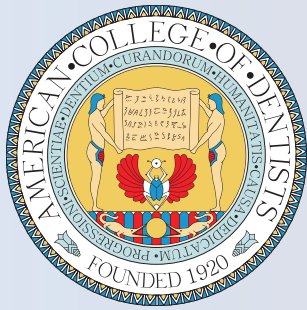


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