


Journal of the American College of Dentists

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Dentistry in a
Regulated Environment

The seal of the American College of Dentists is a large, circular emblem in the background. It features a central shield with a caduceus (a staff with two snakes entwined and wings at the top) and a banner with the Latin motto "PRO BONA ORA ET SANCTA MENTE". The shield is flanked by two figures, one holding a dental instrument. The outer ring of the seal contains the text "AMERICAN COLLEGE OF DENTISTS" at the top and "DEDICATED TO THE CAUSE OF DENTISTRY" at the bottom. The Latin phrase "CURANDORUM HUMANITATIS" is also visible within the inner ring.

Journal of the American College of Dentists

A Publication Presenting
Ideas, Advancements and
Opinions in Dentistry

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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 potentials 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

Following in Father's Footsteps

Recently a colleague challenged me, "Why don't the sons and daughters of dentists go into dentistry any more?" I looked into the matter and discovered about 12% of applicants to dental schools are children of dentists and this number has remained constant for years. But I sensed there was more behind this question than mere numbers. What does it mean to follow one's professional parents? Can we really enter the profession our parents grew up with or must it have changed? What are the fears and hopes of parents as they look at their own past and their children's future?

When I was in junior high school my grandmother's sister showed me a notebook my father had assembled when he was my age. We were both working on the project "What Would You Like To Be When You Grow Up?" My father, who to this day is an expert in the field of notebooks, carefully laid out the case for becoming a livestock buyer. This is an individual who buys small or large lots of cattle, hogs, and sheep for meat packing plants or for resale to other buyers. My father's grandfather, his own father, and his uncle were livestock buyers and meat packers, and he wanted to follow them.

My father did become head livestock buyer for the local meat packing company. Eventually he succeeded his

father as president of the plant and then ran an independent stock yard. He raised purebred sheep on the side. My father was immensely successful at what he did. He held offices and won honors from the local business community and from national associations. His sheep captured trophies and commanded premium prices. He had the respect of those he worked with, from subsistence farmers through bank and university presidents.

I learned a lot from cleaning hog pens, hanging on for dear life to the 4-H steer, and driving miles to buy the last old ewe from a family that needed cash for Christmas, when my father's profit was less than the cost of gas. My approach to life was formed in those early years in Oregon's Willamette Valley following in my father's footsteps.

But we parted ways when I went to college. That was largely my father's decision. From the days I first saw the junior high school career notebook, my father made it clear that I should consider alternatives. In the 1950s it was apparent there was no future in the meat packing industry as he knew it.

Between the years of my father's birth and my graduation from high school, the proportion of Americans engaged in agricultural work fell from 34% to 7%. At my twentieth high school reunion where we all listed our occupations, at least half of the jobs did

not exist at the time we graduated (computer programmer, environmental engineer, dental health plan administrator, etc.). In my father's case, he became president of a local packing plant at about the time when changes in transportation and technology made state packing plants economically dominant over local ones. But the state plants were absorbed, in turn, by regional ones and now, there are only two or three firms operating at the national level which account for virtually all of the meat processing in this country. As a senior in high school, I recall traveling to San Francisco where the Western States Meat Packers Association had its annual convention and dinner dance in the courtyard of the Sheraton Palace Hotel. The association no longer exists. Americans have learned to eat less red meat and synthetic fibers are less expensive than the cost of shearing sheep. The same story can be told by those who own "mom & pop" grocery stores.

Did I learn anything from following in my father's footsteps as he won battles in a losing war? I learned the curious greeting ritual of farmers receiving visitors in the barnyard (never in the house). I learned that forty-five minutes before sunset on a sunny day in December, the shadow and light on hills magnifies their features, just as there is always exaggerated contrast at any border. I learned that forty-five minutes be-

fore sunset on a sunny day in August is a hazy suspended animation of distant sounds, odors, and feelings that seem to never end. I discovered supply and demand have a reciprocal relationship — except in the cases of government and lawyers. I know there are no farmers' wives in purgatory; that matter was already taken care of. I learned people appreciate an explanation when they receive disappointing news. I found out reputation will open more doors and keep better company than will money, although it is quite fragile. And I learned that good fences, well placed gates, and patience are more effective for moving livestock than is vigorous activity.

I also learned that life consists of equal parts hard work, "BS," and dumb luck. This is a lesson which bears some reflection.

Hard work is straight forward. But, as the writer of Ecclesiastes reminded us almost three thousand years ago, it is necessary for a satisfying life but no guarantee of material prosperity.

When it comes to BS, it has not always been easy to follow in my father's footsteps. He is not an avid practitioner of the art. But I cleaned a lot of hog pens as a boy and I know what I'm talking about on this subject. I spent many hours leaning against a fence with one foot on the bottom rail as farmers do, listening to them say many things that weren't true, and knowing that I

knew that they knew it just wasn't so. Veracity is never an issue. The art of BS is always in the telling of the story and the relationship of mutual belief in what cannot be positively proved wrong. Having a special brand of BS is how farmers set themselves apart from the government, their means of smoothing over awkward situations and disappointments, a sign of character, and even a way to gain status or run for political office. BS is as unavoidable and as useful in social relations as it is in agriculture.

When I went to college, I learned that proper people do not speak of BS. Instead we talk about argot — the private language of a profession which marks membership and excludes non-members. And we pronounce puffery — the promotional exaggeration with a tinge of humor that is both meant to be taken seriously and not to be taken seriously. We indulge in effete affectation such as utilizing a big word when a small one could be used. I guess this is what my father had in mind when he used to say, "There's a lot of BS down at the university."

Dumb luck explains a lot in life, but it is hard to understand. In fact, a good definition of luck would be the forces affecting our lives that we cannot control or understand. All luck is dumb in that sense. Dentistry and agriculture in this century have both been influenced

by changes in the environment, although these essentially unpredictable forces have been as kind to dentistry as they have been harsh on farmers. It doesn't matter how efficiently you run the local packing plant when meat packing is going to be done at the state or national level.

Despite what the TQM gurus would have us believe, a certain amount of variation in the system is appropriate. This is called the law of requisite variance — individuals, breeds of animals, and organizations such as the ADA will survive as long as they have the diversity within them that matches the dynamism of their environment. The wisdom of living things generates random variation as a means of protecting itself against the dumb luck of our world. I can remember my father explaining to me why there are so many breeds of sheep and how each has been adapted to its own environment. Heaven protect us from those who would impose a universal standard of health care or reduce the accreditation of schools to a check list.

As a farmer and the developer of a new standard of Shropshire sheep, my father understands the delicate balance between husbandry, genetics, and providence. He also understands BS is of limited value in managing luck. His life has been a dialogue with the imponderable factors influencing his profes-

sion. There were meetings with government meat inspectors and labor union officials; trips across the country and even to Europe to meet the people who knew the most about raising sheep. And when the unpredictable nature of multiple births and weight gain of lambs became an issue, my father developed a system of flock management based on detailed records that is only now being proposed in dentistry under the heading of "outcomes-based practice."

A dentist friend of mine recently said, "The only people you always want to do better than you do are your children." The wisdom of that comment lies in the difference between reproduction and evolution. My father, the farmer, realized this when he urged each of his sons not to follow in his footsteps. The world has changed, so the new generation must change. It is true, after all, the sons and daughters of dentists are not really going into their parents' profession. They are going into a

new one with the same name. And all youth must learn from following in their parents' footsteps how to blend hard work, BS, and a dialogue with uncertainty.

Get ye the sons your fathers got, and God will save the queen. — A.E. Houseman,
A Shropshire Lad



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



Letters to the Editor

To the Editor:

This letter is in response to Drs. Formicola and Redding's article on PGY1 which appeared in the fall issue of the *Journal of the American College of Dentists*. Their article supports a fifth post graduate year because record numbers of graduates today wish to have a year of postgraduate education in order to build on their initial competency gained in dental school, and states that there are not enough positions available to fill the need. Hence the need for a PGY1.

This assumption is disputed by me for the following reasons:

1. From what I have learned from many student contacts, recent graduates are applying for residencies because their predoctoral clinical education is inadequate. Their criticisms range from too many medical subjects to inadequate clinical work and insufficient numbers of experienced faculty. I believe that this is the unspoken reason for the rush to postdoctoral general dentistry programs.

2. My position is substantiated by an article entitled "Perceived trends in operative dentistry skills: A ten year comparison" written by Pink and Smith and printed in *Operative Dentistry* in 1993. The authors conducted two surveys of 357 examining board members and found a continuing decline in candidate ability as perceived by these examiners of dental licensing agencies over the ten year period.

Pink and Smith also suggest that dental educational methodology needs to be improved and curricular changes considered to strengthen the ability of recent graduates in the field of clinical restorative dentistry. Schools of dentistry need to consider increasing curricular emphasis on restorative dentistry.

3. Welker, in the September 1992 *Journal of Prosthodontics* questions the dental curriculum's relevance to dental practice. He states that there is too much irrelevance in the dental course of study. This is also in concurrence with the Institute of Medicine report which urges schools to revise their curricula — Recommendation #4.

The IOM, in Recommendation #6, also urges that dental students and faculty participate in efficiently managed clinics and faculty practices in which patient-centered, comprehensive care is the norm. Revising the curriculum to accomplish this should not be seen as a stop-gap method of avoiding overall reform of the entire dental curriculum.

The article by Drs. Formicola and Redding confuses the issue: dental schools have to revise their curricula to eliminate irrelevancies, create clinical guides for the different disciplines, and start in-service training of their faculty. Standards have fallen to shocking levels of incompetence as evidenced by the high failure rate on the boards. Adding a fifth post-doctoral year is no substitute for improving the previous four years. By concentrating on what is relevant, faculty will have more clinical time

available to teach subjects such as esthetic dentistry, overdentures, and perhaps implants. In the real world of today, this is the most useful way to prepare students for private practice.

Jules M. Hoffman
Former Assistant Clinical
Professor of Prosthetics
Columbia University
School of Dental and Oral Surgery

Dear Dr. Chambers:

Nowhere in the PGY1 article did we state or imply that the PGY1 year was a substitute for curriculum revision of the predoctoral program. In fact, in the article we quoted the IOM study recommendation (#7) that urges dental education to do both, e.g., reform the undergraduate curriculum and provide postdoctoral education for every graduate. We once again concur with the IOM report regarding the need for reform of the undergraduate curriculum and agree that the postgraduate year should not be seen as a way of avoiding such reform. The emphasis we placed in the article, however, was on the PGY1 year because that was the subject for the fall issue of the *Journal*.

Those who use needed reform of the undergraduate curriculum as a

Letters



reason for not pursuing the further development of a PGY1 year do not serve either the graduates of the nation's dental schools or the profession well. In short, both are needed.

Sincerely yours,

Allan J. Formicola, DDS, FACD
Dean, Columbia University
School of Dental and Oral Surgery

Spencer W. Redding, DDS, MEd, FACD
Associate Dean for Advanced Education
and Hospital Affairs
University of Texas
Health Sciences Center at San Antonio

Dear Dr. Chambers:

Recently I had the opportunity to read the collected articles concerning Postgraduate Year 1 (PGY1) published in the fall 1995 issue of the *Journal*. These articles provided an excellent overview of an issue of great importance to many individuals and groups within dental education. Specifically, they illustrated the many positive educational and professional benefits to be derived from the PGY1 experience. However, conversations with my colleagues in community private practice (and with

some friends in dental education) do not indicate as much understanding of or support for the PGY1 experience for dental school graduates as might be appropriate.

In dynamic times such as these, predicting the future is difficult, but I am convinced that a number of factors will combine to make PGY1 training increasingly vital to the well being of the profession. A few factors are rapid changes in science and technology, pressures from public and private payors and from consumers, and the imperatives of our country's demographics. These factors will likely drive dentistry further into the mainstream of health care and move dentistry closer to medicine. The growth of dental group practice, the emergence of forms of dental reimbursement other than traditional fee-for-service, and the generalized need to structure dental delivery systems that can better provide low-cost, high-quality dental care will be driving forces in the increasing consolidation of the business of dentistry. Our academic health centers in general, and our dental schools in particular, are struggling with ever-increasing costs against a backdrop of declining resources and growing competition. One of the strategies recommended in the 1993 Pew Health Professions Commission report was to develop a more integrated continuum of resources for educating dentists. This recommendation was based in large part on concerns relative

to the costs of dental education and student indebtedness and on the recognition of the value of PGY1 experience for all dentists. Certainly, further development of PGY1 opportunities for dental school graduates cannot address all the factors above; however, I believe the role of the PGY1 experience in our profession's response to the future will be critical. As noted in the articles by Drs. Gowan, Retzlaff, and Demby, there may be tremendous opportunities now and in the future for public/private initiatives to develop additional PGY1 programs. The extent to which the private practice community and the educational community can work together to develop hybrid PGY1 programs will be a significant factor in determining the future quality and character of our profession.

The College has a tremendous opportunity to guide and promote greater interaction between the private community and the educational programs. I encourage the College to exert its leadership in the support of the PGY1 concept and thank you for making this a theme of the fall issue of the *Journal*.

Sincerely,

Raymond S. Garrison, DDS, MS, FACD
Chairman
Wake Forest
The Bowman Gray School of Medicine
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Dentistry in the 21st Century: What Can Congress Do?

The Lose-Lose Guidelines of Federal Regulations

Charlie Norwood, DDS, FACD

Dr. Randy Bragdon of Bangor, Maine, decided early in his dental practice that he wanted ironclad protection in his clinic against the transmission of any form of infectious disease to a patient or employee. So in 1978, well before the AIDS virus entered the picture, Dr. Bragdon instituted his own stringent infectious disease control policy.

Under Bragdon's guidelines for his office, any patient with an active case of strep, hepatitis, tuberculosis, or other contagious disease would of course be accepted for treatment, but Bragdon would provide the treatment at the nearby hospital, where operating room antiseptic conditions were available.

Dr. Bragdon's policy worked to perfection from its inception until 1994, but then led to disaster. Not from disease, but from the courts.

On a crisp September New England day, Sidney Abbott entered Dr. Bragdon's dental office, requested treatment, and informed Dr. Bragdon that she was HIV positive. Dr. Bragdon accepted Abbott as a patient, examined her in his office, found a cavity, and informed her that in light of her condition he would schedule treatment at the hospital.

Abbott immediately filed suit under the Americans with Disabilities Act,

claiming her constitutional right to equal access had been denied.

After two years of court proceedings, a federal judge found Dr. Bragdon guilty, while incredibly noting in the decision that Bragdon's policy did indeed reduce the risk of infection for patients and employees.

At the same time and only 300 miles away in Northampton, Massachusetts, another case was under way in federal court in which the plaintiff claimed that Dr. Anthony Bregilo was to blame for an HIV infection that would have been prevented by Bragdon's now illegal infectious disease control guidelines. According to attorneys for the plaintiff, James Sharpe was treated in a room in which an HIV-infected patient had been previously treated, which allegedly led to the virus being transmitted to Sharpe. The Environmental Protection Agency (EPA) and the Centers for Disease Control and Prevention (CDC), both were waiting in the wings for the outcome in order to set new regulations and "recommendations."

In February 1996, the jury fortunately found in Dr. Bregilo's favor. However, many regulatory activists feel that in spite of this setback, they sooner or later will be able to "document" a patient-to-patient transmission of the HIV virus in a dental office. This will

provide a free hand to rewrite the way dentists practice — something already well under way by the Occupational Safety and Health Administration (OSHA).

Choose: Meet the Standards or Treat the Patient

When I look back at the list of factors that led me to sell my dental practice and run for Congress, OSHA regulations led the pack. Imagine being told by OSHA bureaucrats in Washington, D.C. to buy a washer and dryer for my dental office in Augusta, Georgia, and to tell every nurse and hygienist on staff to change clothes before going home and wash their uniforms on the job.

If I thought for one second that doing so would prevent someone from getting sick, I would have done so with or without a regulation, and so would every other dentist in the country.



Representative Norwood is a freshman member of U.S. Congress from Georgia, a former practitioner in Augusta, and Fellow of the American College of Dentists. His address is 1707 Longworthy Building, Washington, DC 20515.

Dentistry in a Regulated Environment

The OSHA regulation writers never considered the fact that dentists are at even greater risk from blood-borne pathogens than nurses and hygienists; if anyone is going to catch something, the dentist is first on the list.

When bureaucrats issue rules, there's no thought if the risk is real, or whether the rule comes anywhere near justifying the cost of compliance. That's how we wind up with regulations that forbid roofers from chewing gum while working and other mind-numbing rules like posting notices instructing professional truck drivers to look behind their truck before backing up.

Now we face a new potential adversary in the EPA, which stands ready to enter the dental regulatory business if the AIDS epidemic provides an opening.

What is a dentist to do? The only obvious solution to the dilemma of protecting patients and employees from infections while not violating the "rights" of disease carriers, or OSHA regulations, or incurring the regulatory wrath of the EPA, would appear to be for all dentists to implement operating room standards of sanitation in dental treatment rooms. But at what cost?

Estimates run as high as \$150,000 per treatment room in up-front expenses, with additional clean-up costs after each patient. For the patient, these standards would likely double or triple the cost of a standard dental check-up. This kind of inflation would result in the inevitable: fewer dental visits and an increase in disease.

Who's the Boss?

If over-regulation and politically-correct practice mandates were our only worries, it would be more than enough to seriously impede patients from receiving care. But it's just one side of the increasing pressures on dentistry to conform to non-health related standards. A quick look at the disaster facing the private-practice dentists of Jacksonville, North Carolina, vividly points out a whole new avenue of concern.

The Department of Defense (DoD) decided several years ago to implement

a nationwide managed-care plan for dependent dental care, under the guidance of Pennsylvania-based United Concordia Companies, Incorporated. The plan, known as the DoD Family Member Dental Care Program, was in place nationwide early this year.

Jacksonville dentists, located just outside the sprawling Marine Corps base at Camp Lejeune, were not happy with the plan's reimbursement and treatment standards and opted not to sign the agreements offered by Concordia. Many Jacksonville dentists contend that their market is so heavily dominated by military dependents that Concordia's discounted fee schedule is not offset by other business, as occurs elsewhere in the country.

*Welcome to
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Now Concordia has informed Congressional staff involved in the case that they are proceeding with a plan to open new dental clinics in the Jacksonville area using dentists from outside the community, forcing a large percentage of dental patients in the area to transfer or incur severe reimbursement penalties. If the Concordia plan goes into effect, private practice dentistry in the Jacksonville area within a short time will be irrevocably altered at best, and at worst destroyed.

