Journal of the American College of Dentists

Winter 1996
Volume 63
Number 4

Ethics of Managed Care
1996 Annual Meeting & Convocation

Journal of the American College of Dentists

A Publication Presenting Ideas, Advancements and Opinions in Dentistry

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

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

The 1996 subscription rate for members of the American College of Dentists is $30 included in the annual membership dues. The 1996 subscription rate for nonmembers in the U.S., Canada and Mexico is $40. All other countries are $50. Foreign optional air mail service is an additional $10.
Single copy orders: $10.

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

For bibliographic references, the *Journal* is abbreviated J Am Coll Dent and should be followed by the year, volume, number, and page. The reference for this issue is J Am Coll Dent 1996;63(4):1-64.

Publication Member of the American Association of Dental Editors

Objectives of the American College of Dentists

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

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

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

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

D. To encourage, stimulate and promote research;

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

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

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

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

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the 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.

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

The business office of the *Journal of the American College of Dentists* can be reached by:

Phone: 301.977.3223
Fax: 301.977.3330

Features

Ethics of Managed Care
1996 Annual Meeting & Convocation

Alternative Approaches to Ethics

Departments

FROM THE EDITOR

Future Gazing and Leadership

I am not a fatalist. From time to time, I enjoy contemplating my futures — always in the plural — and planning what I might do to tip the odds in favor of those that seem most attractive to me.

Just for fun, let's divide the world into three groups, depending on how people orient themselves with respect to the future. One group has its back to tomorrow — not so much because they are enjoying today, but because they are still trying to explain why the good old days were better. Others are turned sideways. They catch glimpses of what is coming, but their hands are full with the moment. Others know exactly where they stand and are looking to see what is next. Perhaps you have encountered drivers in these three categories in parking lots recently or served on committees with them.

The very definition of proactivity — being reactive in the future tense.

It is not a question of declining to participate — individuals with futures are better off than those without them. I am reminded of the formerly popular futurist John Naisbett, who wrote in *Megatrends*, "Trends, like horses, are easier to ride in the direction they are already going."

The American College of Dentists has recently become proactive. We have a new strategic plan which will guide our energies in the following core areas: section vitality, ethics, financial stability, proactive image, and membership. Two summer conferences have looked at the future of information technology and the future of the dental profession. The convocation speaker this year was Dr. Jennifer James, who guided us through a profound and challenging look at emerging demographic and value changes in society.

My great concern with all the new attention to future gazing is the belief of some that the future is predetermined and the only question is whether we will be in the first sitting or be left to clean up. Getting the proper orientation toward the future is not as easy as it might seem. It certainly isn't good enough just to see the future; just think of how popular those folks are who go around saying "I told you so."

There are those who accurately perceive emerging trends and position themselves to respond to them. Some do well in the stock market, others establish their practices in growing communities. They study, they sense, and they respond. And there is much to admire in this orientation. It is the very definition of proactivity — being reactive in the future tense.

But it isn't enough. It's still reactive. Being proactive might well mean being first to sign up for lucrative managed care programs — because that is the trend, right or wrong. Responsiveness to the future might mean dressing casually and treating patients informally because those are emerging norms elsewhere in society. Maybe we should reach all decisions by consensus since some of the leading organizations are now experimenting with this. And if it is true that the role models for young heroes of the day are the Teenage Mutant Ninja Turtles, perhaps the College should be the first to serve pizza at the dinner dance following the Convocation.

Being proactive has been oversold.

Proactivity and leadership are both future-oriented perspective, but there is a difference. Being proactive means anticipating actual future events and getting into postion to benefit from them.

Leadership means working to create a better future. It may involve building a practice that is more responsive to patients' needs; it might include working to modify an emerging trend that has undesirable side effects; and leadership could even mean vigorously resisting movements that would damage our future.

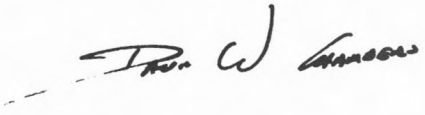
Being proactive has been oversold. First, there is no such thing as *the* future. There are many of them. So our task is to accurately predict which futures are feasible. Second, we are part of any future that is of interest to us. This means we create as well as respond to our futures.

Should the Section sponsor a breakfast meeting at the state dental meeting when rumor has it that expected attendance might not be good? In the conventional proactive sense of reacting to predications — no. But with leadership creating the future the Section wants — yes! Should dentistry respond to the trend for price sensitivity in dental care? Should it anticipate the Federal Trade Commission's view that dentistry is a trade? Should dentistry become part of medicine? I don't want to be dragged backwards into the future; I don't much relish being dragged frontwards either.

There is more to leadership than being first.

Consider, for example, the matter of dental research. It is understood that new materials and methods drive the nature of dental practice and that breakthroughs can be counted on to occur, even though their precise nature is difficult to predict. It is also understood that new science must be expressed in terms of factors such as economics, public and professional acceptance, and technological dissemination. It is difficult to imagine how dentistry can be proactive with regard to these futures. But leadership is well within grasp in terms of advocating adequate funding, building the infrastructure, promoting continuing competency and outcomes-based practice programs, and improving the standards of scholarship and dental journalism.

There is more to leadership than being first. Leadership means both seeing which futures are feasible and working to increase the chances of the desirable ones coming to pass. It may start with future gazing, but it goes beyond. Mostly it's being at the table, in the corridors, on the phone, and in the journals where the future is emerging.



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

The Most Respected Voice in Dentistry

ACD President-Elect's Address
September 27, 1996
Orlando, Florida

Charles V. Farrell, DMD, FACD

First, I thank you, the Fellows of the College, especially Richard V. Tucker and Basil M. Plumb, for making it possible for me to serve you. I am indeed privileged! Second, I congratulate the new Fellows for your election to fellowship and also for your active participation that brought you to the attention of your sponsors. To the sponsors, thank you for nominating these fine candidates.

Each of us has received perhaps the highest honor of our careers. We were nominated and approved by our peers for our achievements in our chosen profession. No one but our peers are qualified to make that judgment. As former President Coolidge said, "No person was ever honored for what he received, but for what he gave." You have given much.

Today I will provide a historical perspective on the College and suggest some areas where you can exert your leadership.

The College was established in 1920, in part to promote the highest ideals of ethics and professionalism. We are concerned about the responsibility a dentist assumes by being a member of our profession. The College projects these ideals in several ways:

- By publishing the *Journal of the American College of Dentists*
- By issuing papers on timely topics
- By conducting workshops and seminars such as the "Vision of the Future: Dentistry 2010" held this past July in Chicago and the "Infotech Conference" held in 1995
- By working with like-minded organizations.

An example of the latter was a joint effort with the American Association of Dental Schools, the Commission on Dental Accreditation, and the Council on Dental Education of the American Dental Association to have courses in ethics and professionalism included in the curricula of dental schools as an accreditation requirement.

Our College is its members, who in their daily lives exemplify the ideals of ethics and professionalism. Since this is the case, our College doesn't do anything *for* you as a member — it does everything *with* you.

I look to my own fellowship as providing the opportunity to better serve my profession and society as part of an effective and influential organization in a way I could not have accomplished alone.

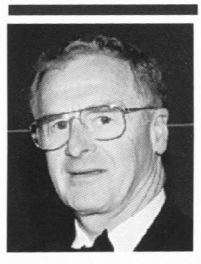
The College believes that with fellowship comes the obligation to continue efforts to further the principles of ethics and professionalism. You will note that I did not say ethics and professionalism "in dentistry" because I believe these principles extend to our relationships with society at large.

I hope your efforts will also extend to a strong support of the College

- By nominating your deserving colleagues for fellowship
- By contributing to the American College of Dentists Foundation when you want to remember or honor a colleague, and especially include it on your annual giving list
- By contributing an article or letter to the Journal
- By attending section meetings and activities.

Our Legacy

The College has a very rich heritage. Those who have preceded us left a legacy of achievements and an implied obligation to continue pursuit of the highest ideals of ethics and professionalism.



Dr. Farrell practices general dentistry. His office is located at 1800 C Street, Suite 223, Bellingham, WA 98225

The founders of the College include dentists who have richly endowed the profession; names such as Woodbury, Hartzel, M. M. House, C. N. Johnson, Arthur Black, and Hinman. These are but a few of the distinguished individuals who have made a difference in the American College of Dentists.

From its inception, the College has been calling attention to the problems facing dentistry; calling us to be — if you will — the conscience of the profession and to stimulate open discussion and further study of issues facing the profession. This remains one of our principle undertakings.