Where Health Care Went Wrong - And How We Can Fight Back

Welcome to dentistry in the 1990's, where decisions on patient health are made by politically-correct government and private-sector bureaucrats, with

providers forced to place top priorities on lawsuit prevention, adherence to managed care plan guidelines, and OSHA compliance — all before considering the health of the patient and prevention of disease. How did we come to this point? What can we do to correct the problems?

We arrived here largely by the actions of Congress over the last forty years. With every law passed by Congress, Washington bureaucrats created a hundred new regulations and programs that skewed the health care marketplace. To correct the excesses caused by those regulations, each succeeding Congress passed more and more legislation.

The entire country came dangerously close to the ultimate regulation in 1993, as the Clinton Health Care Plan barely fell short of passage in a Democratically-controlled Congress. Most Americans will never realize just how close the nation came to full-blown socialism, with a nationwide health care plan patterned after the program targeted at the North Carolina dentists.

As bad as these excesses seemed, we may have turned the corner over the last two years, beginning with defeat of the Clinton Health Care Plan followed by tentative reform of OSHA through last year's Labor, Health and Human Services and Education Act (H.R. 2127).

OSHA was created in 1971 with modest goals and efforts directed toward worker safety. Now the agency seeks control over every productive activity in the country, spending most of its efforts in punishment rather than prevention. We are all too familiar with the "tooth fairy" story of regulations that left dentists in the dark as to whether it was legal to give a child an extracted tooth.

The kind of excess enforcement policies that led to this misconception would have taken a huge hit under H.R. 2127, if President Clinton had not vetoed the act. The bill would stop OSHA from being a police force that buries dentists in regulations, conducts no-notice inspections, and levies overwhelming fines. It decreased funding on en-

forcement by one-third, increased funding for safety prevention, and halted OSHA's attempt to write new ergonomic standards.

The new Congress is ready to go even further with OSHA reform, if it ever manages to get past the obstructionists. The OSHA Reform Act (H.R. 1834) is ready to be debated this year and puts common sense in regulations by making OSHA a friend, not a foe of dentistry. It requires regulators to first issue warnings before leveling fines or orders, as long as no accident has occurred and there is no immediate danger to workers; and allows phone and fax investigation procedures instead of on-site investigations.

Turning the Tables

The efforts are not limited to just OSHA. Congress is finally willing to question the EPA on the reality of the risks we seek to avoid with the thousands of environmental regulations the agency created since its inception. But so far, Congress hasn't had much success in receiving answers.

The Democratically-controlled Congress of 1990 passed legislation legally requiring the EPA to submit a cost-benefit analysis of its regulations, with the first report due in 1991 and follow-up reports over the next two years. The EPA blatantly failed to comply with a single report to date.

What would happen if you failed to file a legally mandated report to the EPA or OSHA? One due in 1991, with a follow-up in '92 and '93? And one that you have still not filed today? We know the answer: you would have been driven out of business, jailed, or both. Yet to this day, the EPA has simply thumbed its nose at Congress.

Last December I joined eight other Congressmen and Senators in filing a class-action lawsuit seeking a court order to force the EPA to abide by the law. As I see it, an agency of the federal government has no right to tell citizens to abide by regulations while refusing to do so itself. And when we finally have real cost-benefit data in hand, we can

start along a path on which science and reason determine our environmental and workplace rules instead of a federal government bent on imposing political ideology through bureaucracy.

Saving Money Without Losing Choice

We are also beginning the difficult task of addressing the excesses of managed care, with proposals that may well bring relief for providers caught in the vise of situations like that in North Carolina. This past year I introduced The Family Health Care Fairness Act (H.R. 2400) that takes a big first step towards addressing some of the dictatorial stances a few managed care and preferred provider organizations seem to have adopted, while not damaging the overall ability of managed care organizations to seek reasonable cost-savings in health care.

H.R. 2400 sets a ground floor, a minimum set of national standards all health care plans must follow, while still minimizing federal government involvement in national medical care policy. Under this act, the Secretary of Health and Human Services would establish a process to certify managed health care plans, including mandating an adequate mix and range of health care providers on the basis of license and credentials; consumer choice would be maintained through point-of-service arrangements that assure access to necessary specialty and primary care services and continuity of care.

The bill also seeks to return a sense of fairness for patients and providers, like those outside Camp Lejeune, by including effective grievance procedures, patient satisfaction measures, and clauses providing for non-discrimination against providers and against patients because of their health status.

The managed care debate has yet to impact dentistry to the same extent as the rest of the health care industry; but we can fully expect the standards of managed care to be extended into our field, as the North Carolina dentists discovered.

Managed care is quickly redefining how medical health care is organized, financed, and delivered. Yet, dentistry must be approached differently from medicine when considering managed care legislation, since the delivery of dental care differs significantly from that of medical care.

While medical managed care calls for a new emphasis on preventive care, dentistry has always been prevention-oriented, especially for children through use of fluoride, annual exams, and high-visibility public education programs.

Managed medical care requires the use of general practitioners as the primary care giver. Unfortunately, most physicians today are specialists, requiring significant "reorientation" of the medical community, beginning at the medical school level, to produce enough general practitioners.

Dentistry consistently has maintained an optimum general dentist-to-specialist ratio of 80:20. Thus, the vast majority of dental care is already being provided by general dentists as the primary care giver.

While medical care often requires hospitals and other advanced treatment facilities with large support staffs to effectively deliver services, dentistry is normally performed at a single-site dental office, using small, efficient staffs.

Furthermore, the current system of dental care benefit plans already contains the concepts of managed care being developed for medicine. Current dental benefit plans generally cover most preventive services, which keep down the overall cost of dental care. These plans require patients to share a percentage of the cost in the form of copayments and deductibles and often place annual or lifetime financial caps on selected treatments or total costs of care.

A significant portion of medical care costs in the U.S. is subsidized by federal and state tax dollars. In contrast, about 50% of all dental care in the U.S. is paid by patients, 45% by third-party payers, and only 5% is paid from government

Dentistry in a Regulated Environment

funds. And because of dentistry's un-complicated infrastructure, the concept of direct reimbursement can be easily applied to the delivery of dental care, thus eliminating the billing headaches of the medical industry.

Hope for the Future

The problems facing our profession seem daunting. In spite of making great progress in attacking them over the last year, there is still a long battle ahead of us to overcome four decades of heading in the opposite direction.

But the winds of change are finally blowing. The new Congress is re-examining legislation and regulations passed in previous sessions and determining whether the intent of the law is being met.

In the process, those who seek reform are under attack by every radical group in the nation. If we dare to question an EPA or OSHA regulation, we

are accused of being out to destroy the environment or the safety of consumers. I knew this would be the case before ever leaving Georgia for Washington. I'm willing to take the heat, as are all the other members of the freshman class of the 104th Congress.

Whether we are ready for it or not, dentistry in the 21st century will be dramatically different from today. But in determining what role Congress and the federal government will play in these changes, we need to remember the advice of Thomas Jefferson, "Government that governs best governs least." As we enter this period of transition, I believe Jefferson's advice should be our guide.

Congress must provide the proper legislation to set fair standards, assure access, and guarantee quality. However, government should not impose itself in an obtrusive, counter-productive manner, as is currently the case.

Whether we are Democrat or Republican, conservative or liberal, we all want to avoid every possible on-the-job accident. We want clean water and air. We want safe and affordable health care. We may differ on the pathway but we all agree on the destination.

But what is really at stake in the debate is not just dentistry, safety in the workplace, or the environment. It is our freedom. We can sit and do nothing and enter the 21st century with every family in America paying \$6,000 a year in federal regulatory cost, and every facet of our lives, both professionally and personally, governed by a central bureaucracy in Washington.

Or we can find the courage to stand up against special interests and enter the new millennium with a rebirth of the American dream that has created the greatest economy and the greatest health care system the world has ever known.

Continued Competency Assessment: What the California Dental Association is Doing

Robert S. Gartrell, DDS

Scrutiny by regulatory agencies becomes easier and more convenient as time passes and technology improves. Public outcry for professional accountability increases with the journalistic accountings of abuses by health care providers and managed care programs. From within the dental profession, a renewed clamor for freedom of movement among states has grown. These issues have not gone unnoticed by the California Dental Association (CDA), which recognizes the significance of these influences on the profession and the delivery of care.

One of the most effective means of functioning in a regulated environment is to develop standards that make sense, instead of waiting for others to impose regulations. Self-regulation is one of the marks of a profession.

Rising to the occasion, the CDA Board of Trustees concluded that implementation of a voluntary competency assessment program would be an effective method to address these modern concerns and provide a direct member benefit. The Board resolved that, "An ad hoc committee on voluntary continued competency assessment be formed to develop a voluntary continued competency assessment system..." The committee, now in its embryonic stages, has already outlined the program it expects to be implemented.

Dentistry has progressed from a time of individual mentorships, its earliest form of education, to today's complex educational system, with formal predoctoral and postgraduate programs. A series of sophisticated examinations is in place to test both entry-level cognitive and clinical skills and abilities, but little has been introduced to objectively measure competence of the practitioner beyond the initial demonstration.

New scientific technology is rapidly changing the dental profession resulting in significant changes in the patterns of practice. Despite these changes, once a dentist leaves the formal education process, the individual is left to his or her own devices to maintain professional skills.

As defined by *Webster's New Collegiate Dictionary*, a **professional** is a person "requiring specialized knowledge and often long and intensive academic preparation." This definition implies that a professional has not only achieved some degree of special knowledge, but also maintains the expertise and skills. The *Code of Ethics* of both the American Dental Association (ADA) and the California Dental Association address the responsibility of practitioners to maintain professional skill and development. Maintaining a prescribed skill level is the responsibility and obligation of the individual, warranting the title **professional**.

Yet, how does a consumer know that the dentist is meeting this obligation?

Never before in the history of the dental profession have there been so many changes in the system of health care delivery. Public and regulatory agencies are calling for more systematic scrutiny of practitioners over their lifetime rather than just at the onset of a career. Periodic examination is espoused as a logical and reasonable method to assess continued competency. The rationale for post-licensure assessment is multifold: expansion of knowledge and new technology, the desire to keep current, and patient pressures.¹

For the most part, the organized profession has met its obligation to maintain performance standards through educational programs at all levels. Peer review committees, organized through the component societies of CDA, are effective in identifying patterns of substandard practice, even though reviews are instigated on a complaint basis. As to the continuing learning process, Cali-



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fornia requires dentists to take continuing education courses to maintain their licenses.

CDA, through its Board of Trustees, anticipates changes in credentialing and broader freedom of movement within the profession. Changes in both the form and format for delivering dental care in a managed care environment provoke a more proactive role by the organized profession in the regulation and control of the practice of dentistry. The issue of "quality assurance" has been a continuing theme in many legislatures and regulatory agencies. CDA observed these changes and concluded that organized dentistry should forge the design and implementation of future change. Who better to set the standards than the dental community itself?

In the medical community, practitioners and auxiliaries are under the routine scrutiny of peers, through direct observation and audit committee review. External review takes place within the common ground of the hospital, and although not fail-safe, review improves quality of patient care through the monitoring process. Additionally, health care facilities routinely undergo scrutiny through various accreditation processes. Practitioner competency is also continuously monitored through these processes.

Unlike medicine, dentistry is a cottage industry; individual dentists practice in separate offices with little peer intrusion. With only a few exceptions, an individual's practice need not undergo external review. Little is known, therefore, about a dentist's level of competency until a specific incident provokes outside assessment. The literature demonstrates that initial granting of a license to practice says little about the likelihood that subsequent performance will improve as needed.²

The profession recognizes the characteristics of competency. Competency can be defined as "the state or quality of being adequately or well qualified."³ Measuring competency is complex. Levels of cognitive and clinical skills

must be evaluated in an inter-related and coordinated manner. Certainly, a synthesis of cognitive and motor skills, as well as more unclassifiable characteristics, are essential to delivering quality

Public and regulatory agencies are calling for more systematic scrutiny of practitioners over their lifetime rather than just at the onset of a career.

care. In his article, "The assessment of professional competence," Michael Kane described one of the inherent difficulties in designing a program to measure competency in a field in which little outsider intrusion has been imposed, and in which the variables in practice decisions make competency difficult to quantify:

Experts have been known to disagree about how to handle specific situations that arise in professional practice, making it difficult to evaluate an examinee's performance in that situation. This inherent difficulty is exacerbated by the impact of client/situation variables on professional performance, because the variability in performance across clients and situations make it difficult to draw accurate conclusions about a practitioner's general level of competence based on a sample of performance.³

CDA's Planned Program

In entering the post-licensure competency assessment field and in making a commitment to develop a voluntary program, CDA recognizes that practices vary in size, type, delivery of care, and in the selection and implementation of treatment options. CDA also understands that any successful evaluation

program must ultimately improve a provider's delivery of dental care and serve as an educational opportunity. Cost of the program must be reasonable so all dentists can participate.

The five-member committee appointed by CDA's president to accomplish this difficult task described its goal, "To develop a cost-effective program for voluntary assessment of competency which can be used to reliably confirm whether the quality of dentistry provided by the individual meets current professional standards."

While in the early stages of development, the committee has attempted to focus on the crux of the problem in designing a program suitable to California dentists. Professional competency is, at least, the ability to "use appropriate knowledge, skills, and judgment to provide effective...services over the domain of encounters defining the area of practice."⁴ Competency cannot be easily benchmarked; no one answer is typically the only correct solution. Post-licensure competency assessment, then, must place professional judgment, temperament, insight, and style as a high priority.⁴

Presently, dentists are required to be externally scrutinized only at a few propitious stages in their careers, none of which occur after passing a licensing examination. Dentists are subject to evaluation at the following stages: prior to admission to dental school, the examinee must take the Dental Aptitude Test (DAT); following course work in basic and clinical sciences, Part I of the National Dental Board Examination is taken; after further course work, Part II of the National Dental Board Examination must be passed; following graduation, a state or regional licensure examination must be passed. Once a dentist completes the licensure process, no further performance assessment is likely unless the dentist chooses to continue in specialty training. Only one dental specialty, oral and maxillofacial surgery, has implemented a "re-certification" program, requiring specialists to reaffirm

their professional skills by undergoing examination once every ten years.

Medical organizations have designed accreditation programs to assess medical facilities as well as provider performance. Accreditation, by medicine's definition, is a voluntary, peer-conducted, periodic process of determining compliance by an organization or facility, using published standards of an accrediting agency. As a process undertaken by an organization or facility, accreditation measures compliance to standards determined by an external agency. Accreditation focuses on overall quality outcome improvements. Trends in care, for instance, over a large number of patient encounters are measured so change can be evaluated (i.e., last year, 100 infant inoculations were administered; this year, 150 inoculations were administered; therefore, the quality of care has improved in the area of infant inoculation).

The quality improvement process has been embraced by many in the health care industry since indirect or surrogate statistics can be easily compiled at a low cost and some very basic inferences about the quality of care can be made based upon the statistics. What this method ignores is that successful outcomes do not give a full picture of competency. Professional judgment over a range of patient situations is of equal importance. Also integral to competency assessment is evaluation of a practitioner's integration of new technology and scientific advances into the delivery of care. As a result, accreditation can have only limited application to the dental profession.

CDA's committee therefore concluded that the continued competency assessment program it designs will include assessment of: (a) general baseline knowledge; (b) practitioner's application of knowledge, professional judgment,

and skills in patient care delivery; and (c) appropriateness of the diagnostic and treatment decisions in the practice environment by looking at patient outcomes.

As to the first component, assessment of baseline knowledge, a form of objective assessment may be applicable. The committee is considering a program that will appraise cognitive skills considered basic in the recognition, diagnosis, and management of common oral health care problems. Possible tools to implement this component could be modification of the National Board Examination or development of a new appraisal mechanism through a joint effort of CDA and the dental schools.

In addition, a self-assessment tool would likely be required as a part of the process. An individual could measure self-perceived strengths and weaknesses. As an educational tool, a self-assessment would guide the practitioner through areas considered important for competency and could identify areas where improvement could be made.⁵

An in-office survey and audit phase is planned as part of CDA's program to assess the practitioner's application of knowledge, judgment, and professional skill. The survey will also be used to assess appropriateness of the diagnostic and treatment decisions of the provider. The survey will be conducted by peers and could include on-site observation of patient care, review of completed cases, and chart audits. The facilities and operations in the office could also be assessed. The office assessment will use the "Quality Evaluation for Dental Care: Guidelines for the Assessment of Clinical Quality and Professional Performance," Third edition, 1992, already in place at CDA.

Ultimately, a committee of dental peers will review the gathered data to assess competency. Decisions will be

based upon realistic, reasonable, and attainable standards, subjected to continuous review and scrutiny for appropriateness. Evaluators will be calibrated to ensure uniform implementation of standards.

Conclusion

Organized dentistry intends to rise to the occasion and implement a voluntary, valid program for post-licensure competency assessment. While influences from outside the profession may have catalyzed the development of this program, the profession itself has the challenge of designing a competency assessment methodology that meets the needs of the profession as well as the needs of the external forces seeking professional accountability. CDA expects to deliver to the profession a cost-effective educational tool for assessing professional competency which can serve as a framework for future competency assessment vehicles.

The committee, appointed by CDA President Michael Miller, is composed of five dentists: Chair, Robert Gartrell, Calvin Lau, Steven Schonfeld, Bevan Richardson, and Edward Cowan. The Project Director is Linda Seifert.

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The Changing Marketplace: Informed Choices; Safe Action

Mark S. Rubin, JD

Most of you have heard about the “trend in managed care,” how “managed care is coming.” Many of you expressed concern and interest, sometimes in not so delicate terms. Some have complained that your dental societies and lawyers only tell you what you can’t say or can’t do about managed care. However, there is a wide range of activities individual dentists and their professional societies *can* undertake in the changing marketplace without crossing the legal line, especially when the focus is on patient care.

This article explores positive advocacy paths that can be *safely* traveled in the changing dental marketplace.

Before our journey begins, we all need to be on the same page regarding the legal risks; therefore, I am putting **the fine print** right up front. It’s also important to note, this article isn’t intended to sway you towards or away from managed care, but simply to stimulate your thinking about how to reduce your legal exposure, whatever route you choose. And, although not focused on ethical issues in managed care, it may stir your contemplation about them.

A Hypothetical Case

Managed dental care is coming to your town. You feel threatened, economically and otherwise. Thinking about ways you and other dentists in your community can combat managed care;

about agreeing with other dentists to set fees at certain levels; or threatening boycotts of managed care plans? Then, you also should be thinking about up to three years in jail, fines of up to \$350,000 (or two times the gain from the wrongdoing, or twice the loss to the injured party), and paying the other side’s attorneys’ fees (in addition to your own). All this risk is for each violation and none of it is covered by your malpractice insurance.

Those are just the legal risks associated with violating the antitrust laws. (See the April, October, and November 1995 issues of the *Journal of the American Dental Association* for more detailed discussions.) You also could be sued for disparagement, under theories of libel or slander, perhaps for criticizing a plan’s quality without data to support such a statement; or for tortiously interfering with someone else’s patients; or even for breach of contract. These lawsuits could lead to significant damage awards against you. Even if you successfully defend such claims, doing so can prove incredibly expensive and disruptive to your practice and life.

So why read on? Because there is a range of *safe* activity dentists and their professional societies can undertake in the changing marketplace. This activity can range from making and implementing informed personal decisions and communicating them to others, including your patients; finding creative ways to compete in the changing mar-

ketplace, including by communicating with plan purchasers, promoting direct reimbursement, and forming individual practice associations; helping change the rules of the game through lobbying; and making the laws work for you, by possibly raising emerging concerns about managed care in the courts.

The Challenge

Did the FAR SIDE daily calendar for a day last June capture a big part of the problem? It pictured a rather large dinosaur, with a fairly small head, at a lectern speaking to his colleagues, who appeared pensive and were listening carefully. And what sayeth the lead dinosaur? “The picture’s pretty bleak, gentlemen.... The world’s climates are changing, the mammals are taking over, and we all have a brain about the size of a walnut.” While I submit your brains are significantly larger and better, speaking about legal issues in managed care across the country last year made me wonder whether this attitude may have too-closely captured dentistry’s worst fears. Many dentists opposed to managed care felt this climate change at



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"Safe" Action Strategies in the Face of Managed Care

A guiding rule: Place the patient's health first.

- Compete — Offer a better service
Talk with plan purchasers and patients
Promote direct reimbursement
Form IPAs
- Work to Change the Rules — Lobby
Consider promoting state action
- Make the Laws Work for You

their core; those signing up with plans often had serious concerns about maintaining their autonomy within this "new" practice mode. Each sensed his or her rights might be eviscerated. And fearful of the economic changes and legal (particularly antitrust) constraints, they often expressed little hope of survival, whether measured economically, in terms of practice satisfaction, or otherwise.

The challenge, it seems, is to resist a defeatist mindset. To take a careful look at the changing marketplace and make some potentially hard practice and personal choices. To gain information in order to make informed choices. To have faith in your brainpower, and the collective brainpower of your professional societies. To consider that one constant shared by dentists in and out of managed care provides a viable focus for legislative and legal options: dentistry's dedication to the patients it serves. And to minimize the all too common use of the law "as a defense for cursing the darkness rather than lighting a candle." I can't promise that resisting the "chicken little" mindset will solve all your concerns, but it is a first step. If you do not resist the mindset, the sky may be more likely to fall one day.

In this context, I offer an array of scenarios for *safe* activity (subject to the legal caveats) in the changing marketplace, including legal and legislative options for relaxing the rules that apply in

these arenas. I encourage you to think of this as an exploration of the "positive boundaries" of antitrust and other related laws.

Individual (Informed!) Choice

Choice is a cornerstone to *safe* action: your personal choice about whether to participate in managed care; your patients' choice of dentist; your ability to talk with your patients about these choices. All of these things can be done safely, legally. Ultimately, deciding whether to join a managed care plan is a new twist on informed consent: what's really at issue is your consent — your individual informed choice, based on what's right for you, personally and professionally.

There is a wide array of information to help dentists make and implement informed choices in the changing health care marketplace. I'm most familiar with the material from the American Dental Association (ADA), highlighting the importance of choice by bearing the ADA trademark "Managed Care; Making Choices." The ADA's *A Dentist's Guide To Managed Care Marketplace Information* can help you work through practice, financial, and legal issues. The *Financial Impact Analysis of Plan Contracts* computer spreadsheet lets you input personal financial figures and information about a particular plan and run an infinite number of "what if" scenarios to help assess if the plan is likely to be fi-

The Fine Print

Caveats: Because these issues are often complex and require case-by-case analysis, you should not rely on this information as legal advice. Although each activity identified here might be accomplished without significant legal risk if undertaken in a vacuum, you do not live and will not be acting in a vacuum. If you engage in one of the *safe* activities, your action may be tainted by other things you or sometimes others do. Activity that is *safe* on its face will not survive antitrust scrutiny if other action reveals it is no more than a veiled call for a price fix or boycott of a managed care plan.

You must consult your personal attorney for advice on what's *safe* in your situation. Your attorney may inform you that even *safe* activity can get you sued and force you to pay significant sums in legal fees to defend your position. No doubt your attorney will reinforce the theme of choice: only you can decide whether managed care is right for you and, whatever you decide, how you will choose to act thereafter in the marketplace.

nancially advantageous for you. ADA members can take advantage of the Contract Analysis Service, providing free legal information about specific managed care plan contracts when submitted through your state dental society. And once you've made your choice, the *Managed Care Resource Packet* has a variety of useful items, including sample letters to patients to explain your choice, infor-

mation to help patients understand their dental coverage, sample speeches and letters to the editor, and more. Though none of these resources is a substitute for professional financial or legal advice, they can be valuable in helping you understand your options and communicate with your patients and others once you choose.

Compete

Let's say, for whatever reason — professional, practice, financial, legal, ethical, personal — you've decided not to participate in managed care. You are concerned about your ability to effectively survive and thrive in the changing marketplace. What can you safely do? Here are some options.

Win the game of competition. The antitrust laws are sometimes called the rules of the game of competition. But, just because they prohibit you from taking concerted action with other dentists (remember the price fixing and boycott issues) does not mean the game is over. You are legally free to compete individually and win. Find the way that is right for you. Reduce your overhead, if possible; increase your marketing efforts; find a niche for your practice; or simply provide top quality care with a personal touch. If you do so on your own, without disparaging your competition, in all probability you will be *safe*. All of these options ultimately focus on patient care, which legally is always the safest route.

Talk with plan purchasers and your patients. There is a school of thought that many employers may not fully appreciate (or care enough about) the relative benefits or lack of benefits offered by certain managed care plans. This may reflect a lack of understanding about many common differences between medical and dental plans. The ADA, several dental societies, and many individual dentists have developed communication strategies to help employers appreciate the plans they purchase.

If you convey factual information and do not disparage managed care plans, it can be *safe* to talk with plan purchasers and inform them about limita-

tions in their dental plans (e.g., restrictions on levels of care, specialty referrals, etc.). Of course, it is safest to focus on the health care needs of their employees, rather than your pocketbook, and you will want to be sure the discussions do not amount to a mere veiled threat of a boycott.

You can convey similar information to your patients, subject to the same legal restrictions noted above. (You may be further restricted contractually if you already signed on with a plan that obligates you to maintain information about the plan and its limitations on a confidential basis.) Often, employees don't understand limits in their dental benefits, and you can safely educate your patients to help them make their personal choices. With this information, patients can set reasonable expectations or, if they are not satisfied with their benefits, be better informed if they discuss a plan's shortcomings with their employer.

Promote direct reimbursement. Direct reimbursement, the ADA's preferred dental benefits delivery model, can be safely promoted as an alternative to managed care. The model is simple. Employees go to the dentist of their choice, have the necessary care, pay the dentist, provide a receipt to their employer, and get reimbursed for the percentage set up in the company's direct reimbursement (DR) plan. (This model has been modified in some cases to respond to concerns of some employers and patients.) DR can be promoted safely by focusing on its benefits, such as patient choice and less of the dental dollar going to overhead. The ADA has actively promoted DR for years to employers nationwide through its Purchaser Information Service (PINSERV). Many dental societies and the Alliance for Direct Reimbursement Plans also promote DR.

Of course, a DR promotion that is no more than a call for an unlawful boycott is problematic. Likewise, unsubstantiated disparaging remarks against managed care plans offered to support a DR plan could pose legal risk. It's safest to market a DR plan on

its true beneficiaries, patients, and let the merits of the plan speak for themselves. In other words, promote what you are for, rather than criticize what you are against.

Form IPAs. There is a clear legal way, short of merging practices, for dentists to band together and compete with managed care companies: individual (or independent) practice associations, or IPAs. Under guidelines issued in 1994 by the Department of Justice and the Federal Trade Commission, IPAs meeting certain conditions, establishing safe harbors, are unlikely to spur legal challenge except under extraordinary circumstances. Provided they share substantial financial risk, exclusive networks (where members are barred from joining other networks) with 20% or less of providers in a market, or non-exclusive networks with 30% or less provider participation will generally not be challenged.

Importantly, IPAs with provider participation exceeding the government's safe harbors may still be *safe* under traditional antitrust "rule of reason" analysis. Dental IPAs with significant provider participation may have insignificant market power. This is not lost on the FTC staff, which in a recent meeting with ADA officials discussed the importance of market power in any determination regarding anticompetitive effect.

One reason dentists may not have formed numerous IPAs is the perception that statewide networks would be hard pressed to satisfy the antitrust laws. While this issue and the related one about dental society sponsorship remain difficult, in January, 1996 the Department of Justice approved a proposal to form a statewide physician network in Oklahoma. This evidences the enforcement agencies' intent to facilitate new, legally *safe* ways for health care providers to compete in the changing marketplace.

Change the Rules

The antitrust laws are an approximately one hundred year old set of laws. You might think these laws do (or should)

not apply to the professions, but they apply to virtually everybody in this country. True, there is an exemption for one "learned profession." It's not dentistry. Nor is it medicine or law. It's baseball. Go figure.

It's not likely that even a genie in a bottle could secure an antitrust exemption for dentistry. True, Congress occasionally considers providing a modicum of antitrust relief to health care providers, as evidenced by a pending bill (H.R. 2925) that would ease formation of provider networks; however, such bills typically have not sought broad antitrust relief. Without a major change in the antitrust laws, there are two existing exemptions that merit discussion. One flows from the right to petition the government: dentists, like everyone else, enjoy certain additional freedoms when it comes to lobbying activities. The other relates to states' rights: individual states can enact legislation to take dentistry, or any other profession, out of the rubric of the antitrust laws. Let's look at each option.

Lobby. There is a specific exemption for good-faith lobbying activities. The safest lobbying focuses on patient care. The ADA engages in nearly constant lobbying on managed care issues on behalf of dentistry. Perhaps the best example is H.R. 2400, the "Family Health Care Fairness Act of 1995," sponsored by Representatives Charlie Norwood (R-GA) and Bill Brewster (D-OK). The bill seeks to protect patient choice and to require standards of due process for patients and providers who participate in all health plans, including those who are self-insured. When introduced, then ADA President Richard D'Eustachio called the bill "an important first step toward protecting both patients and health care providers from a delivery system that might otherwise over-emphasize the bottom line at the expense of good oral health."

ADA's lobbying on H.R. 2400 is perfectly appropriate. The same can be true for dental society lobbying and regulatory efforts focused on patient choice and care, including to promote: (a) mandates that fee-for-service op-

tions be made available in all benefits packages; (b) "point of service" options; (c) prohibitions of overbroad "hold harmless" clauses; (d) restrictions on "gag orders" that inappropriately interfere in the doctor-patient relationship; (e) requirements that plan information be adequately disclosed; and (f) "any willing provider" legislation, allowing any willing and qualified dentist to participate in managed care plans on the terms offered by the plans.

Let's take a detailed look at one specific example of the *safe* activity recently undertaken by the ADA: written comments ADA sent to the FTC after the ADA/FTC discussion of IPAs mentioned above. The comments reflected ADA's belief that changes in the health care marketplace give rise to serious concerns that merit adjustment in the FTC's enforcement activities. The comments indicated that, absent some leveling of the playing field, the marketplace changes could adversely affect the delivery of dental care to the patients served by Association members and, ultimately, the oral health of the American public. The comments focused on the need for relief to facilitate the formation of dental IPAs, by expanding the safe harbor for network formation to those without significant market power (irrespective of their percentage of provider participation), and relaxing the requirements for sharing financial risk (e.g., withholds).

The comments highlighted that the threat of antitrust enforcement (particularly because dentists were the subjects of the first federal criminal, health care, antitrust investigation in a half century), along with some realities of the dental marketplace, may significantly chill the development of IPAs. The net effect may be the loss of dental IPAs that could serve as meaningful procompetitive forces in markets increasingly controlled by managed care plans. The comments also emphasized that differences between the medical and dental marketplaces, including the significantly higher dental overhead (in the range of 62% to 65% of billings versus private medical practice levels closer to 45%),

can make accepting a deep discount difficult and support relaxing the *safe harbors* as applied to dentistry. The comments closed by noting appreciation for the FTC's continuing attention to issues in the evolving health care marketplace and looking forward to continuing dialogue with the agency about ways to promote the efficient delivery of dental care.

These are a few examples of *safe* lobbying and regulatory activity. Additional ADA initiatives may ensue after development of more quantitative data on quality issues in managed care.

Consider promoting state action. Another exemption flows from states' rights. Under the state action exemption, individual states can pass legislation exempting dentistry from both federal and state antitrust laws. To do so, a state must actively supervise the activity it wishes to make exempt. Whether any particular state law satisfies the active supervision requirement depends on the specifics of the law and its implementation: the more active the state's oversight, the more likely that the intended antitrust relief will be created. In contrast, paying mere lip service to the active supervision requirement will not create the intended relief. Obviously, the decision to seek such legislation will raise questions about the relative desirability of state regulation. Is the tradeoff worth it? If so, dentists should remember that the exemption will only extend to the activity supervised by the state.

Make the Laws Work for You

The rapid changes in the healthcare marketplace have opened a veritable Pandora's box of antitrust and consumer protection issues, all of which flow into concerns about the delivery of patient care. These issues may play out in Congress or with the antitrust agencies; they may be as likely to emerge in the courts. Wherever they surface, they may be the key battleground for the next era of managed care. And whatever your position on managed care, there may be important ways you can make the laws work for you.

Perhaps the single burning issue is quality. There is a risk that as managed care plans seek to import the medical model into dentistry, patient care may suffer. Because the information on quality is mostly anecdotal, the ADA is developing studies to better assess the possible impact of managed care on patient care. Until hard data are available, it can be important to avoid making claims about quality, except where factually substantiated. Of course, individual dentists can find *safe* ways to express their concerns about their personal ability to provide quality care under certain conditions.

There are numerous *safe* ways to raise questions about quality, and perhaps to have them answered via additional lobbying or in the courts. As noted throughout this article, focusing on patient care is generally the safest legal route. For example, a published analysis of data from the National Association of Dental Plans (NADP) indicates that the average premium dollars available for dental care from a typical dental HMO plan would not cover dentists' average fees for certain basic preventive services (such as oral exams and tooth cleanings) based on historical utilization rates. This raises at least two patient care issues. First, the current safe harbors (for IPAs) may not effectively allow dentists to compete with such plans. Second, dentistry prides itself on prevention; the prospect of not being able to provide preventive care, not to mention other necessary restorative care (such as crowns, fillings, and bridges), could prove problematic. (See the January 1996 *JADA* for details.)

Similar considerations may turn regulatory attention on the potential abuse of power by managed care plans in the evolving marketplace, especially by those with dominant market power. Managed care plans should not be allowed to misuse such power to the detriment of the public. They should be watched very carefully to ensure they do not encourage undertreatment or promise more care than they are pre-

pared to deliver. The Department of Justice's Managed Care and Fraud Working Group is already looking at such problems, including fraudulent marketing, financial solvency, and false statements in the managed care setting. Private lawsuits may eventually also provide disincentives for inappropriate actions by plans.

Let's look at some specific examples. Some dental managed care plans (and arguably the employers who select them) wrongly suggest they are providing full dental coverage, when in fact they are not. This hidden problem (e.g., a Least Expensive Alternative Treatment clause shared in small print with the consumer) may go unnoticed until consumers try to rely on coverage they do not really have. Likewise, under-funded managed care plans may negatively impact the health of the American public. Further, at least one dental managed care company appears to have publicly blackballed dentists simply for not agreeing to participate in the plan — something three different state regulators are already investigating.

In addition to the potential for misleading consumers, managed care plans may unfairly tie the hands of providers, which could impact patient care. The lay press loudly criticized "gag order" clauses found in some managed care contracts, which attempt to prohibit providers from discussing all treatment options with their patients, thereby jeopardizing the patients' ability to give informed consent. Other examples are contractual risk shifting clauses (such as hold harmless provisions), in which plans seek to shift liability risk to providers. These may be anticompetitive or otherwise legally problematic, especially to the extent that powerful plans impose such clauses and restrict treatment options. Likewise, plans with dominant market power that "deselect" providers due to alleged "overutilization" may be inappropriately forcing out dentists who are providing appropriate care. Coupled with the potential built-in incentives to undertreat in certain plans

(particularly capitation), I am concerned that managed care plans may be allowed to misuse their power in ways that will put patients at risk. It is arguably equally important that employers be held accountable for knowingly making bad selections of managed care plans the employers believe to have a history of significant (e.g., malpractice) problems.

I cannot lay claim to a crystal ball, and am reluctant to make any serious predictions about how these important issues will resolve. I hope the antitrust and consumer protection agencies choose to take a hard look at them. Whether or not we see regulatory activity, there will probably be lawsuits against managed care companies, and perhaps the employers and doctors who contract with them.

What's Next?

This exploration of positive advocacy paths that can be undertaken in the changing marketplace has hopefully led you to this conclusion: if you avoid the "chicken little" mindset and act on your informed individual choices, you can affect the future. There is much that you and your dental societies can do in the changing marketplace without crossing the legal line, especially if the focus is on patient care. You can make and implement informed personal decisions and communicate them to your patients and others. You can find creative ways to compete, including by communicating with plan purchasers, promoting direct reimbursement, and forming individual practice associations. You can help change the rules of the game through lobbying. And you, your patients or their employers may be able to raise important emerging concerns about managed care in lobbying efforts and perhaps in the courts.

To close on the theme of *safety*, the one prediction I can safely make is this: the ADA will continue to monitor developments on behalf of dentistry.

Should the Federal Trade Commission Allow Dentistry to Require Its Members to Adhere to a High Standard in Advertising?

Bernard L. Allamano, JD

Abstract

The California Dental Association (CDA) has been engaged in a dispute with the Federal Trade Commission (FTC) for over ten years. At issue is whether CDA's advertising restrictions have the effect of prohibiting truthful and nondeceptive advertisements and whether this constitutes a violation of Section 5 of the FTC Act. The case is now before the Commissioners of the FTC; they must decide whether their staff or CDA is correct in interpreting the law. This paper reviews the basics of antitrust law, the facts in the record, and how the Commissioners might resolve some of the questions presented by this case.

The antitrust laws, including the Sherman Act, the FTC Act, and state antitrust laws, are designed to protect competition not competitors. The thrust of these laws revolves around the question of whether competition has been hurt by the acts of the defendant. The term "restraint of trade" is used to describe an act that harms competition. To be unlawful, a restraint must be *unreasonable*.