From its inception, the College has been calling attention to the problems facing dentistry.

Soon after its founding, the College created a Commission on Journalism, whose efforts resulted in profound changes in dental journalism and the establishing of the *Journal of the American College of Dentists* in 1934. The report of the Commission also lead to the creation of the American Association of Dental Editors.

In the 1930s, the American College of Dentists was involved in studies of health insurance as it was evolving in Europe. The William J. Gies Award was established during this decade to pay tribute to this outstanding individual whose impact on the dental profession is almost immeasurable.

In the '40s and '50s, the committees of the College were involved in studies of the cost of dental care, dental research, the certification of specialists, the expanded use of auxiliary personnel, payment plans, and hospital dental services.

In the '60s, the College continued its study of the distribution, availability, and cost of dental services. Service corporations were evaluated. Workshops on the image of dentistry and dental manpower needs were conducted.

The decade of the 1970s saw many changes. The College office moved from St. Louis to the Washington, DC area. The American College of Dentists Foundation was established. Procedures for nominations for fellowship were detailed, with strict adherence to objectivity. The sections of the College were rechartered to include regencies, giving all Fellows direct representation on the Board of Regents. Projects of the College during this time included a self-assessment examination, a project library, and an oral history on dental research with Dr. George C. Paffenbarger.

In the '80s, the nomination process for fellowship was again revisited, and greater efforts were made to increase understanding of the process by the Fellows of the College. During this period, professional ethics were under pressure because of court rulings that removed restraints on professional advertising. This remains an issue today: one only needs to look at the yellow pages — where specialties that don't exist have been created — to see the tasteless pronouncements by dentists.

In response to this phenomenon, the College adopted guidelines on advertising and reaffirmed the principles of professional conduct, through revision of the Objectives of the College and the Code of Conduct. The publication *Dentistry: A Health Service* was distributed to all senior dental students. The booklet outlined the professional standards of practice.

The initial studies and contacts with ADA and AADS concerning the teaching of ethics in the dental schools as a requirement for accreditation that I mentioned earlier began during this period. The *Journal of the American College of Dentists* became a reviewed professional publication. The Journal, in my opinion, is an outstanding publication that will be a resource to you. It addresses issues that are relevant to our efforts to promote ethics and professionalism. The oral history program was continued and resulted in the publication by the College of the book, *The Hillenbrand Era: Dentistry's Glanzperiode,* authored by Dr. Clifton O. Dumment and his wife Lois.

The first of what has become several strategic planning workshops was conducted and resulted in the decision by the College to acquire its own office. The Campaign for the '90s was initiated and contributions led to the purchase of our office in Gaithersburg, Maryland. The College modernized its office procedures with updated computer technology and was able to bring much of the printing procedures in house, resulting in significant savings. The accounting procedures were revised to reflect the actual cost of each of the College's areas of activity and to allow the comptroller to more easily comply with the increased reporting burden placed on nonprofit organizations by the IRS.

I think this brief history gives you a glimpse into an organization that contributes a great deal to our profession. We have had a vital and continual impact on dentistry, especially in the area of ethics and professionalism.

Leadership Opportunities

Let's turn to today and tomorrow. To quote one of Yogi Berra's malapropisms, "If you don't know where you are going, you might wind up some place else." We in the College believe we know where we are going.

The College has established a process for soliciting input from Fellows to help develop our strategic plan. This in turn flows into operational planning and budgeting. Our most recent strategic plan update was undertaken this spring. The plan addresses the external forces likely to directly and indirectly impact the College over the next three to five years.

Among the external forces identified were the changing moral value systems in our society. A recent *Wall Street Journal* article emphasized this situation. While a small majority of respondents still think that moral values are more important than economic issues, large groups within our society are more concerned with economic issues. This, of course, has

The Board of Regents highlighted five core issues to be emphasized in the coming years. *Ethics* will continue to be the prime focus of the College. We will examine ethical issues, including managed cost programs. We will promote the teaching of ethics in all sections.

The sections will be asked to be more involved in the implementation of the mission of the College.

The *sections* will be asked to be more involved in the implementation of the mission of the College. In turn, the Board of Regents will strive to provide more support to the sections to accomplish this goal.