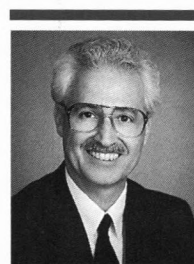
The CDA case is not about "boycotts" or "price fixing" or "monopolies." It concerns an agreement among competitors, through their membership in a professional association, to restrict member advertising. The FTC must prove that a contract, combination or conspiracy exists for the purpose of re-

straining trade, the restraint affects interstate commerce, and is unreasonable. The theory of the FTC staff is there is an agreement among 75% of the practicing dentists in California to restrain truthful, nondeceptive advertising by agreeing to limit the information dental consumers receive and use to learn about the availability of dental services.

To prove a restraint is unreasonable, the agency may choose one of three methods. They may use the *per se* rule and show that the act is one that always or almost always tends to restrict competition and decrease output. The U.S. Supreme Court restricted the use of the *per se* rule to cases where no elaborate study of the industry is needed to establish that their nature and effect are

plainly or manifestly anticompetitive. The courts emphasize the *per se* rule should be invoked only upon the strength of unambiguous judicial experience demonstrating that particular conduct is a "naked restraint of trade" with no purpose except to stifle competition. The *per se* rule was not appropriate for the CDA case.

At the other extreme is the "rule of reason" approach. With the application of this rule, a practice is only condemned if the analysis of its purpose and its actual effect on competition show the restraint is unreasonable. The fact finder must weigh all the circumstances in deciding whether the practice is unreasonable. The real question is whether the practice promotes competition or suppresses competition. Usually, the agency must prove that the practice decreases output. To do so,



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they must assess the market impact of the practice.

They must define the "relevant market," which has both product and geographic dimensions. They must then analyze the restraint's effect on competition within the market, including factors such as price, output, and product quality. If the impact is substantially or significantly adverse, the agency may condemn the practice.

The third approach, sometimes called the "truncated analysis," involves a short cut in the rule of reason approach. Where the impact of a restraint on price competition is obvious on its face, the courts have stated that the entire market analysis is not necessary. This is the approach used by the FTC staff in prosecuting the CDA.

The approach in an appropriate truncated case, as enunciated by the FTC in their 1988 decision in *Massachusetts Board of Registration in Optometry (Mass Board)*, is to ask the following: Is the restraint "inherently suspect?" If it is, is there a plausible efficiency justification for the practice? And if it is plausible, is the justification really valid? In *Mass Board*, the Commission stated that the truncated rule is "more useful" than the traditional *per se* rule. In reality, use of the truncated rule is highly favored by the FTC staff because it provides an easier method to prove a violation of the FTC Act. It is highly questionable whether less information about the economic effects of a practice could ever be "more useful."

CDA maintains this approach should not be used in its case because there is nothing "inherently suspect" about the standard used by CDA to review advertising (false or misleading in a material respect) or the manner in which CDA reviews advertising issues (notice and hearing for those members who are disciplined and a review by a state committee for applicants). In addition, the effect on competition is not obvious; thus, the CDA case is not an appropriate one for application of the truncated approach.

The Findings and Conclusions of the Judge

The FTC case was presented before an agency Administrative Law Judge during a two-week period in February 1995. There were over a thousand pages of exhibits, scores of witnesses, and written briefs presented by both sides. The judge issued his initial decision in July 1995, using the truncated approach, and found that CDA had violated the FTC Act; but he also found that CDA did not possess "market power." This anomalous result sparked an appeal by CDA and another round of legal briefs, this time to the Commissioners themselves. Oral argument before the Commissioners occurred on November 15, 1995.

The judge found that CDA reviews advertising in two ways. It sometimes brings charges against a member for violating the CDA *Code of Ethics*. Most often, however, it reviews the advertising of applicants for membership and informs the applicant of the changes, necessitated by the *Code of Ethics*, required before membership can be approved. He found that CDA requires price advertising must be exact and without omissions. Discount offers must include: (a) the dollar amount of the non-discounted fee; (b) either the dollar amount of the discounted fee or the percentage of the discount for the specific service; (c) the length of time, if any, the discount will be honored; (d) a list of verifiable fees; and (e) identification of specific groups qualifying for the discount. Across-the-board discounts must include the regular fee for each discounted service.

With regard to truthful non-price advertising, the judge found that claims of quality are prohibited because CDA believes they are not susceptible to measurement or verification. Claims of superiority are prohibited because they imply other dentists are not as caring. Guarantees are prohibited and phrases that play on patients' fears and anxieties are also prohibited. The judge found that CDA purports to use the "false and misleading" standard but, in fact,

the standard is ignored or improperly applied.

One of the reasons given by CDA for its activity in this area is the State Board of Dental Examiners does not have the resources to enforce state advertising laws. Thus, CDA attempts to fill a void and protect the consumer. CDA also purports to follow state advertising laws, but the judge found that its efforts were not a sufficient justification because a professional organization represents the interests of its members and not the interests of the public.

The judge concluded that CDA's advertising restrictions affected interstate commerce, the restrictions are a result of a conspiracy to restrain advertising, and these practices violate Section 5 of the FTC Act. To reach the final conclusion, the judge applied the truncated approach in his analysis of CDA's activities. He concluded the advertising restrictions were inherently suspect, although he never explained how they were so. He also concluded CDA did have a legitimate interest in fostering truthful, informative advertising by its members but CDA has not followed its policy and created confusion among its members as to what is or is not acceptable in their advertising. He found that CDA's actions are consistent with a mind-set which believes advertising by dentists is demeaning, a view the Supreme Court has long condemned. The judge found that all of the restrictions are inherently suspect, apparently because he believed that CDA's restrictions have the effect of an outright ban on these forms of advertising. He went on to find, under the second step of the truncated approach, that CDA's restrictions are not justified.

At that point of the decision, the judge inserted his anomalous finding that CDA's members do not have market power and that they cannot exercise market power in any relevant market in California. More specifically, he found:

CDA's enforcement of its *Code of Ethics* with respect to advertising has no negative impact on competition

in any dental market in California because it cannot erect any barriers to entry into any dental market in California.

The only entry barrier into dental service is the acquisition of a license issued by the California State Board of Dental Examiners and the need to complete dental school and the acquisition of an office and dental equipment are not barriers to entry. The over-supply of dentists which complaint counsel pointed to as an entry barrier is, according to CDA's expert witness, strong evidence of low entry barriers. CDA membership is not a prerequisite to successful practice in any California dental market.

Even if CDA occasionally questions member advertisements which are not false or misleading in a material respect, the activities of CDA with respect to their enforcement of their *Code of Ethics* relative to advertising has no impact on competition in any market in the State of California, particularly with respect to price and output.

The inconsistency between his finding of liability and his finding of no ability to violate the law is the stuff appellate cases are made of. The FTC staff feels it proved its case. CDA feels it has been vindicated because the judge agreed they could not be found guilty under a "rule of reason" analysis.

So who is correct? The FTC Commissioners will make that determination some time during the year.

Commissioners' Choices in Deciding the CDA Case

When oral arguments were held before the Commissioners, the two sides were each given forty-five minutes to present their cases and to respond to questions presented by each of the five Commissioners. Several issues emerged from the questioning as concerns of the Commissioners. The following is the author's analysis of possible resolution to these issues.

First, if one accepts that consumers have been deprived of certain truthful information, does it necessarily follow that competition has also been banned? And if it has been banned, has it been

The inconsistency between the judge's finding of liability and his finding of no ability to violate the law is the stuff that appellate cases are made of.

harmful in a substantial or significant way? These questions obviously are raised under a "rule of reason" analysis and indicate the Commissioners are at least open to considering that CDA's activities must be measured under this rule. The problem with the answers is the FTC staff did not attempt to prove any actual harm to consumers nor did they attempt to prove any of the other factors usually considered in a "rule of reason" analysis, such as any harmful effects on price, output, and product quality. Thus, the Commissioners are left with a take it or leave it situation because it would be pure speculation to answer these questions without any findings of fact to rely on. The only relevant findings made by the judge were those conceding the economic impact of CDA's advertising restrictions and these findings support a contrary conclusion.

The judge stated in his decision the FTC staff did not produce any convincing evidence CDA members acted or could act together to raise prices or reduce output. He also concluded there is a surplus of dentists in California. These meager findings support the conclusion that CDA has not and could not cause any substantial or significant harm to competition by its practices. Thus, the Commissioners must conclude that it

does not necessarily follow that restriction of truthful information causes harm to competition. They must also agree that under the "rule of reason" CDA has not violated the FTC Act.

It is interesting to note, the FTC staff attempted to prove harm to consumers without any evidence and, at the same time, criticizes CDA for its belief that consumers may be harmed by certain forms of advertising, such as claims of quality, superiority, and comparative claims. Under a "rule of reason" analysis, the issue would have been addressed.

The second question raised under the truncated approach is: must the Commission conclude in all cases where *any* restriction on truthful information exists that the practices are "inherently suspect?" Under prior FTC and court decisions, only certain types of cases were considered candidates for the truncated approach. The activities included a group boycott, usually considered to be a *per se* violation; a total ban on various forms of advertising by a state agency that was judged to have market power; an agreement not to open for business on certain days, which the Commission considered analogous to price fixing, and a joint rate filing by a trade group which would also appear to be analogous to price fixing. In the CDA case, the practices do not fall under one of the *per se* categories and the lack of market power makes them even less suspect.

On this issue, the Commissioners should clearly reject the FTC staff request as being too broad. The reason price fixing, group boycotts, and the like are considered *per se* violations is experience under the various antitrust laws has taught that these practices are nearly always harmful to competition. Since restraints on truthful advertising, as a category, have not been proven by judicial experience to be harmful to competition in every situation and, in this case, were proven not harmful to competition, there is no rational for the Commissioners to conclude otherwise.

The final question, again under the truncated approach, is should the FTC apply the truncated rule when there is a finding of no market power? The author believes if the practices already were adjudged to be "inherently suspect" and the efficiency justifications were rejected as invalid, the defendant should be given the opportunity to prove it does not possess "market

market power conclusion and the case would proceed as before. This option would pose no significant burden on the agency. The defendant would have the added burden of hiring expert witnesses. The only other alternative to assure that an anomalous result does not recur is to prohibit the defendant from proving its innocence — a concept foreign to most legal proceedings, al-

The CDA case presents an opportunity for the Federal Trade Commission to allow a respected profession the prerogative of holding its members to a higher standard than commercial enterprises.

power" and thus could not violate the law. Clearly, the reason the Commission and its staff use the truncated approach is because it allows them to avoid presenting a full market analysis.

But what if the defendant is willing to present its own market analysis and lack of market power evidence? Shouldn't the opportunity be afforded to them? If the burden is on the defendant, the FTC staff need only submit enough evidence to refute the lack of

though present in a *per se* case. If the Commissioners elect to allow their staff to proceed with a truncated approach against a defendant with no market power, they will need the backing of the federal courts and that may be more than they can expect to achieve. CDA has already committed to appeal such a decision to the federal court of appeals and to the U.S. Supreme Court, if necessary.

Conclusion

The CDA case presents an opportunity for the Federal Trade Commission to allow a respected profession the prerogative of holding its members to a higher standard than commercial enterprises. There is a place for federal government regulation of activities of purely private, voluntary associations. However, when a private organization lacks market power and after considerable thought, concludes that it is desirable for it to be more restrictive than the state government or the federal government in the area of member advertising, it should be allowed this option. When it is proven that commerce has not been harmed, the antitrust agencies should cease to meddle in the internal affairs of private organizations. That is good government and good for consumers. One hopes in most cases it does not take ten years for the FTC to realize the entity is not capable of violating the law. Pursuit of the matter after such knowledge is obtained amounts to harassment, over-regulation, and a misuse of valuable government resources.



The ADA Washington Office

Craig Palmer, ADA Washington Editor

A question often asked of the American Dental Association (ADA) Washington Office is, "What are your issues and how do you represent the profession?" A short response would number the issues greater than the twenty-two professional and support staff members of this long-standing lobbying arm of the ADA with representation as changing as the political landscape. But capturing the essence of lobbying in words is as unlikely as an unregulated environment for dentists.

Historical perspective may help. Representation of dentists with government policymakers dates from the civil war when the issues were status, image, and quality of care and the representatives were ad hoc entrepreneurs. More formal representation was established in the post Depression, pre World War II era. The more recent proliferation of federal alphabet soup agencies — AHCPR, CDC, EPA, FDA, FTC, HCFA, HRSA, NIH, OSHA, and others — and increasing scrutiny of the profession by elected and appointed policymakers has taken the relationship of dentist and government in new, more demanding directions.

The ADA's Washington Office today is defined less by lobbying than by adapting to changing political demands, reshaping the profession's voice with our grassroots and coalition advocacy. Staffed by experts in law, legislative and regulatory processes, and communications, the office monitors and influences legislation and regulations, establishes

political liaison in Washington and the states, and speaks for the profession in policy-making arenas.

A department of state government affairs, with seven additional staff positions at ADA headquarters in Chicago, reports to and is organizationally part of the Washington Office. The Council on Governmental Affairs and Federal Dental Services is directly related to and supported by Washington Office staff. The council, charged with oversight of legislative and regulatory policy, also represents interests of dentists in the federal, military, and civilian services.

Where do the profession and government meet? Interaction begins with policy from the ADA House of Delegates. The Washington Office is charged with managing the policy flow in both directions, profession to Congress, White House; and regulatory agency and government to dentist.

Legislative issues important to dentists in the second session of the 104th Congress include: patient freedom of choice of provider and other managed care concerns; Occupational Safety and Health Administration (OSHA) reform; restructuring of the federal-state Medicaid program; appropriations for dental education, research, Indian Health Service dental care, and student aid; insurance and medical liability reforms; the Employee Retirement Income Security Act (ERISA) and tax benefit policy such as medical savings accounts and increased deductions for the self-employed for health coverage.

A regulatory agenda of comparable demand involves the profession with the Federal Trade Commission (FTC) and Justice Department on antitrust relief; the Environmental Protection Agency (EPA) on waste water issues; the Food and Drug Administration (FDA) on dental devices and tobacco regulation; OSHA on ergonomics, tuberculosis, indoor air, nitrous oxide, hazard communication, and blood borne pathogens; and the Departments of Veterans Affairs and of Health and Human Services on reorganizations that could diminish dental presence.

Not as easily categorized are other issues, including the military issues that demanded the profession's attention since its inception and take shape today around dentist officer parity and pay, the emerging risk assessment technique that borrows from toxicology and epidemiology, child abuse reporting laws, national practitioner data bank, Drug Enforcement Administration (DEA) registration for controlled substances, and other demands of Washington representation. The Washington Office also administers the American Dental Political Action Committee (ADPAC), manages the nascent grassroots action network of volunteer dentists in each congressional district, and provides important communications support for the profession. The Washington Office hosts the profession's showpiece political meeting, the biennial ADA public affairs conference for state and national dental leaders.

Agencies



While the budget battle continues in Washington, the Department of State Governmental Affairs is preoccupied with a likely Medicaid transformation that could vest greater management control with states, but at possible cost to the minimal public dental coverage currently available. Many of the profession's managed care concerns translate to state legislative issues. Fluoridation, insurance, and dental hygienist issues are also important to constituent societies.

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The Washington Office invites member inquiries about legislative and regulatory issues.

"The Profession of Dentistry:" The University of Kentucky's Curriculum in Professional Ethics

David A. Nash, DMD, EdD, FACD

Abstract

Among the most important learning that occurs in our nation's colleges of dentistry is learning to be a professional. While knowledge, perceptual-motor skills, and problem-solving abilities are basic to becoming a dentist, helping aspiring colleagues to apply their newly developing skills with integrity must be a fundamental concern. Increasingly, we are realizing that the quality of health care depends as significantly on the character of the health professional as it does on the individual's knowledge and skills. Concern for character, virtue, and integrity is the domain of ethics. This paper advances a justification for including a curriculum in professional ethics in our dental educational programs. The professional ethics curriculum at the University of Kentucky, "The Profession of Dentistry," extends through all four years of the Doctor of Dental Medicine (DMD) program. The paper describes the major goals pursued in the curriculum and outlines the content of each of the four, sixteen-clock-hour courses. Learning ethics experientially through living in a college community is reviewed in the context of the College of Dentistry's comprehensive Code of Professional Conduct and Academic Responsibility. An assumption of the curriculum is, if the professional relationship of dentistry with society is to be sustained, each new generation of dentists must understand the nature of the profession and the ethical obligations of becoming a member of the dental profession.

must understand the nature of a profession and the ethical obligations incurred as a member of the dental profession.

The professional ethics curriculum at the University of Kentucky, entitled "The Profession of Dentistry," extends through all four years of the Doctor of Dental Medicine (DMD) program. Each year for four years, students participate in sixteen hours of classroom interaction and learning focused on ethics in the context of the dental profession. The College's dean is the course director and an active participant in each course. The dean's role is both substantive and symbolic — substantive in providing an integrating perspective and symbolically expressing the value, importance, and relevance of ethics to the dental profession. While classroom instruction and learning are fundamental to a professional ethics curriculum, there must also be a laboratory for learning, in this case, participating in the ethical life of the college community. This experiential learning of professional ethics by

Among the most important learning that occurs in our nation's colleges of dentistry is learning to be a professional. While knowledge, perceptual-motor skills, and problem-solving abilities are basic to becoming a dentist and demand major time and attention in our curricula, helping aspiring colleagues apply their newly developing skills with

integrity must be a fundamental concern. Dentistry is a profession because of its commitment to serving the public in gaining the benefits of oral health. The caring behavior of previous generations of dentists, and their commitment to ethical conduct, have earned the profession the trust and confidence of society. To sustain this professional relationship, each new generation of dentists



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The Profession of Dentistry I — First-Year Course

- ☐ Ethics and Life...as a Dentist: *How should we live...and, as dentists, should we live differently than others?*
- ☐ The Terrain of Ethics: *What's ethics all about?*
- ☐ Ethics of Aspiration: *What goals should I set for my life?*
- ☐ Psychology of Aspiration: *How should I pursue my life's goals?*
- ☐ Living in Society: *How can humans live in a society where everyone is pursuing their personal best interests or goals?*
- ☐ The Ethics of Obligation: *How should I behave to promote a cooperative society where I, and every other human, can pursue a life's plan?*
- ☐ The Concept of Profession: *What does it mean to be a member of a profession...to be a professional?*
- ☐ The Ethics of Profession: *As a dentist, should I live differently than the ordinary person, and if so, how and why?*

students is framed by the College's *Code of Professional and Academic Responsibility*, which also guides the behavior of faculty and helps place the responsibility for morally appropriate conduct within the individual, where it ultimately resides.