The board will enhance the *image* of the College through increased public relations efforts and information technology methods.

Emphasis will be given to our *membership*. We want to retain our members and encourage all of them to consider nominating their worthy colleagues for fellowship in the College.

Financial considerations will always be with us. We will focus on expanding non-dues revenue and increasing contributions to the American College of Dentists Foundation. The Foundation is the engine that drives the program train of the College.

Our profession needs every one of us to exert leadership skills to address the challenges before us. There are major issues facing our profession today: The quality of dental education, including continuing education; licensing issues, including relicensure; and managed cost programs.

Dental Education. Earlier this year, the state governors and chief executive officers of many leading companies met to urge that the standards of education be raised significantly. This also applies to dental education. Once again, we need leadership to raise the standards. This issue was the subject of the Institute of Medicine's report *Dental Education at the Crossroads.*

I am a restorative dentist in private practice who spent about ten years as either an examining agent for or member of a state licensure examining board and as a clinical instructor in a dental school. I have found that not every dental school graduate is ready to treat patients. The students recognize this, which may account for the trend of graduates seeking an extra year of training in postdoctoral general dentistry programs.

One of the recommendations of the IOM report was to eliminate redundant course content. I know that repetition in education is out of vogue, but it served those of use who are a little more experienced quite well. We are told that there are not enough patients to provide students with a needed variety of clinical experience. There are students who graduate from dental schools never having had the experience of placing a cast restoration other than a full crown on a live patient!

There are a significant number of Medicaid recipients in need of oral health care. Why are these patients not being treated at our public institutions? We all know the answer. I would urge all officials of state-supported dental schools to seek relief from the requirement that their clinics be financially self-supporting so that this population could be given access to dental care. This would also satisfy the recommendation of the IOM report that the availability of dental care of the underserved population be increased.

Licensure. It is my contention that licensure examinations, in addition to evaluating clinical competence in some areas of general practice, serve as a check and balance. Can licensure examinations be improved? Of course! I know from experience that examining boards work very hard to make examinations reasonable and fair. I believe licensure examinations play a very important role in helping maintain standards in clinical dentistry.

Recently, the ethics of the use of human subjects as patients in licensure examinations has been called into question. Many of these patients are paid by the candidates to participate. If this is the case, is it ethical to use paid human subjects for the evaluation of newly developed drugs? Is it ethical to use human subjects in teaching situations in dental schools? Are we evolving into a situation where graduating dental students will treat their first human being when they open their offices?

Continuing competency evaluation of dentists is another area that deserves consideration by the profession. I realize that there are several entities looking into this topic. It is my perception that the two largest problems in this area are acceptance by the profession and the logistics of administration. I will be suggesting to the board that we consider exploring this issue, with the goal of stimulating discussion on all aspects of this topic.

Continuing competency evaluation of dentists is another area that deserves consideration by the profession.

Managed Cost. Dentistry is under pressure, almost as never before! Our ability to be in charge of our destiny is under attack from sources both from within and without. In the name of social engineering, access, cost control, or the bottom line, these sources would interfere with the most critical of professional relationships — that of the dentist and patient. This, of course, affects ethics and professionalism and is the very essence of autonomy. Namely the ability of a patient, in consultation with his or her health care provider, to choose the treat-

ment received without any form of interference from an outside organization, be it governmental or private. Most of these interferences are very subtle, usually in the form of economic coercion.

Our colleagues in medicine have already lost control of their profession. Their treatment, their fees, and their relationship with their patients are beyond their control. Even worse, in some cases physicians are prohibited by contract from offering their patients treatment options that they know are viable but are not covered by the managed cost organization. This places the health care provider in the position of no longer being responsible to the patient but to the managed cost entity.

In dentistry, graduates are being lured by offers to repay their student loans if they will sign a contract to participate in some managed cost plans. We, as leaders of our profession, must do our best to alleviate this sad situation. Another of the IOM report recommendations was to find ways to limit the negative effects of high student debt. Can the College play a role in this area? I hope so!

We cannot let outside organizations interfere with the dentist-patient relationship in the treatment offered and provided to our patients. A recent dental magazine article had an account by a dentist detailing the methods of structuring and analyzing a capitation practice so that the practitioner could glean a higher percentage of income from not treating patients. Is it ethical to accept money for not treating patients? All too frequently, ethics and transcendent principles seem to be put aside in the name of economic expediency.