Purpose of the Curriculum

Professional education in dentistry exists to educate good dentists — dentists equipped and committed to helping their patients and society gain oral health. In achieving this intention, dental educators acknowledge that the complex knowledge base and the sophisticated perceptual-motor skills of dentistry must be applied with integrity by the individual practitioner. Graduating knowledgeable, skilled clinicians is a necessary condition but not sufficient for ensuring quality oral health care. The further requirement is the commitment of graduates to applying their abilities with integrity, that is, providing quality care in their patients' interest. Ultimately, good dentistry depends on individuals committed to treating their patients and society fairly, that is, ethically. Thus, the justification for teaching professional ethics in dentistry is to facilitate the personal

and professional development of aspiring dentists into socially and professionally responsible human beings.

Some argue that the moral conscience is developed early in life and if student dentists are not morally virtuous upon matriculation, instruction in ethics is futile. Early moral education is an important determinant of one's commitment to the moral life. Moral virtue is the habit of making good and right choices. Through repeated behaviors in our formative years, habits of action are developed, some supportive of living the moral life, others potentially not. Intelligent reflection, with disciplined substitution of alternative behaviors, is necessary to break bad habits and replace them with good ones.

Education is a reflective experience that leads to behavioral change. In fact, education cannot be said to occur absent behavioral change. To suggest that education cannot change behavior, including behavior with moral consequences, is to adopt an intolerable skepticism about education. No doubt the virtue of student dentists varies, with some finding it easier to do the good and right thing once an appropriate course of action is determined. While

acknowledging variations among individuals, the intention of the professional ethics curriculum is to facilitate all student dentists becoming good dentists. The curriculum works to dispel the idea morality is optional — it is only for those wanting to be either altruistic or religious; and to help students understand morality is essential to cooperation among people living in a civil society where each person may achieve the greatest good and suffer the least evil. While the curriculum seeks to elicit a sense of moral obligation, it is not intended to change behavior directly as this could be considered indoctrination. Rather, it provides a framework for students to sense and consider the moral obligations they incur in society, both as individuals and as dentists. Such intelligent reflection can serve as a basis for determining whether changes are required in their moral habits and behavior.

Goals of the Curriculum

The intent of the curriculum is fulfilled by the following:¹

To sensitize student dentists to the moral dimensions of life and professional practice. A goal is to assist students in understanding that human beings live in a complex matrix of relationships, with consequences for good and evil. Certain behaviors can be judged right or wrong, depending on the context and consequence. Ethical problems frequently are embedded and unidentified in life's circumstances. Evaluating situations in the context of their potential for good and evil sensitizes students to the idea there is a moral perspective. Ethics is the branch of philosophy that reflects on the good. Ethics as a discipline is concerned with goodness and badness, rightness and wrongness, virtue and vice, approval and disapproval, ends and means, and judgments of value and judgments of obligation. Professing dentistry as a life's calling intensifies the moral dimension of life, as patients seek relationships with dentists in order for dentists to do good for them with regard to their oral health.

To develop skills of ethical analysis. The cognitive tools of ethics are required to critically and reflectively consider alternative courses of action with the potential for good or evil consequences. Ethics is the science of the moral. Analysis skills must be developed in using the concepts, principles, and rules of ethics. Problem-solving abilities in ethics have real practical value. Choices in life have consequences for the individuals making choices and those affected by their choices. Critical thinking in ethics assists student dentists as human beings and as health professionals in discriminating between good and evil and, therefore, right and wrong behavior.

To foster respect for disagreement and toleration of ambiguity. Although precise and rigorous, ethics does not necessarily enable one to determine that only one action is moral. Choices sometimes must be made between conflicting goods, and at other times, choices must be made among alternatives all with potentially negative consequences. Equally virtuous people may disagree on courses of action. However, care must be taken to ensure that the grounds for disagreement among them are reasonable and logical. Dentists, as all humans, must learn to be tolerant of other's views to the extent these views comport with human rationality. A curriculum goal is to enable student dentists to acknowledge that much of human life is ambiguous and to learn to tolerate ambiguity. Tolerance for ambiguity acknowledges there are many dimensions of existence in which no definitive behavior is ideal or conclusive.

To assist student dentists in explicating the moral responsibilities in becoming a member of the profession of dentistry. The relationship of the profession of dentistry with society and with individuals is best understood as a cooperative relationship, with mutual benefits and burdens. Professing of dentistry as a life's work is a promise to society to care for its oral health and to use the art and science of the profession to cure oral disease. The good of both parties is basic to the complex relationship of care-provider and care-re-

ceiver. However, because the relationship is complex, circumstances emerge in which harm can occur. To be concerned with ethics is to be concerned with good and harm, benefit and burden. The curriculum seeks to explicate concepts, principles, and rules that should be considered in forging cooperative relationships that ensure all parties obtain the greatest good possible and are treated justly or fairly. The curriculum explores the terms of cooperation when patients seek the care of dentists, as well as between the profession and society in general.

To motivate continued learning of ethics. Authentic education prepares for and promotes further learning. A substantive goal of the curriculum is to develop a positive attitude toward ethics so dentists will seek opportunities to further their knowledge and understanding after graduation.

The curriculum is not intended to disavow or discredit any student's ethical tradition or heritage. Rather, in achieving the above goals, one's ethical precepts will be placed in the larger context of a pluralistic society. The concepts, principles, and rules of ethics used

throughout the curriculum are foundational — ones intelligent, reasonable people can agree upon — and are not knowingly inconsistent with any religion's or culture's ethical tradition.

The Curriculum

Ethics and Life As a Dentist. The first-year course begins with matriculation in the college. From the first day as new colleagues in dentistry, it is intended that students begin to understand the essential nature of life as a professional...as a dentist. The major question the course addresses is, "How should we live and, as dentists, should we live differently than others?" The sidebar outlines the topics and questions of this course. A rational basis for living the moral life as an ordinary human being is discussed. Through exercises, students clarify their life-time goals, considering why and how they should pursue such goals. A pivotal issue is exploring how it is possible for human beings to live in a society where everyone is pursuing their own personal goals. From this question evolves the imperative to live the moral life, of cooperating with others to achieve well-being for all. Teaching and

The Profession of Dentistry II — Second-Year Course

- ☐ Ethics in Clinical Dentistry: *How do dentists interact with their patients for the good of both?*
- ☐ The Patient as a Person: *What are appropriate attitudes toward patients?*
- ☐ The Virtues in Professional Ethics: *What is the relationship of virtue to behavior?*
- ☐ The Ethics/Duties of Dentists: *What specific duties do dentists have to patients in the clinical setting?*
- ☐ Informed Consent: *How do I gain a patient's valid consent to benefit their oral health?*
- ☐ Confidentiality: *How far does the dentist's obligation to respect the privacy of the patient extend?*
- ☐ To Treat or Not Treat: *To what extent may a dentist exercise preference in whom to and whom not to treat?*
- ☐ The Responsibilities of Patients: *What are the duties of patients to their dentists?*

The Profession of Dentistry III — Third-Year Course

- ☐ Justice and Jurisprudence: *How do society and dentistry interact for the good of the public and the profession?*
- ☐ Relationship of the Profession and Society: *What metaphor or model can we use to best understand the relationship of dentistry to society?*
- ☐ Contextual Framework for Law: *What is the role of law in American democracy?*
- ☐ Contract Law and the Dentist-Patient Relationship: *What commitments are made when entering into the dentist-patient relationship that are enforceable by law?*
- ☐ Torts and the Dentists: *What "rights" do patients have when "wronged" by their dentists?*
- ☐ Justice and Health Care Allocation: *What is just in allocating health care?*
- ☐ Appropriating Justice Between Dentistry and Society in Kentucky: *What are Kentucky's laws governing the practice of dentistry?*

learning then move to the extraordinary moral duties of being a dentist. The nature of the profession is carefully considered, drawing on the literature of history and sociology. The extraordinary ethical conduct required in becoming a member of a learned profession, such as dentistry, is explicated based on the social covenant professions have with the public.

Ethics in Clinical Dentistry. During the second year, student dentists grapple with the question, "How do dentists interact with their patients for the good of both?" In this course, future practitioners consider the unique duties of dentists including: respecting patients as ends in themselves, not merely means to our ends as dentists; the importance of clear and reciprocal communication with patients; and how dentists can respond to patients empathetically. Benefiting patients with the highest quality of care is advanced as a moral imperative. Yet, students consider the obligation of dentists to respect their patients' autonomy as a critically important moral principle. Discussion focuses on ways in which dentists can ensure patients' full participation in clinical decision-making. Methods for gaining an informed consent to

care are role-played. An interesting and lively discussion is always precipitated with the question "To what extent may a dentist exercise preference in whom to and whom not to treat?" Issues associated with treating culturally diverse, economically deprived, medically compromised, and generally difficult patients are discussed. The course also considers patients' responsibilities to dentists — a welcomed balance. In this course and throughout the curriculum, small discussion groups are used, with faculty members facilitating consideration of ethical issues derived from case scenarios. This methodology permits student dentists to become actively engaged with the topic and to appreciate the practical relevance of ethics to clinical dentistry.

Justice and Jurisprudence. Issues of ethics are ultimately grounded in the principle of justice: what is fair. Jurisprudence is best taught and understood in the context of law approximating and appropriating the ethical ideal of justice. This matter is addressed in the third year of the curriculum. The question is raised, "How do society and dentistry interact for the good of the public and the profession?" Students struggle with issues

of fairness in the complex relationship between society and the profession and between the individual patient and dentist in the caring relationship. The concept of covenant is used as a metaphor for understanding the nature of these relationships. As the covenant relationship is regulated and monitored by society, contractual obligations enforceable by law are discussed, as is the issue of torts or wrongs suffered by either party in the relationship. Student dentists also study the problem of justice in allocating health care and consider different systems for ensuring that all members of society have access to a reasonable level of oral health.

The Organized Profession. In year four, the curriculum focuses on the organized profession and its role in professional ethics. Professionals organize their efforts to benefit society. Some benefits require professional action only attained through concerted effort. In this course, the question is asked, "How do dentists interact with one another?". Students are introduced to the history of dentistry as a profession, including its development through the twentieth century. The structure, functions, and benefits of organized dentistry are outlined. A particular focus is professional self-regulation. The American Dental Association's *Principles of Ethics and Code of Professional Conduct* is examined closely and used as a guide for discussing practical implications of professional ethics. Peer review, disciplinary hearings, and professional sanctions are considered. The question of why and when dentists should challenge the integrity of their colleagues is debated. In this context, the ethics of "whistle blowing" is considered. The course and curriculum conclude the week of graduation with an assessment of the future of dentistry and the important role each new graduate can play in ensuring the profession's future by serving the public faithfully and fairly.

The Learning Laboratory

Individuals learn moral values and moral behavior through experience,

that is, interacting with others. A pedagogical approach that relies on classroom exchanges alone likely will not be successful in achieving the intention of the "Profession of Dentistry" curriculum. To be appropriated personally, professional ethics must be directly experienced through life with members of the college community and through the policies and practices of the college as an organization. Teaching through personal example and role modeling are powerful instructional tools. An approach to collegiate life that relies on external authority and fear of punishment to ensure moral integrity will not have the effect of developing dentists with enlightened ethical judgment and a personal commitment to the moral life.

As a consequence, the college developed a *Code of Professional Conduct and Academic Responsibility* to engage student dentists and faculty in the moral life of the college and to provide a vehicle for professional self-regulation. Through understanding of and commitment to a codified standard of behavior, members of the college participate in an experiential laboratory for transmitting and learning principles of professional ethics and responsibility. Integrity is an essential professional quality and self-governance is an important professional responsibility. The college's code becomes a means to guide and govern behavior within the college community.

The linkage of the curriculum to a code of academic and professional responsibility, integrated with the University of Kentucky Medical Center's Professional Behavior Code are significant features of the approach to professional ethics. The college's code includes behavioral standards for health professionals, adopted by the broader medical center community. These standards are drawn from the practice acts of the health professions. Generally, the standards address actions that would violate the tenets of being a professional and cause damage to the covenant between the health professions and the public. Specific examples of such behaviors are: endangering patients or the public; de-

ceiving, defrauding, or harming the public; failure to maintain confidentiality; falsification of health records; abuse of a controlled substance or drug; and chronic or persistent use of alcohol. The scope of the college's code includes academic infractions, such as plagiarism, cheating, and falsification of academic records, as well as misconduct in research. Non-academic infractions, such as theft and lying are also addressed.

The design and scope of the *Code of Professional Conduct and Academic Responsibility* are comprehensive and intended to address professional life and its associated responsibilities. Combining the college's code with the professional ethics curriculum enables the College of Dentistry to integrate its expectations for professional development with the larger medical center and university communities.

Conclusion

The University of Kentucky's "Profession of Dentistry" curriculum offers students a comprehensive introduction to the ethics of the profession of dentistry and affords graduates four years of experience in living the life of a self-

governing, responsible professional person. The college's "Profession of Dentistry" curriculum, its *Code of Professional Conduct and Academic Responsibility*, and its spirit of community offer responsible leadership for the important topic of professional ethics. What is more basic, more important, or of more ultimate concern than, "how should we to live...and why?"

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Acknowledgment

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The Profession of Dentistry IV — Fourth-Year Course

- ☐ The Organized Profession: *How do dentists interact with one another?*
- ☐ A Retrospective on Teeth: *How has humankind historically treated oral problems?*
- ☐ Development of the Profession of Dentistry in America: *How has dentistry emerged as a profession?*
- ☐ Architecture of the Profession: *How is the profession organized today?*
- ☐ The ADA Principles of Ethics and Code of Professional Conduct: *What are the profession's standards of self-regulation?*
- ☐ Professional Self-Regulation: *How do dentists work with one another to preserve the relationship of the profession with society?*
- ☐ The Ethics of Whistle Blowing: *Why and when should dentists challenge the integrity of their colleagues?*
- ☐ The Future of Dentistry: *What can I expect in my professional future?*

A New Paradigm for Increasing Access to Dental Care: The Oregon Health Plan

Lester E. Block, DDS, MPH, and James R. Freed, DDS, MPH

Abstract

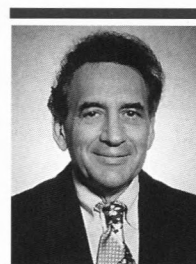
The Oregon Health Plan, one of the most controversial health care proposals to emerge in recent years, was implemented on February 1, 1994. The plan's intent was to control cost and increase access to health care for Oregon's low-income and Medicaid population. A key feature was limiting covered services to a state-approved list created by an open public process. Services were ranked from most important to least important, with covered services to be determined by available funding. For the first time, the listing included a merged set of medical and dental services, with many dental services ranked higher than medical services. Oregon's Medicaid program, which previously did not cover any adult dental care, now has one of the most generous set of Medicaid dental benefits in the United States. From the perspective of increasing access to dental care, this article suggests that the dental profession should re-examine its current policy supporting the separation of medical and dental benefit packages.

One of the most controversial health care proposals to emerge in recent years is the Oregon Health Plan, often referred to as the Oregon Health Care Rationing Plan. The plan arose in response to two major societal health policy concerns: the high cost of health care, and the lack of access to care for some segments of the population. Oregon experienced both problems, with the cost of Medicaid growing at double-digit rates for a decade¹ and 450,000 individuals without health insurance.²

The Oregon Basic Health Services Act of 1989 was intended to expand access to health insurance by targeting three segments of the uninsured population: those with incomes below the federal poverty level, including the Medicaid population; those unable to purchase health insurance because of a pre-existing health condition; and those who are employed but with no employer-based health insurance.³ Expansion in coverage was to be achieved by limiting coverage of services to a state-approved list. The most publicized aspect of the plan has been the limiting or

rationing of beneficial care, which elicited considerable comment in the medical literature.⁴⁻⁸ There has been limited analysis of the dental aspects of the plan, although it dramatically altered dental care benefits in the state. For the first time, dental and medical services were combined into a single set of health care services.

This paper first describes the method used to prioritize health services within the "Standard Benefit Package," the cornerstone of the Oregon Health Plan. It defines the health care services necessary to achieve and maintain good health and, by excluding some services, serves to control the cost of health care.



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Second, the paper describes which dental services are included and where they rank in comparison to medical services. Third, the paper analyzes the dental health policy significance of the plan with respect to access to care.

Method Used to Prioritize Health Services

The Oregon Basic Health Services Act of 1989 created a Health Services Commission charged with developing a list of health services ranked by priority, from the most to the least important. The criteria used to determine which services to include and their priority ranking were: (a) effectiveness of treatments; (b) cost and benefit of treatments; and (c) the value placed on the treatments by the public.⁹ Mental health and chemical dependency services were not included in the original list but were added in 1992.¹⁰

The Health Services Commission consisted of eleven members including five physicians, four consumers, a public health nurse, and a social services worker. There was no dentist on the commission. The commission grouped services into one of seventeen categories of care based on effectiveness, cost, and benefit of treatments. Services in Categories 1-9 were considered "essential," those in 10-13 "very important," and

14-17 were "valuable to certain individuals." Services first were ranked within categories, but in the final list were moved up or down based on public values and commissioner judgment. Thus, "essential services" could be ranked lower than services in the "very important" category.⁹

The commission used several approaches to gather public comment. There were forty-seven community meetings, twelve public hearings, and a telephone survey of 1,001 individuals.⁸

The commission published its first list of services on May 1, 1991 which included 709 items, each representing a "condition/treatment pair."¹¹ For example, a medical condition, such as bone fracture, was paired with a treatment, such as reduction of the fracture. Each pair was listed using the International Classification of Disease (ICD)¹² for the condition and the American Medical Association's Current Procedural Terminology (CPT)¹³ for the treatment. For dental conditions, treatment was indicated by the Current Dental Terminology (CDT).¹⁴

Once the 709 condition/treatment pairs were created, a projection was made of the cost to fund the complete list for the current Medicaid eligibles plus the estimated 120,000 individuals who fell at or below the federal poverty

level. The legislature determined that enough funding was available only to pay for 587 of the 709 listed items.³

Since the plan would affect the Medicaid population, it could not be implemented until a waiver was granted from the Health Care Financing Administration (HCFA). HCFA initially turned down Oregon's request to modify its Medicaid program. The basis for the denial was that the Health Plan violated the Americans with Disabilities Act because Oregon used a quality of life measure which was assessed using a public opinion survey. Advocates for the disabled argued that the public was biased on the quality of life of the disabled, especially where the disability would remain after treatment, and this bias led to a lower rating of services for persons with disabilities.¹⁵

In response to the denial by HCFA, Oregon devised a revised list which did not use the survey data and did not consider quality of life. The revised list of 688 items, published in October, 1992,¹⁶ was resubmitted to HCFA. The plan was approved with some conditions and restrictions in March, 1993.¹⁷ A third list, produced on April 19, 1993, included several revisions and an expansion to 696 items. In this revision, the term "condition" in the condition/treatment pairing was replaced by "di-

Table 1. Preventive Dental Services Authorized Under the Oregon Health Plan — Line #280.