One of the most effective methods available to counter the problems created by involvement in managed cost programs is that of direct reimbursement. Organized dentistry strongly supports this concept, but it needs all of us to get the word out. Talk to your patients, especially those who are in positions to influence their company's health care programs. Urge your state dental association to become involved in and contribute to the alliance if it is not already involved. Above all, get involved yourself!

The Most Respected Voice in Dentistry

These will be some of the areas of concern to the College as it fulfills its role as the conscience of the profession, stimulating study, dialogue, and solutions.

Again, each of us needs to exert our leadership skills to meet these fantastic opportunities that are disguised as insurmountable problems. It is my goal that the College become the most respected voice in dentistry.

Let me leave you with this thought:

Are you an active member,
The kind who would be missed
Or are you just contented
That your name is on the list?

Do you attend the meetings
And mingle with the crowd,
Or do you stay at home
And complain both long and loud?

Do you take an active part
To help the College along,
Or are you satisfied to be
The kind to just belong?

There is a section program scheduled
That means success if done,
And it can be accomplished
Only with the help of everyone.

Attend the meetings regularly
And participate with hands and heart;
Don't be just a member,
But take an active part.

Think this over Fellows:
Are we right or wrong?
Are you an active member,
Or do you just belong?

I thank you all and may God bless you!

Leadership: The American College of Dentists

Convocation Address
September 27, 1996

W. Robert Biddington, DDS, FACD

It is a very special privilege to participate as this year's convocation speaker because it provides an unexpected opportunity. An opportunity to communicate my thoughts concerning leadership as a responsibility for fellowship and an opportunity to convey my personal feelings about the American College of Dentists.

Like each of you, at the time of graduation from dental school, I never dreamed that becoming a dentist would provide so many rewarding experiences and so many opportunities to serve the public through the dental profession. And as I reflect, I am convinced that selection to fellowship early in my dental career had a major influence on my entire professional life — one that created within me a high level of confidence and a special desire to represent the College and the dental profession in the very best way possible.

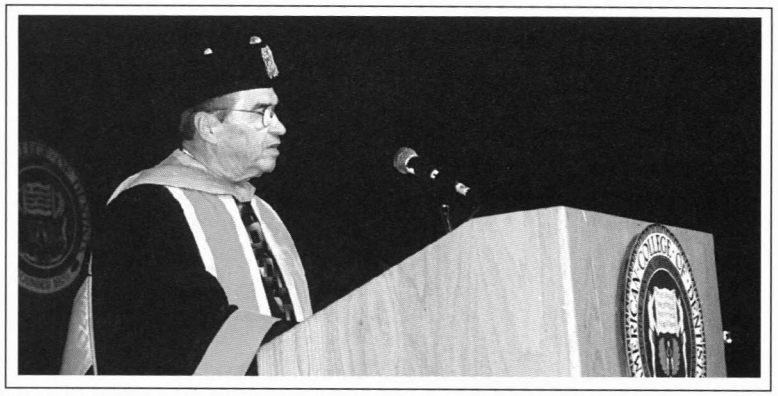
My association with the American College began with election to fellowship in 1960. That was a very special day; one that initiated a whole series of events providing the opportunity to participate in College matters for over thirty-six years. During this time I had the privilege of serving as Treasurer, Secretary, and Chairman of the West Virginia Section; Regent for Regency 4; Vice President, President-Elect, and President of the College, and President of the American College of Dentists Foundation. These were exciting and rewarding years. Having the opportunity to address today's seventy-sixth annual convocation is especially gratifying, and I accept this assignment with complete humility, for it was President Sharma who made this day possible. Thank you, Prem.

I never dreamed that becoming a dentist would provide so many rewarding experiences.

Thirty-six years ago, Dr. Kenneth V. Randolph, then Dean of the West Virginia University School of Dentistry, stood beside me at the 1960 convocation in Philadelphia as my sponsor to fellowship. He was the first to congratulate me and the first to provide excellence and leadership in every aspect of my professional and personal life. By example, Dean Randolph had demonstrated the importance of honesty, integrity, dedication, and commitment in the development of leadership skills. He was my role model, just as I'm sure your sponsor has been yours. I am extremely thankful to Dr. Randolph for having promoted within me the confidence to become involved and the desire to succeed.