CDT Code	Service
00110	Initial oral examination
00120	Periodic oral examination
01110	Prophylaxis - adult
01120	Prophylaxis - child
01201	Topical fluoride-child (including prophylaxis)
01203	Topical fluoride-child (no prophylaxis)
01351	Sealant
05986	Fluoride gel carrier

Comparison Medical Services

Line	Service
#291	Non-insulin dependent diabetes mellitus
#300	Cardiac arrhythmia

agnosis.” Some technical changes were made in April, 1993, and this list was in place when the program began on February 1, 1994.¹⁸ Of the 696 services on the prioritized list, the Oregon legislature appropriated funds to pay for 565.¹⁹ The following analysis is based on the plan when it was inaugurated on February 1, 1994.

Coverage of Dental Services

Because there are only 696 diagnosis/treatment pairs, the Oregon Prioritized List of Health Services uses broad categories, including a number of different services under a generic diagnosis heading. For example, some diagnoses are described only as “dental services” and over 90 Current Dental Terminology treatment numbers are included. Rather than describe every service, selected examples from each diagnosis/treatment pair are used to convey the type of services covered. Some conditions which may be treated by either dentists or physicians are not included. These include facial fractures, cleft lip or cleft palate, and cysts of oral soft tissues. To illustrate the relative importance placed on the dental services as compared to medical services, selected medical services at similar rankings are presented.

The Prioritized List of Health Services uses line numbers to represent the rank order of the diagnosis/treatment

pairs with #1 the most important and line #696 least important.

The first dental diagnosis/treatment pair to appear on the list is “preventive dental services,” at line #280. As shown in Table 1, covered services include initial and periodic oral examination, prophylaxis for children and adults, topical fluoride for children, and sealants. Examinations and prophylaxis are limited to once every six months; topical fluoride can be provided once every six months for recipients through eighteen years of age. Sealants are covered for permanent molars only for children fifteen years or younger.²⁰ These dental ser-

vices rank just above medical therapy for non-insulin dependent diabetes mellitus (#291) and cardiac arrhythmias (#300).

The next dental diagnoses are at lines #330 and #331. “Dental caries (periapical infection)” is #330 and the treatment specified is CPT 41899, “unlisted procedure, dentoalveolar structures.” “Dental services (e.g., infections)” is at line #331, with treatment described as “restorative dental service.”

A list of representative treatments at line #331 and their Current Dental Terminology numbers are shown in Table 2. These are episodic procedures for relief of pain and infection, such as extractions, incision, and drainage. Pulpotomy is included as are denture adjustment, denture repairs, and recementation of crowns and bridges. These dental diagnoses rank below medical and surgical treatment for non-orbital cellulitis (#328) and above treatment for abscess of bursa or tendon (#332) and abscess of prostate (#333).

The next dental services are at lines #478 “dental services (e.g., dental caries, fractured tooth)” and #479 “dental services (e.g., insufficient room to restore tooth).” Over ninety CDT Procedure Code numbers are listed for these two lines, which encompass most basic dental treatment. Line #478 (Table 3) in-

Table 2. Dental Services (e.g., Infections) Authorized Under the Oregon Health Plan — Line #331.

CDT Code	Service
00130	Emergency oral exam
07110	Single tooth extraction
07120	Each additional tooth
07130	Root removal-exposed roots
07210	Surgical removal of tooth
07510-20	Incision and draining of abscess
09110	Palliative (emergency) treatment of dental pain-minor procedures

Comparison medical services

Line	Service
#328	Non-orbital cellulitis
#333	Abscess of prostate

Table 3. Dental Services (e.g., Dental caries, fractured tooth)
Authorized Under the Oregon Health Plan — Line #478.

CDT Code	Service
02110-31	Amalgam restoration primary teeth
02140-61	Amalgam restoration permanent teeth
02330-35	Resin restoration, anterior teeth
02930-31	Pre-fab stainless steel crown-primary/permanent
03310-30	Root canal excluding final restoration (anterior, bicuspid, molar)
04341	Periodontal scaling and root planings per quadrant
07220-50	Removal of impacted teeth, soft tissue and bony
07285-86	Biopsy of hard or soft tissue

Comparison medical services

Line	Service
#477	Acute conjunctivitis
#481	Foreign body in ear and nose

cludes amalgam, resin, and stainless steel restorations for primary and permanent teeth; anterior, bicuspid, and molar root canal therapy; periodontal scaling and root planing; and removal of impacted teeth. Root canal treatment is not allowed for third molars and is limited to permanent teeth with a favorable prognosis. Periodontal scaling and root planing is allowed once every two years.²⁰

Line #479 (Table 4) includes cast crowns, including porcelain fused to metal, pontics, crown buildups, cast posts, denture relines, tissue conditioning, gingivectomy, and root canal retreatment. Crowns and bridges are limited to anterior permanent teeth only and recipients must be sixteen years of age or older. Bridges are limited to four units including abutment teeth. For posterior permanent or primary teeth, stainless steel crowns are permitted.²⁰ Medical diagnoses approximating these lines are acute conjunctivitis (#477), foreign body in ear and nose (#481), hearing loss over age of three (#482), and reconstruction of disorder of the shoulder (#483).

Surgery for symptomatic impacted teeth is at line #495 and interdental wiring for avulsion of teeth is line #496. "Dental services (e.g., tooth loss)" is at line #499 and the services covered are

space maintenance, gingival flap procedures, including root planing, complete and partial dentures, and open and closed reduction of maxillary and mandibular fractures (Table 5). Removable cast metal and resin prostheses are limited to recipients age sixteen or older. The nearby medical diagnoses are

medical therapy for parasitic infestation of the eyelid (#494) and fracture of one or more phalanges of the foot (#500).

The next three lines containing dental care are #508 (exfoliation of teeth due to systemic causes), #510 (retained dental root), and #511 (specific disorders of the teeth and supporting structures). A variety of treatments are listed using CPT rather than CDT numbers. The services include excision of fibrous tuberosities and osseous tuberosities, alveolectomy, and excision of lesions or tumors. Medical services at this level are treatment for osteoporosis (#504) and medical and surgical treatment of carpal tunnel syndrome (#513).

Line #535 is described as "dental services (e.g., malpositioned tooth)." Although the diagnosis includes "malpositioned tooth," no orthodontic services are listed. A variety of services is included such as acrylic partials, laboratory relines of complete dentures, removal of exostosis, and frenulectomy. Treatment of candidiasis of the mouth is at line #542.

Treatment of atrophy of edentulous alveolar ridge is line #548. Again, a vari-

Table 4. Dental Services (e.g., Insufficient room to restore tooth)
Authorized Under the Oregon Health Plan — Line #479.

CDT Code	Service
02751	Crown, porcelain fused to predominantly base or noble metal
03346-48	Root canal retreatment (anterior, bicuspid, molar)
04210-11	Gingivectomy or gingivoplasty
05730-41	Reline complete and partial dentures
06211-12	Pontic, cast predominantly base or noble metals
06241-42	Pontic porcelain fused to predominantly base or noble metal
06751-52	Crown, porcelain fused to predominantly base or noble metal
06791-92	Crown, full cast predominantly base or noble metal

Comparison medical services

Line	Service
#482	Hearing loss - over age of three
#483	Reconstruction of shoulder disorder

Table 5. Dental Services (e.g., Tooth loss) Authorized Under the Oregon Health Plan — Line #499.

<u>CDT Code</u>	<u>Service</u>
01510-25	Space maintainer fixed or removable
04220	Gingival curettage surgical per quadrant by report
04240	Gingival flap procedure including root planing per quadrant
05110-40	Complete upper and lower and immediate upper and lower denture
05213-14	Upper and lower partial denture, cast metal base
05936	Obturator prosthesis
07270	Tooth reimplantation or stabilization of accidentally avulsed or displaced tooth or alveolus
07710-80	Maxilla and mandible open reduction, closed reduction

Comparison medical services

<u>Line</u>	<u>Service</u>
#500	Fracture of one or more phalanges of the foot

ety of treatments is listed using CPT numbers. Services include bone grafts, partial and complete subperiosteal implants, and endosteal implants (e.g., blade and cylinder) to reconstruct the mandible or maxilla. Vestibuloplasty is included in this line item.

TMJ splints for TMJ disorder are at line #555. This ranks just above medical therapy for non-sexually transmitted urethritis and inflammation of lacrimal passages.

No dental services are listed below #565, the last funded line item. TMJ surgery for TMJ disorders (#666) is excluded as are orthodontia, and a number of dental services described as "dental services (marginal improvement)" (#678). Services such as topical fluoride for adults, apicoectomy, three-quarter crowns, tooth transplantation, application of desensitizing medications, and occlusal adjustment are excluded. Examples of medical diagnoses not covered include acute tonsillitis other than beta-streptococcal (#644), acute upper respiratory infections and common cold (#647), pharyngitis and laryngitis (#651), and cancer of various sites with distant metastases where treat-

ment will not result in a 5% five year survival (#672).

Health Policy Implications

The goals of the dental profession include providing services for a larger segment of the population than currently receives care, and for "oral health to be considered an integral part of the overall primary health care of an individual."^{21,22} Over the past thirty years the percentage of individuals having at least one dental visit per year increased from 37% in 1958²³ to 57% in 1989.²⁴ However, there remains much to do to increase access, particularly among groups without insurance. One likely cause of low utilization of dental care services is the lack of insurance, with only about 38% of the population covered by some form of dental insurance²⁴ compared to about 89% with medical coverage in 1989.²⁵ This disparity in coverage indicates, to a large extent, that oral health care still is not considered an integral part of health care.

The Oregon Health Plan deserves attention by dental policy analysts because of its dramatic effect on improving dental coverage for hundreds of thousands of individuals. Prior to imple-

menting the plan, Oregon's Medicaid program provided no dental coverage for adults. Oregon now has one of the most generous dental Medicaid benefit packages in the country, including coverage for services such as endodontic treatment, scaling and root planing, along with basic preventive, restorative and prosthodontic services. Cast crowns and bridges are included with limitations. Further, over 100,000 individuals not previously covered by Medicaid were brought into the plan and provided dental coverage.

From a public policy perspective, it appears the most reasonable explanation for this change was the process used by Oregon in revising its Medicaid program. The central feature in that process was inclusion of both dental and medical services in the same benefit package. The decision to develop a "Standard Benefit Package" meant that dental services had to compete with medical services for inclusion. The competition took into account the effectiveness, the cost and benefit of treatment, and the public's value of the treatment. The final ranking of dental services in Oregon indicates dental care services compare favorably with many medical services which suggests dental treatment is regarded as effective, cost beneficial, and valued by the public. As one news report indicated, "It emerged that Oregonians placed a high value on certain services: prenatal care, dental care, and hospice care, for example, all ranked high, and all are included in the Oregon package."²⁶

That dentistry fared so well in this competition should lead to examining dentistry's policy on combining medical and dental benefits. Although there is a policy to integrate oral health as part of overall primary care, the fundamental approach of organized dentistry with respect to coverage of dental care has been to have dental services considered separately from medical services. The Task Force on Access, Health Care Financing and Reform of the American Dental Association concluded, "Dental benefit programs should continue to be

treated separately from hospital-medical-surgical benefit programs.”²⁷ The Association’s testimony to the House of Representatives on health care reform was, “The Association urges a *separately* administered and delivered dental benefits program under Medicaid...”²⁸

The Coalition for Oral Health, formed in response to proposals for health care reform, sought to include dentistry in health care reform, but did not specifically call for merging medical and dental services into one package. The coalition stated, “We believe that a basic package of preventive and primary health care benefits, including comparable oral health benefits, should be required to be available to all Americans as part of both public and private insurance programs, and should be available in both private and community-based settings.”²⁹ The services suggested by the coalition for inclusion were primarily preventive services, emergency care, restorative services excluding metal casting, non-surgical periodontal services, and full dentures with partial dentures to be phased in as rapidly as possible. The coalition concluded, “It is essential that oral health benefits be considered no differently than any other form of health care.”²⁹

It is important to note that although the coalition supported a plan which included dental services, it recommended the inclusion of a very limited set of dental benefits. Presumably, this was done in the belief that if the coalition proposed more comprehensive coverage there was a much greater risk that dental services would be totally excluded from the final plan. This may have been the case if inclusion of dental benefits was viewed as an add-on. When dental benefits are considered in this way, they are not considered on their merits relative to the non-dental benefits, as was done in Oregon. As a result, they often are not part of the overall package and are only included after the non-dental benefits are decided.

Thus, both the ADA and the Coalition for Oral Health took positions which would result in a more limited set

of dental benefits than now appears in the Oregon Plan, a plan devised by non-dentists. The ADA viewed dental services as “discretionary” and the coalition’s proposal would have resulted in including only the most basic of dental services, although it stated that the oral health of thousands of citizens would benefit from providing other dental procedures (e.g., crowns, bridges, and removable partial dentures).²⁹ The coalition took this position although it began by asking “...why should we accept exclusions based on parts of the body?”²⁹

Given the goal to increase access to care and the importance of insurance in achieving this, it seems the reason to keep dental benefits separate from medicine is the belief this will lead to greater coverage of dental services. This belief must be examined in light of the Oregon experience. When dental coverage is developed under a separate benefit package, it is usually added after implementing the medical plan, and then only if additional funding becomes available. In addition, a dental plan standing on its own can be a convenient target for budget cutters faced with two distinct programs and who elect to eliminate or drastically reduce one without considering the relative importance of the services. A program seen as an add-on to an existing program is more likely to be reduced or eliminated.

As an example of the potential vulnerability of separate dental benefits packages, a survey of 357 benefits managers and human resources officers of medium-sized and large employers was conducted in 1993 to determine whether they would maintain their dental coverage if health care reform were enacted. Thirty-five percent responded they were “not at all likely” to continue to offer dental coverage as a supplement to President Clinton’s standard benefit package which included only emergency dental care for adults.³⁰

Another example of the vulnerability of separate dental benefit packages was the recent threat of a \$70 million Medicaid funding cut in New York state. An

early target for elimination was non-emergency adult dental care. While a concerted effort on the part of several dental organizations before the state legislature resulted in continuing that care,³¹ the dental program in New York was a visible target for elimination.

Until recently, Oregon exemplified the same phenomenon. The Oregon Medicaid program had an adult dental program. When a budgetary shortfall occurred in 1991, all adult Medicaid dental care including emergency care was eliminated, making Oregon the state with the lowest adult dental benefit Medicaid program in the country. This contrasts sharply with what occurred after the plan was implemented. When it was determined that the original fee schedule for the capitation portion of the dental program had been compiled with rates that were too low to attract enough dentists to participate in the program, the Oregon Health Services Commission increased fees by 40% in September, 1994.³² Dental services were not reduced to fund the increase in fees. The additional \$3.7 million required to fund the program was found within the \$400 million overall health plan,³² and there was no reduction in the dental benefit. Like many states, Oregon currently is having a budget short-fall. Some cuts in the Medicaid program may result,³³ but these will be from the bottom of the priority list and will not target dental services.

Conclusion

Following the recent policy discussions engendered by the proposed Health Insurance Act of 1994, it is especially important for the dental profession to examine its policy regarding integrating medical and dental care benefits in health insurance programs. For the dental policy makers who previously opposed including dentistry as an integral part of a national health care program due to concern that dental benefits would be diminished, the Oregon experience suggests otherwise.

The significant improvement in dental coverage as a result of the Oregon

Health Plan is perhaps best captured by the experience of a young rural female Medicaid patient during a visit to her physician just prior to the plan's implementation. The patient requested an appointment for a routine physical and the removal of several moles on her neck — a benign cosmetic procedure then covered by Medicaid. During the physical, the patient revealed a common ailment of the rural poor — a significant number of decayed teeth. Her physician asked if she had considered having her decayed teeth "repaired." "I'd love to," she said "but Medicaid won't cover them." The physician informed her that removal of the moles would not be covered after implementation of the plan but that dental care would be covered. "With the money we save by not removing your moles," the doctor said, "we can pay for your teeth."³⁴

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Student Views of Professional Ethics

The emphasis of the American College of Dentists on professional ethics often takes the form at the section level of consulting and presenting programs at dental schools, or sponsoring essay competitions for students. In this issue, we present four winners of student essay competitions — one from Georgia, two from Indiana, and one from Oregon. We thank Fellows Manuel Weisman, Charles Kerkhove, and George Ronning for identifying and forwarding these essays.

There is a freshness and optimism in the views of these young professionals. They are a joy to read.

Ethics and the Student Dentist

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For the dental profession to remain as one of the most trusted professional groups, we must inspire patients that their best interest is paramount. The ethical standard applied in dentistry requires the dental student to live by this code from the first day of his career. How does the student know the way to act to benefit his patient — the process is learned. Where are we if this ethical standard is abused by those in authority as opposed to being reinforced in the minds of students?

At what point in a dental student's career is the responsibility of a patient's welfare shifted to the student? How easy it is to hide the smallest flaws in dental work instead of admitting to them and seeking to solve the problem. In the past four years, we had coursework to empower us to become "ethical dentists," but when and how does the transition take place? For seniors, the role of faculty in the clinic is very differ-

ent from previous years as we are given a good deal of freedom to make our own decisions. This new freedom often presents us with a dilemma of sorts of how to work for the patients to provide the acceptable clinical standard. Every June the squeeze is felt to complete requirements, take boards, and plan to start work — all within a short period of time. But where do the patients fit in the scheme of things? Are they sometimes given less than adequate treatment simply to satisfy the requirements of a department?

How shall we as professionals govern ourselves? What is our standard to judge all actions as living up to the highest ethical standard? Ethics is the systematic study of what is right and good with respect to conduct and character.¹ In each person's mind, he must seek out and discover what is right and good with respect to how to conduct life and by what character he will be known. This ability is learned throughout life and must be a constant focus in his mind. Any process or experience engraved in a dental student's mind is there as a result of learning. What we see is what we do; which is a familiar text

used since childhood. The moral responsibility each student has must be learned from someone who is usually within the dental school setting. Dental ethics is an application of ethical rules and principles to the practice of dentistry.¹ Would it be called ethical when a professor comes to the operatory, sits down, and proceeds to "work" on a patient in a harsh, abusive way? What is the learning process here? Will this be the manner in which a dental student learns to treat his patients in the future?

Where must the process begin to assure all dental students will live up to the highest ethical standards? Is it the responsibility of those admitting students into the school to evaluate every aspect of the applicant's ethical upbringing? Is the first week of dental training the appropriate time to instill all of the ethical standards to live by for a person's career?

One day in the Fall quarter of my senior year, I was preparing a Class II amalgam preparation when I noticed I had slightly nicked the adjacent gold crown. The dilemma arose — should I leave the small area alone, for I was working on my own, or should I smooth and repolish the area? The choice was easy. Here was a patient putting all of her trust in me to provide the best care possible. The decision was mine, and I repolished the tooth.

In today's society, there are no safeguards to insure that those who begin their careers as dental students will proceed to carry the highest regard for the welfare of their patients. There must be a time of freedom to branch out and discover one's own talents and rapport

with patients as their sole dental provider.

In the dentist-patient relationship, the patient regards the dentist with the highest esteem and trusts all decisions made by the dentist. What is the motivation for the dentist to act and what will be the moral implications of these motivations? The American Dental Association states, "...the ethical statements which have historically been subscribed to by the dental profession have had the benefit of the patient as their primary goal."² For all that dentistry is worth, the benefit to the patient is paramount. Dentists are not factory workers with patients "coming down the line" to be worked on like a machine. These are human beings, the same as the dentists.

Every dentist must constantly ask himself if he is working for the benefit of the patient, this is a thought process that begins in dental school. Now is the time to examine the decisions being made and to think if the principles taught in school are being adhered to or if, perhaps, those ideals have lost their significance in the race to become a dentist.

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The Ethical Consequences of Health Care Reform

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During the past year, political awareness in the United States was elevated to heights rarely seen outside of wartime. Issues such as fundamental political beliefs and economic policies were among the topics debated; but no single issue influenced this enhanced consciousness more than health care reform. Opinions from constituents overwhelmed elected officials and they realized that the issue was too important not to listen.

As a result, the issue was tabled for further review. Although no proposal was instituted, the topic is far from dead. Health care reform will undoubtedly return in some form or another. In the future, the dental profession must prepare to deal with the almost inevitable changes that reform will bring. These changes will likely affect many aspects of dentistry including the ethical considerations that must be addressed if practices are to maintain a high standard of care.

The proposed system of health care reform featured cost containment efforts pointing toward expanded managed care. The field of dentistry is somewhat insulated from these changes in that dental insurance features prevention and cost sharing. Rarely does dental insurance cover more than a portion of the costs of major restorations, but we cannot become complacent.¹ If current or future legislative powers implement a system resembling the prevailing ideas, we will likely see more effect on the delivery of dental care.

To see some of the ethical consequences of reform, an overview of similar systems at work is necessary. First, it should be noted that according to a recent NBC poll, 81% of people are satisfied with the current health care system.² Regardless, government feels a nearly complete overhaul is necessary to achieve the contemporary goal of universal coverage.

In a model system in the state of Hawaii, we can see the problems this type of plan presents. In 1974, Hawaii implemented a health care system based on universal coverage using employer mandates to accomplish the desired result. The Hawaiian government required employers to pay for the health care of their employees. Initially, the program worked as planned and the majority of citizens were satisfied. Since then, mandates were added each year and the results have not been so promising. The consequence has been yearly double-digit increases in medical costs, which led to more problems for the employers. Between 1980 and 1990, Hawaiian health care costs rose 191%.² Businesses responded by cutting budgets, freezing expansion plans, and fixing wages. Many Hawaiians now receive fewer health care benefits than they did prior to the implementation of the plan. Current statistics show that 11% of Hawaiians are still without health care coverage, proving that the goal of achieving true universal coverage was not reached.

Small businesses were the hardest hit by the ever-increasing control of the state government. Most cannot afford to hire anyone new and approximately 40% of employers had to reduce their total number of employees due to the increased cost of keeping or adding employees to their staff.

Ethical concerns should not only include how we treat our patients, but also encompass the treatment of employees. Since we generally categorize dental practices as small businesses, this type of effect will be evident. How we treat our employees is a reflection of patient treatment. Increased employer mandates would likely lead to decreased employee wages and eventual loss of jobs on a large scale. We all want to treat our employees fairly, but in such a system, the government would dictate how we handle these relationships. Ethics compels us to respect the work of our employees and reward them accordingly.

Another example of a similar health care system designed to provide universal coverage, may give us insight to pa-

tient treatment if our government institutes a comparable arrangement. This type of system is currently in effect very close to our borders, in Canada. Although this type of system would not be identical to the proposed plan in the United States, many aspects are similar and provide a working model of potential problems. In the Canadian system, health care is afforded to patients by facilities or individual health care providers at the discretion of government, based on the necessity of care or by availability. This means patients are not able to choose their provider based on personal choice, but rather by geographical accessibility. Similarly, the proposed system in the United States included plans for HMOs that would restrict free market choices in the same way.

The greatest health care system in the world was built as a result of capitalistic options allowing patients to seek the best possible care regardless of geographical restrictions. The need for continuing research and development would be greatly depressed because equality of care rather than excellence of care would become the focus. One area would not be allowed to provide better care than another. As a result, advancements in health care would likely be repressed. If we believe that our patients are entitled to the highest standard of care, how can we justify limited growth of a system that is constantly finding better ways to treat patient problems within the current scheme?

Many believe that the standard of care would actually fall under the proposed plan. Treating patients in an atmosphere of restricted growth creates ethical dilemmas for the health care provider. Simply put, better methods of patient treatment would not be available under the proposed system in as timely a manner.

Financial restrictions are another problem common to the Canadian system. Rationing specific treatments such as radiographs is a typical practice. This means that certain procedures are only available to individual patients within an arbitrary time frame. A patient is not eli-

gible to receive additional diagnostic care or treatment if the same care was performed during this period. Health care providers are fully aware that patient needs do not follow a specific timetable. How can we ethically warrant delaying treatment to a patient because of a preset timetable?

In the United States, this type of restriction may be most evident when factoring the role of insurance companies into the equation. A similar timetable is conceivable and the results would be the same. Insurance carriers may dictate our treatment. This seems absurd because insurance companies are not qualified to provide health care to patients. We are ethically bound to render the best treatment available, but with the restrictions of a time frame, adjustments in care would have to be made in order to conform to the guidelines.

From the previous example, the most important ethical concern may stem from the very basis of the entire program. A health care program based on universal coverage eliminates many of the free market aspects of our current system. With the free market structure diminished, dentists and other health care providers may, knowingly or not, be inclined to treat patients in a different manner based on the confines of the system. It would be nearly impossible to afford every patient the highest standard of care available. Free market economics allows patients to seek out the best care obtainable, but with choices of providers moderated by HMOs this process would be hindered. The result would be decreased incentive for dentists to excel in their field knowing that their patient basis would be minimally affected by their performance.

To best illustrate this phenomenon, we need only to remember some examples of monopolies that existed at one time or another in this country. Although this may be an extreme example, some correlations can be drawn between the two types of systems. Monopolies were outlawed in this country for the very lesson stated above. Incentive to provide quality service to con-

sumers was not a factor in business proceedings because clientele would not be effected regardless of how the customer was treated.

To a certain extent, the same principles apply to the proposed health care system and the ethical treatment of patients. We need to aspire to be the best that we can be in our field, and with these aspirations, reap the rewards of our continual search for excellence. Ethically, these rewards should include providing the highest possible standard of care to our patients through every available channel.

In order to retain the current level of political awareness, we should consider health care reform to be in a dormant stage rather than dead. A complacent attitude could prove detrimental to the greatest health care system in the world and to the patients it serves. This issue was clearly too volatile to be brought up at election time. Many incumbents avoided taking a stand, sensing political repercussions. Voters are often influenced by the most recent actions of their elected officials.

To think that the United States can succeed with a plan that has failed time and time again in other countries, may be blind optimism. It is inevitable that some type of reform will be implemented, but this does not mean that the dental profession cannot continue to provide quality care to patients according to new stipulations. Practitioners will learn to adjust in order to excel at the same level. During this period of adjustment and into the future, we must continue to consider the ethical treatment of patients a primary goal to strive for when we plot our course into the next century.

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Striving for Professionalism: Moral Courage in Dentistry

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"Moral courage is a more rare commodity than bravery in battle or great intelligence." John F. Kennedy¹

In recent years, it seems morality has become an even more highly prized commodity since John F. Kennedy expressed his opinion in 1963. Today, society's core is decaying with crime rates on the rise and a proportional decrease in moral behaviors. Ironically, the more immoral society becomes, the more precisely ethical codes have been developed, exercised, and explored in the professions.

The dental profession in particular has followed suit and scrutinized its own ethical cannon in recent years. It seems this profession is attempting to rise above society's resignation to moral mediocrity and is urging its members to strive for moral might. Although the dental profession throughout history has held the highest ethical standards, in recent years a new focus has emerged. Dental ethics are now related to the study of the individual's development of moral beliefs. This has led to the addition of ethics as a relevant course in dental education. In addition, pressures on dentists have enhanced the reevaluation of professional ethics. Legal and organizational pressures have increased the necessity for dentists to endeavor in consciously making ethical decisions in everyday clinical practice.

To begin, it was once thought that ethics were a mere inherent quality of a personage mixed with a bit of common sense, a dash of parental guidance, and a sprinkling of religious experience. However, today's society has proven that ethics are not developed according to that recipe. To be a "good" person today is not just relying on the philosophy of common sense: an ethic "is intensified common sense; it is the con-

densed wisdom of the human race. It can bring us clarity to help us keep sane in a world of confusion and hysteria."²

The realization that moralistic beliefs are not inherent has sparked several theories and studies on ethical development. In fact, "a large body of psychological research...contradicts the widely held belief that young adults hold firm and immutable value systems that dictate the ethical quality of their conduct."³ One such theory by Dr. Lawrence Kohlberg of Harvard University suggests there are six stages of ethical decision-making development. The first two levels involve children before puberty: at these levels children make decisions according to selfish advancement and avoidance of punishment. The third and fourth stages occur from adolescence to early adulthood in which persons look at the opinions and rules of other people. In stage four they consider society as a whole when making ethical choices. This is the level at which most adults stop developing ethically, and they function here throughout their lifetimes.

Stages five and six are only obtained by a small percentage of the adult population; stage six includes only 5-10% of the adult population. These stage six individuals base their moral decisions upon their own unique set of internalized, universal standards. "Stage six involves critical thinking and problem solving necessary for resolving ethical dilemmas in the dental school clinic and in private practice. It represents the level of ethics espoused by and aspired to by the dental profession."⁴ Thus, the highest level of ethical development is that which dentists are urged to strive to achieve.

To further the ethical development of future dentists, dental educators have begun to teach ethics as part of certain dental school curricula. This breaks the traditional thought that ethics cannot be taught. However, "ethical strength like physical strength must be exercised."² Most of these programs have been successful by presenting students with moral-clinical situations and allowing

them to consider the alternative solutions. Students are taught to look at dilemmas by using the five components of a moral point of view. These consist of being adequately informed, being conceptually clear, exercising free decision, being devoid of bias, and being impartial.⁴ The goal is to give students some concrete tools to apply to difficult moral decisions. These implements will aid the forever developing dentist in his or her striving to become ethically clear in all clinical situations.

One key aspect of teaching ethics is assisting the professional to recognize moral circumstances. This ability to discern the situation as involving ethics is completely separate from the capability of moral reasoning. In other words, "Students may be skilled at interpreting the ethical dimensions of a situation (ethically sensitive), but unskilled at working out a balanced view of a moral situation (moral judgment), and vice versa."³ This ability of recognition is imperative to grow with the professional's progress because as technology expands, more ambiguous ethical issues will emerge on a regular basis. The not so obvious capacity to discern a moral case is just another method to aid in the ethical endeavor of the dental professional.

Furthermore, pressures exist upon the professional that can affect the moral judgments made when dealing with patients. Legal pressures coupled with increased malpractice litigation against dentists can place the professional in stressful situations. One question that must be asked is, "Are dentists making ethical decisions based upon their own moral development or from legal pressures and the fear of lawsuit?" The philosophical answer would undoubtedly be "the dentist's own highly developed, internalized set of moral principles." However, the more realistic answer is the doctor's worry of being accused of malfeasance. Laws are steadfast lists of situations that should not be breached; this is a simple and basic approach to ethics. Being an ethically correct practitioner in the first place will

undisputedly keep one within the law's confines. Although these legal codes are based upon moral codes, the core of morality in a profession should be derived from the practitioner's personal responsibility to the patient. Legal codes should be reserved as guidelines for justice — not as guidelines for dental practice. "It is certainly not sufficient to simply meet strictly legalistic minimal standards of practice; rather it is necessary to strive to achieve the highest possible bio-ethical standards."⁵

One especially critical and typical threat to the dentist is informed consent. This aspect of moral legality is highly complex for the practitioner; it is set with several pitfalls, but only if the practitioner has not achieved the highest level of moral growth. The legal definition of informed consent consists of the following: 1) The dentist explains the inherent and potential hazards of the proposed treatments. 2) The dentist explains alternatives (reasons for preferring the proposed treatment). 3) The dentist explains the risks of having no treatment at all.⁶ The patient also has the following set of responsibilities for consent to be informed: 1) The patient must receive a thorough disclosure regarding the proposed intervention. 2) The patient comprehends this disclosure. 3) The patient acts freely in giving this consent. 4) The patient is competent to give this consent. 5) The patient actually consents to the intervention.⁵

Actually, the entire liability of informed consent is held by the dentist. The professional is the one that ultimately makes the decision that all of the professional's responsibilities have been fulfilled; he or she has done their part in relaying the information. Also, the dentist has to be assured that the patient has fulfilled all of his or her responsibilities. All of this must be satisfied before the dentist physically begins the agreed upon treatment. In the end, the dental professional holds complete accountability in the legal concept of informed consent.

What's more, the path leading up to informed consent is twisted with complications. Firstly, the dentist, while ex-

plaining the possible treatments, must be able to discern if the patient is willing to digest what the dentist is explaining. "This means that the dentist must be able to recognize the patient's need for information. This is a skill which is as much a part of dentistry as proper technique with a handpiece."⁶ Secondly, the dentist must be articulate. The dentist must have "the ability to convey that information, and this means that a dentist be skilled in using language."⁶ Also, the dentist must be a shrewd predictor of the patient's reaction to the proposed treatment; he must take into account the patient's fears and views of "dentistry's inherent handicaps: pain, cost, and invasion of space."⁷ Therefore, a professional must be a craftsman of "behavioral dentistry, a term which emphasizes the importance of understanding human behavior for the practice of dentistry."⁷ Most importantly, the dentist must be able to perceive the patient's ability to comprehend; the dentist must be skilled at jumping to whatever dental I.Q. level the patient can understand.

A conflict will undoubtedly arise in the communication process between the dentist being complete and accurate and being intelligible to the patient. The professional must be skilled in delivering a balanced message to the patient. "The ability to strike such a balance is one of the most important nontechnical skills which a competent dentist must have."⁶ To place the maximal stress on the dentist, all of the skills must be used in a very time-constrained environment. Thus, to be an ethical provider of informed consent, practitioners must strive to "carefully rethink some of their routine interactions with patients."⁵

The last aspect of ethical consideration to be discussed is that of the dental profession's organizational expectations. These standards are summarized in the ADA *Principles of Ethics and Code of Professional Conduct*. The overriding goal of dental ethics is the priority of service to the community and particularly to each patient member of that community. In fact the first principle is "The competent and timely delivery of quality

care within the bounds of the clinical circumstances presented by the patient, with due consideration being given to the needs and desires at the patient, shall be the most important aspect of that obligation."⁸ This is the ultimate obligation; it is that of altruism.

It is obvious that when one enters a profession he or she is automatically taking on a whole set of obligations regarding what is to be placed above personal preference. Entry to the profession should be structured upon the comprehension of that profession's ethical standards along with a conscious pledge to sustain them. However, this is rarely achieved before graduation from dental school.⁸ These obligations should be taught early in the dental education system so they may be consciously practiced throughout the clinical experience before graduation.

To further complicate the dental professional role of ethicist, he or she is pulled in contrary ways because practices exist in complex professional-economic-social environments. This forces the dentist to form hierarchies of allegiances, "...first to patients, second to themselves as individual agents, third to their profession, and fourth to their society. These competing allegiances exist in almost every clinical encounter and their existence often generates clinical-ethical dilemmas."⁹

Probably the most common clinical-ethical situation arises because of economics. The exchange of money for services has historically aroused controversy. Placing the dentist's needs secondary to those of the patient's is a psychological struggle for the ego; placing the dentist's economic needs secondary to the patient's is a physical struggle for the business. Dentists are expected to run a business without being preoccupied with business concerns, which are always selfish in nature. Hence, striving to be a business person must take into account professional obligations to ethical standards.

In conclusion, dental ethics is the heart of a highly adroit clinical practice. It has been proven that dental ethics can

not only be taught but can be practiced in the dental school education experience. This will enable dentists to achieve the highest level of moral judgment capability which will in turn aid dentists in dealing with the pressures of private practice. The dental profession must struggle to consciously uphold the legal and organizational ethical commandments while placing the individual practitioner below patients in a moral hierarchy. To put it simply, ethical expectations placed on the dental professional seem so difficult that they may ironically appear impossible to achieve completely in today's society. However, perhaps a more appropriate view of ethics should be that these codes are suggestions to strive for moral courage in dental clinics and practices everyday.

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Dental Ethics As I See It

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My primary reason for applying to dental school was to provide top quality service for the public. At least that is what I recall saying in interviews and on application essays. Was I being completely honest? No. In my mind, making good money and having plenty of time to play golf is what made dentistry most appealing. Now as a senior dental student, I am beginning to realize that real success and lasting satisfaction in the dental profession are had by adherence to a stringent code of ethics.

The first principle of ethics in the dental profession is service to the public and quality of care. I have always believed in the saying, "Do unto others as you would have done unto you." What would I have done unto me? I want a treatment plan that best serves my needs. And if feasible, my desires in dental care would be served. I want quality dental care. I want to be treated with respect, gentleness, and compassion. I will continually try to provide that same care to my patients.

As a dental student, the care I render to my patients is regulated by faculty. A common attitude among students is to find the most lenient instructor to check off procedures, with hopes of avoiding more work. Students are elated when an instructor overlooks or misses some-

thing that they know to be clinically unacceptable. Such an attitude is detrimental to the profession and to the public. I recall placing an OL inlay on tooth #15 with a questionable gingival margin. I tried to convince the instructor that I could pull the gold to close the margin. I remember the instructor asking me the *million dollar question* — "Would I want the same restoration to be placed in my mouth?" The answer was clear. No! I must provide the same quality care to my patients that I would want. In just a few short months, upon graduation, I will not have the luxury of having an instructor look over my shoulder. Will the quality of my provided dental care be any less?