This is a great day for everyone present, especially for the candidates receiving fellowship. This is a very special time in your life, for today you become a Fellow of the American College of Dentists, the highest honor one can receive in American dentistry. I congratulate each of you on your outstanding contributions to the dental profession and your excellent service to the public. You have demonstrated the competence and the leadership qualities that are so essential in your role as Fellows of the American College of Dentists.

As you heard earlier this morning, leadership is one of the most distinguishing characteristics of the American College of Dentists. The twenty-three founders of the College were the leaders of the dental profession in their day. They founded the College in 1920 because of their deep concerns for the issues and problems that faced the profession, and, quoting from the *American College of Dentists History: The First Fifty Years*, because of "the need for a force that could offer guidance in the crisis that they felt existed."



Dr. Biddington is Associate Vice President at the Robert C. Byrd Health Science Center, University of West Virginia.

Working for Ethics Education

Since its inception, the American College of Dentists as an organization has contributed to provide leadership for dentistry in many ways. Two separate but related initiatives begun by the College in the mid-1980s serve as excellent historical examples of how College leadership has had a positive effect on the teaching of ethics and professionalism in our nation's dental schools. How did this occur?

First, the College contacted the Commission on Dental Accreditation and encouraged the Commission to take appropriate action to enhance the competency of dental students in the area of ethics and professionalism. This recommendation was supported by the American Dental Association's Special Committee on Ethics and Professionalism. The Commission responded by adding two curriculum standards which require all dental schools to provide instruction in ethics and professionalism for continued accreditation. This was a major step, for in the mid-1980s, the curriculum of many dental schools did not include an ethics education component.

The College then focused its attention on the complete absence of instructional guidelines needed to assist dental schools in the design of an ethics curriculum. Since the American Association of Dental Schools is the organization responsible for developing all dental education instructional guidelines, the College turned to the AADS for assistance. Following many months of negotiation, the American Association of Dental Schools agreed to be the sponsoring organization for the development of the guidelines and the American College of Dentists agreed to fund the project. A special committee, consisting of two ethicists serving as advisors and representatives from the College, the ADA's Council on Dental Education, and the AADS, developed the guidelines. These guidelines were published in the *Journal of Dental Education* in February 1989.

As a result of actions taken by the American College of Dentists, the Commission on Dental Accreditation, the ADA Special Committee on Ethics and Professionalism, the ADA Council on Dental Education, and the American Association of Dental Schools, all U.S. dental schools are now required to include instruction in ethics and professionalism in the curriculum and the dental faculty responsible for the educational process have ready access to instructional guidelines to assist them in this effort.

This example not only demonstrates the importance of American College leadership, but also illustrates the value of cooperation and collaboration among dentistry's leading professional associations and organizations. I was pleased to note that the Commission on Dental Education's revised Accreditation Standards for Dental Education Programs, which must be implemented by all U.S. dental schools in January 1998, require that schools must now present evidence that graduates are competent in ethics and professionalism — a significant move beyond requiring that instruction be offered.

A Wealth of Proven Talent

I now want to turn to each of us, as Fellows of the College and candidates for fellowship. Section I, Article I of the bylaws states that "Active Fellows shall be those elected persons who, through unselfish devotion, have made notable contributions to the advancement of the dental profession." The bylaws also stress that individuals being considered for fellowship should have the potential for further accomplishments and should continue to be involved in "extra curricular" activities which go beyond those ordinarily expected.

All of us were elected to fellowship because of our previous contributions and leadership qualities. As we work to resolve the current issues facing the dental profession, the importance of individual leadership and the need for individual leadership cannot be overemphasized. Today's issues are many in number and extremely complex, not only involving the dental profession but all of the health professions and all aspects of health care delivery.

It is not my intent in this presentation to provide a complete list of the current issues facing the health professions and the public, nor will I attempt to prescribe solutions. However, I will identify a number of the issues that require the immediate attention of all of us as leaders.

Among these issues are:

- Access to health care as a basic human right
- Cost containment as a critical element in providing universal access
- Stable funding for dental education and dental and medical research
- Licensure and relicensure of health professionals
- Air quality and the appropriate management of waste water and biofilm in water lines
- Federal Trade Commission regulatory issues
- Interdisciplinary education of health professionals
- Expanded role of the private practitioner in dental education
- Expanded role of health care auxiliaries
- Revision of the accreditation process for all health professions education programs
- Relationship of the dental school to the health sciences center and the university
- Issues related to affirmative action
- Demographic factors and immigrant population
- Oversupply or undersupply of health-care providers
- Impact of information technology

The list of current issues is lengthy and constantly changing. As dentists and Fellows of the College, we must be fully aware of the problems facing the health profession and fully informed on these issues. The opportunities to provide leadership have never been greater.

I was especially pleased to read in the Summer 1996 issue of *News & Views* that the current three-year strategic plan positions the College to continue to take a proactive role in collaborating with others in the identification of solutions to these current issues. In July, the American College of Dentists held a national conference in Chicago titled "Dentistry 2010: Visions of the Future." One of the major thrusts of this conference was emphasizing the importance of leadership during times of change. Conference participants discussed key leadership skills needed to lead others during difficult times and to assist others in identifying solutions to current issues. The Leadership Skills Workshops at the annual meeting and this morning's symposium, "Thinking in the Future Tense," are additional examples of our initiative in leadership training during these times.

We must be involved in producing satisfactory outcomes to today's issues.

The Institute of Medicine's report *Dental Education at the Crossroads: Challenges and Change*, states that "effective leadership, especially leadership to be exercised in difficult times, is not an easily purchased commodity or a readily created talent." This statement further emphasizes the importance of leadership and the critical need for leadership at this time in the history of the profession.

It is my opinion that once again, as in 1920, the dental profession is most fortunate, for as I look across this audience I see a wealth of proven talent. Each and every Fellow and candidate for fellowship has already demonstrated the potential to provide leadership for the profession. My charge to you is to continue to participate in section and regency activities and in your local, component, constituent, and national dental societies and associations. As Fellows of the American College of Dentists, we must be involved in producing satisfactory outcomes to today's issues; outcomes which will benefit the public and at the same time assure the continuing effectiveness and success of our profession.

Earlier in my comments I stated that becoming a Fellow of the American College of Dentists is the highest honor one can achieve in American Dentistry. Fellowship in the College provides tremendous opportunities to continue to be involved in your profession. Fellowship in the College is very special. It most certainly has been for me.

As a native of West Virginia and a Fellow, I am going to conclude my remarks by adapting and sharing with you one of my favorite stories — one that portrays my affection and true feelings for the American College of Dentists. I'm sure at least some of you are familiar with John Denver's song "Country Roads," particularly the part where the lyrics begin with "Almost heaven, West Virginia..." The story could be about any one of us. The Fellow in this particular version of the story had lived a good and moral life and had made many outstanding contributions to the profession, the public, and especially the College. The person I have in mind was a very religious individual, having a particularly intense desire to eventually gain admission to heaven. Upon his death, the Fellow suddenly realized that this burning desire to gain admission to heaven had, in fact been realized, for there was St. Peter, standing at the pearly gates, greeting all who were being admitted. Immediately, a satisfied smile came across the Fellow's face, for over the gates to the entrance to heaven was a sign — "Welcome to Heaven: Almost the American College of Dentists."

In conclusion, I too extend my personal congratulations to the new Fellows and welcome each of you to the American College of Dentists.

1996 Fellowship Class

The Fellows of the American College of Dentists are the leaders in dentistry and in their communities. They represent the creative force of today and the promise of tomorrow. We proudly welcome the 1996 class of Fellows . . .