I have been taught what "clinically acceptable" means. Therefore I can govern myself because I know what is and what isn't acceptable in dentistry. My best work is above and beyond what is "clinically acceptable." So, in doing my best, whether or not a procedure is clinically acceptable should not be in question! As a practicing dentist, I will have to always do my best whether someone is watching or not.

My desire to attend dental school began as a desire to obtain things. I realize that dentistry is much more than a lifestyle of objects. Dentistry is a group of people providing their best care for their patients. While there are tangible benefits to dentistry, such as cars or a house, the satisfaction of providing ethical and quality care is a greater reward.



Jackson Has a Fright

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Of all the medical sciences, anatomy symbolizes the breadth of biological knowledge — the secrets of the body literally revealed. “When I considered doctoring,” says the dentist-narrator David Hurst about choosing his profession in Jane Smiley’s 1987 novella *The Age of Grief*, “I used to imagine a giant body laid open on an operating table like a cadaver...and myself on a little diving board above it, about to somersault in.”

Because of the complexity of the subject matter and the easily understood method of its exploration, anatomy is a metaphor even for non-medical analysis, interpretation, and understanding. “Anatomize the character of a successful hostess,” wrote American socialite Elsa Maxwell in her 1957 book *How To Do It*, “and the knife will lay bare the fact that she owes her position to one of three things: she is liked, she is feared, or she is important.”

The very image of anatomy, in fact, is the knife. The knife, and the cadaver. “We were used to grease and formaldehyde and death, but we weren’t used to the Dead, or their messengers, the Dissected,” says a first-year medical student in Martin Schecter’s 1992 novel *The Two Halves of New Haven*. “We...had a sense of the anatomy lab as an exceptional place, like a church or a cemetery, that was supposed to frighten you or at least earn your respect.”

As one of the most dramatic rituals of dental training, as well as demanding, absorbing coursework, human dissec-

tion earns the respect of its students. For some dentists, anatomy becomes a passion. Ernest Sloman was dean of the College of Physicians and Surgeons of San Francisco, or P&S, (later to become University of the Pacific School of Dentistry) from 1938 to 1952. Sloman was also an accomplished anatomist. He held a concurrent faculty appointment at Stanford University’s medical school, and contributed for years to the classic medical text *Gray’s Anatomy*. Prior textbooks had shown an incorrect course for the buccal nerve, the branch of the mandibular that supplies cheek mucosa and the posterior buccal gingiva. Sloman’s dissections established a more accurate position. His studies on trigeminal anatomy and anesthesia, and particularly his description of the buccinator nerve, were widely recognized.

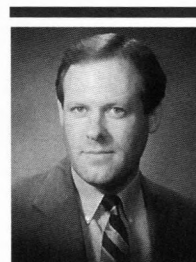
Sloman’s research interests and educational duties required uncommon measures. Every so often the school required a fresh supply of a vital teaching aid that couldn’t be ordered through the supply house detail men. So Dean Sloman would climb into the school station wagon and drive north into the gentle green hills of the northern California wine country. Pulling up to the Napa County state hospital, he would flatten out the back seat and with the help of white coated attendants reap a grim harvest — a car load of human bodies.

The Belgian Andreas Vesalius was the 16th century father of anatomy. Modern medical history has been said to begin with his text *De humanis corporis*

fabrica (On the Structure of the Human Body), written from his own dissections. Surgeon Richard Selzer, in his 1987 book of essays *Mortal Lessons*, describes the picture hanging in a medical school of Vesalius at work: “He is driven by a dark desire. To see, to feel, to discover is all.” The church viewed Vesalius with suspicion for disturbing the dead, and he ultimately was forced to make a pilgrimage to Jerusalem to expiate his dissecting activities. Still, his hard-won knowledge withstood the fear and prejudice, open and accessible to the world.

So the ancient speculations about the workings of the body gave way to observation and understanding, but such discovery came with a price. Here was a pressing demand with an uncertain supply. Where would the study specimens come from? The drive to dissect once made anatomy synonymous with skullduggery. Nineteenth century England was famous for its resurrection men, the grave robbers who grabbed corpses out of morgues and cemeteries to sell to desperate medical schools.

Dean Sloman had his own, tidier solution. He arranged with the hospital dis-



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rectors to have the remains of patients who died unclaimed to be donated to P&S science. He would bring his cache back to the school. The third floor was devoted to basic sciences, including chemistry, bacteriology and anatomy. Through at least the 1930s, the school's anatomical specimens were prepared on site. To the side of the dissecting area was a spotless, tiled embalming room. There Sloman would hoist the cadavers up with big ice tongs clamped to their heads to drain the blood, and then immerse them in vats of formaldehyde for preservation. Although the windows were blacked out and usually kept tightly closed, on one hot and sultry day a window was thrown open in hopes of catching a breeze. A passing visitor on a tour of the school glanced across the way, and fainted at the shocking sight of a cadaver hanging from the ceiling.

Respect or no respect, the unsettling closeness to death endured by young students involved in anatomy lessons — as well as a first-hand understanding of the shock value of the material — inevitably results in horseplay. Perhaps the intensity of the experience requires some neutralizing mechanism. University of Utah folklore professor Jan Harold Brunvald, in his 1989 anthology of urban legends *Curses! Broiled Again!*, recounts an apocryphal tale of medical students who remove an arm from a cadaver in their anatomy lab. They attach a quarter to the hand and set out on the highway. Coming to a toll booth, they extend the arm out the window. The startled toll taker then finds himself holding the gruesome arm as well as the coin as the car speeds away. Following the story from St. Louis to Boston, Brunvald traced the story to San Francisco, where it reportedly stemmed from a real occurrence at another dental school.

At P&S the shenanigans apparently stayed inside the building. Even so, P&S enjoyed a veritable culture of cadavers. Early classes had their group photographs taken with a cadaver or two



1920 yearbook photograph—"A pair of stiff's" propped upright, dressed, and posed casually among the classmates. The students penned poems to their specimens, speculating on who they might have been and imagining conversations with them. A 1920 yearbook photograph shows a student dancing with his cadaver over the caption "A pair of stiff's." The freshman class of 1937 once tried to trap the sophomores in their lecture hall by stacking cadavers against the door. But perhaps the most famous target of student anatomical hijinks was Jackson, the school janitor.

It was generally known that Jackson was nervous about his cleaning duties on the third floor. The lab, with its cache of bodies, neat rows of rigid human outlines laid out under sheets like an entire graveyard risen from the soil, had an especially eerie ambiance in the

dead of night. One year, the students couldn't resist a prank. With a lookout posted for the arrival of the unsuspecting custodian, they assembled one evening after classes and prepared the scene. A steely nerved undergraduate reclined on a vacated dissection table and had a drape arranged over him.

The janitor climbed the stairs, singing softly to himself. He stepped into the room, and began to work, methodically and self-consciously, amid the tense, terrible silence of the covered mounds. It was show time. Suddenly, the counterfeited cadaver rose up on his table, moaning as the shroud slipped to the floor. Poor Jackson started, and for an instant stood transfixed in horror as his wildest nightmare came to life before his eyes. Then with a convulsive, gut-wrenching scream he spun around and burst out of the room. Until his retirement, Jackson would never set foot in the lab again.

The next morning, arriving students discovered the door to the anatomy lab leaning against the wall. It had been torn completely off its hinges.

This feature is adapted from *A Century of Smiles*, University of the Pacific School of Dentistry's 1996 centennial book by Eric Curtis. *A Century of Smiles*, which chronicles dentistry's 20th century rise filtered through the perspective of a San Francisco dental school, is available for \$25 from UOP's Department of Public Relations, 2155 Webster Street, San Francisco, CA 94115. Hardcover, 119 pages, with illustrations.



Brain

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

It seems many of my executive friends are quite knowledgeable about their hearts and their guts. They know cardiac anatomy fairly well, often because of corrective surgery, and they know how to monitor their pulse during an aerobic workout. There is also a high general knowledge of dietary factors. One can have a pretty good discussion of saturated fats and bioflavonoids on any plane trip. And the only books which regularly outsell diet and health books are cook books.

But when was the last time you had a good discussion about your brain? There seems to be a little lacuna there. In fact, there is a pale shade of green when we call people "brainy." But the brain is an important piece of personal equipment that can be nurtured, improved, and certainly used to fuller capacity. It deserves the same respect and workout that our other organs receive.

This department might be considered an introduction to some future owners' manual. As we get into the subject, we are going to find that much of what we know about the world is only imagined, and we need to work better within the limitations placed on us by our mental apparatus.

As the human brain evolved, it added more complex functions on top of simpler ones. The part of the brain connecting to the spinal cord is the medulla oblongata, which regulates basic biological processes such as breathing and blood pressure. Above this is the pons, largely a communication organ

within the brain. The midbrain contains structures such as the hippocampus, amygdala, thalamus, hypothalamus, and pituitary gland, which have regulatory and emotional functions. The cerebellum is in the back of the brain and is concerned with coordinating movement. The cerebrum on top has two hemispheres, each with four lobes: the occipital (vision) in back, parietal (sensation, except smell), temporal (hearing and memory), and frontal (social behavior, personality, and foresight).

Even at this gross anatomic level, it is obvious that different parts of the brain function in different capacities and at different levels of complexity. Coordination within the brain itself is complex and is poorly understood. The recent additions to the brain, which are superior and anterior, increase the flexibility we have in responding to the world — they free us as individuals through choice. The abilities to simultaneously consider alternatives without having to choose among them, to evaluate conditional statements, to contemplate desirable future states, and act creatively, are all located in the frontal lobes.

A typical human brain weighs about three and one-half pounds and contains ten billion neurons, give or take. Activity along the neuron is electrical and between the neurons, at the synapse, it is chemical. There are approximately 100,000 mental reactions per minute. Many neurons fire spontaneously during rest, with some going off as many as ten times per second, even in the absence of stimulation. As impressive as

this may be, the human brain is not the largest. Elephants win in that category. It is even possible that dolphins have a more complex brain structure than we do.

In the one hundred years since Broca discovered in 1860 that loss of certain speech functions could be correlated with loss of brain tissue in localized areas, our understanding of the brain has been dominated by the metaphor that specific activities, perceptions, and memory could be correlated with specific sites in the cerebral cortex. We even indulged in the myth that creative individuals are "right-brained" and scientists use their left brain. This computer model fit well with the Positivist philosophy of science popular at the beginning of this century and with an objective view of the world.

As attractive as this theory of objective correspondence between the world and sites in the brain might be, it simply will not account for experience. Seemingly similar activities such as playing a piano piece from memory or from a score take place in different parts of the brain. People lose the ability to name farm animals but not other animals and know the uses and function of all animals, creating suspicion about what it means to know something. Semantics and syntax are stored in different areas.

And as complex as the brain is, it simply cannot remember everything an individual remembers if it has to assign a neuron per memory. Some principal other than objectivity is necessary if we are to understand how the brain func-



tions. The best answer at the moment is that intelligence — useful brain functioning — is a matter of overall organization or patterns of interconnectedness within the brain. Research with rats raised in an enriched environment, compared to those raised in an impoverished one, show richer patterns of interconnectedness in certain parts of the brain and an increase in the glial support cells rather than an increase in neurons. (There is considerable evidence that neurons in the brain do not proliferate or regenerate; and that we actually lose a small proportion every year.)

To illustrate the point that intelligence is a matter of brain patterns, we will consider in some detail the case of reading. As you take in this line of text, your eyes dart at about four fixations per second. The movements, called saccads, are jerky and not smooth. During the movement, there is no perception and virtually all of the time in reading is spent moving the eyes. The point of fixation is roughly the size of a word, and the area around the point of fixation grows less and less intelligible. At this rate a reader who fixated on each word would read approximately 250 words per minute, a typical speed. The problem with this explanation is that roughly one quarter of the saccads are retrograde, looking back over previously seen material.

Two things are obvious from this explanation of the reading process. First, there is some active process that controls where the fixations will take place. It is true there are innervations running from the eye to the visual cortex and from the eye to the motor cortex. There are also connections between the visual and motor cortices. Saccads are neither smooth nor random; they are controlled by an interpretation of the meaning of what is being read and such simple syntactical rules as new sentences begin new thoughts and punctuation often signals a bending of the train of thought.

It is equally true the perceptual process in reading involves reconstruction and filling in the parts which, although not seen, certainly must be there. We

take in words or phrases without having to process the constituent letters. Good readers, in fact are often poor at catching typos. We are unaware of all but the most gross of the jerky forward and backward fixations of our eyes. And many people are incapable of seeing, even under the most controlled experimental circumstances, the blind spot in their visual field which corresponds to the place on the retina where the optic nerve exits and there are no cones or rods.

Let's consider the case of memory. From the name of Walter Mondale's vice presidential running mate to where the keys to the car might be; from the difference in pressure on a hand piece for cutting dentin or enamel to whether one likes broccoli, the number of individual memories is much too large to be associated with objective locations in the brain. There is some research showing that a certain type of memory can be transmitted from one worm to another through RNA. There are some notions about protein migration down the neuron. And there are some good theories about alterations in the pattern of receptor sites at the synapse. But the best candidate for explaining brain memory is some analog to the hologram.

In making a holographic image, a laser beam is split with one half being directed at the receiving plate, and the other half reflecting off the object to be recorded back to the recording plate. What is actually inscribed on the hologram is the interference between the reflected object and the reference beam. In normal light, the hologram has no particular meaning. It is only meaningful when reconstructed through laser projection. Because each piece of the recorded hologram captures the relationship between that piece and all others on the image, stored holograms have the unusual feature that the whole image can be reconstructed from part of the hologram. They also have enormous storage capacity and a characteristic that resembles the phenomenon of recognition in human memory — the "I know

that I know that" sensation. It is certainly not true that the entire brain, or even the cerebral cortex, is a holographic recording system. But certain areas of the brain may function in something like this fashion, or at least be organized along the principle of relationships rather than objects.

Recently there has been popular interest in the features of the brain involving emotions. Both *Time* and *Newsweek* had cover stories on this topic. It is certainly true that sensitivity to one's own emotions and to other's, and control of one's emotions are marks of personal growth and cultural evolution. Emotional behavior has many of the same characteristics as perception, memory, and motor performance in that they are an interaction between brain structure and experience establishing new brain patterns over time.

Like other brain functions, emotions are a complex interaction among several parts of the brain. What makes emotions so unusual is they function at both the most primitive and the most advanced levels. Much of emotional life takes place in the mid-brain, involving the amygdala, which has the power to very rapidly mobilize chemical excitation throughout the body, and the hippocampus, which serves as a storage facility for early memories associated with emotions. The other area associated with emotions is the frontal region, which is involved in weighing future desired results and alternatives. It is well connected to other parts of the cerebral cortex.

The mid brain emotional reaction is rapid and sloppy. It is so quick that smells or sights associated with an angry response, for example, have already triggered an emotional mobilization before the stimuli reach the cortex and before it can actually be determined what the emotional stimulus is. Quite literally, we can know that we don't like something before we know what it is. Much of emotional development involves the capacity of higher cortical centers gaining control over the expression of mid-brain emotional activity.



Finally a word about the right-brain/left-brain mythology. It is true that the left cerebral cortex processes information predominantly in a serial fashion, which is more favorable to reading, logic, and the spoken language. The right cerebral cortex normally processes information in a parallel fashion, which is more conducive to grasping images and relationships as a whole. The reason for this appears to be a matter of efficiency. Because the brain processes the same material in a serial and a parallel fashion simultaneously, and com-

pares results on a constant and virtually instantaneous basis, a fuller understanding of the world is achieved in a much quicker time. Creative individuals use both sides of their brains more than non-creative individuals do. For example, much of music functioning is on the right side, while perfect pitch, a characteristic found more commonly among professional musicians, is located on the left side.

There is new interest in the human brain: its structure, organization, and potential. The newer views are demanding

a broader definition of intelligence, to include all of the socially effective behavior mediated by the brain. There is also an increasing awareness that our smooth, complete, and objective world is a construction or a projection of the brain and not a characteristic of the way the brain actually functions. Perhaps it is prophetic that the most highly evolved and most recent of brain functions, those located in the frontal lobes, are especially concerned with contemplating the future and dealing with ambiguity.



Recommended Reading

Csikszentmihalyi M. *Flow: The psychology of optimal experience*. New York: NY: Harper & Row, 1990. Exploration of the transcendent thrill and focus that comes from expert performance.

* Goleman D. *Emotional Intelligence*. New York: Bantam Books, 1995. ISBN 0-553-09503-X; 351 pages; about \$24.

Criticizes the narrow view that success in life is primarily, or exclusively, a function of inherited, rational intelligence. Argues that self-control, zeal and persistence, self-motivation, and other emotions are critical to success in life and, although some of these emotions can be located in various parts of the brain, they can also be altered by experience and drugs. Goleman is equally against the exclusively rational life and the life of impulses.

Gardner H. *Frames of mind: The theory of multiple intelligences*. New York, NY: Basic Books, 1983.

A recent popularization of the theory that various aptitudes actually represent different mental capacities — “intelligences.” Gardner believes there are seven: linguistic, logical-mathematical, musical, spatial, bodily-kinesthetic, and two forms of personal intelligence, one directed toward other persons and one directed toward oneself.

Hines T. Left brain/right brain mythology and implications for management and training. *The Academy of Management Review*, 1987, 12, 600-21.

Review of the management literature showing that the claimed differences between right- and left-brained “personalities” cannot be confirmed in fact.

* Restak RM. *The Modular Brain*. New York, NY: Touchstone Books, 1994. ISBN 0-684-80126-4; 199 pages; about \$14.

Modular theory of the brain holds that there are separate functions — so many that the number is unknown — that operate in coordination, but are not synthesized into a single, unified action or consciousness. Database organization in computer programming is an apt metaphor.

* Russell, Peter. *The Brain Book*. New York: Penguin Books, 1979. ISBN 0-452-26723-4; 270 pages; about \$13.

A combination introduction to the structure and function of the brain, some interesting connections between brain and behavior, and self-help to improve mental skills, especially memory. Sixteen short chapters presented in an accessible style. Probably written for students or the lay public. There is an optimism throughout the book — characteristic of the '70s — that mental function can be improved through effort.

Lighter Reading:

The EQ factor: New brain research suggests that emotions not IQ may be the true measure of human intelligence. *Time*, 2 October 1995.

Your child's brain: How kids are wired for music and emotions. *Newsweek*, 19 February 1996.

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each summary is about five pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Office in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on the brain; a donation of \$50 would bring you summaries of all the 1996 leadership topics.

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