Richard J. Ackerman, Jr.
Kansas City, MO

Stephen Akseizer
Syosset, NY

Stanley A. Alexander
Stony Brook, NY

Rocklin D. Alling
Birmingham, AL

John A. Anderson, Jr.
Grand Forks, ND

Noel H. Andrews
Darmouth, NS, Canada

M. Alan Bagden
Springfield, VA

Robert E. Barsley
New Orleans, LA

Bruce D. Bates
Roseville, MN

Richard A. Battistoni
Oak Park, IL

Richard C. Beauchamp
Edmonton, AB, Canada

O. Ross Beirne
Seattle, WA

Bradley B. Beiswanger
Indianapolis, IN

Paul C. Belvedere
Edina, MN

Gene S. Bloom
Englewood, CO

Charles H. Boester
Parma, OH

Joseph L. Boland
Macon, GA

Fred G. Boustany
Boston, MA

John F. Bowley
Lincoln, NE

Ronald K. Bowman
Indianapolis, IN

Ralph J. Brandon
Punta Gorda, FL

Nona I. Breeland
Chapel Hill, NC

Earl Broker
Jenkintown, PA

Jack S. Broussard, Jr.
Pasadena, CA

Alan R. Brown
Kansas City, MO

Keith E. Bruce
Stuart, FL

Jeff J. Brucia
San Francisco, CA

William T. Buchanan
Jackson, MS

David J. Cantor
Fairfax, VA

Daniel M. Castagna
San Francisco, CA

Enrique C. Castillo
Fremont, CA

Frank A. Catalanotto
Gainesville, FL

William T. Cavel
Omaha, NE

Hugh R. Clark
Yuma, AZ

G. Thomas Cloyd
Clinton, IN

Larry M. Coffee
Denver, CO

1996 Fellowship Class

Robert A. Coleman
Livonia, MI

Wisdom F. Coleman, Jr.
Memphis, TN

Janice E. Conrad
Salem, MA

Louis J. Cortegiano
Maspeth, NY

Frank J. Courts
Gainesville, FL

David Cowan
Toronto, ON, Canada

Gary A. Crim
Louisville, KY

Bertram M. Cronson
Fairfield, CT

Benjamin J. Cumbus
Montgomery, AL

Charles W. D'Aiuto
Longwood, FL

Patrick J. Dalton
Carlton NSW, Australia

Charles P. Daly
St. Johns, NF, Canada

Roy G. Daniels
Sedona, AZ

Mitchell H. Davich
Morristown, NJ

Bruce R. DeGinder
Williamsburg, VA

Ronald H. Delfini
New Haven, CT

Allan S. Deutsch
New York, NY

Lawrence B. DiBona
Wellesley Hills, MA

Barry Dolman
Montreal, QU, Canada

Maureen Donley
Buffalo, NY

John C. Doswell, II
Richmond, VA

Michael C. Duggan
San Antonio, TX

James M. Duncan
San Antonio, TX

Terry L. Duncan
Wichita, KS

Arthur F. Eddy
Shirley, MA

Samuel G. Eddy
Knoxville, TN

Bill G. Edwards
Lubbock, TX

Mona T. W. Ellis
Orangeburg, SC

Archie A. Estey
Mundelein, IL

Ernest S. F. Evans
Los Angeles, CA

Russell G. Eyman
Warner Robbins, GA

Salvatore J. Fanale
Hasbrouck Heights, NJ

George H. Fann
West Columbia, SC

R. Kent Farnsworth
Sacramento, CA

Cecile A. Feldman
Newark, NJ

Stanley Fellman
Hartford, CT

Steven C. Ferber
Jacksonville, FL

Paul L. Fischl
Evanston, IL

Ollie C. Fisher
St. Louis, MO

Patrick A. Fleege
Seattle, WA

Frank L. Flores
Costa Mesa, CA

James F. Fondriest
Lake Forest, IL

Dennis W. Ford
Lawrenceburg, IN

Edward S. Freedman
Lancaster, PA

Nora M. French
Sterling, VA

James D. Frey
Fort Wayne, IN

David C. Frost
Concord, NH

Lynn K. Fujimoto
Pearl City, HI

Howard R. Gamble
Sheffield, AL

Faustino G. Garcia
Coral Gables, FL

William C. Gaylord
Flagstaff, AZ

Robert J. Gherardi
Albuquerque, NM

Raymond A. Girardot, Jr.
Denver, CO

Jerold S. Goldberg
Cleveland, OH

Louis J. Goldberg
Buffalo, NY

Roy Gonzalez, Jr.
San Antonio, TX

James C. Gordon, Jr.
Winchester, VA

Anthony M. Grasso
Muncie, IN

Arthur J. Greenspoon
Montreal, QU, Canada

John O. Grippo
Longmeadow, MA

Paul A. Gruber
Sheboygan, WI

Peter M. Gutierrez
Sebastian, FL

Lloyd J. Hagedorn
Fort Wayne, IN

Joseph F. Hagenbruch
Harvard, IL

James A. Haljun
Santa Monica, CA

Mary F. Hamill-Tamucci
Norwalk, CT

Robert B. Hammond
Daytona Beach, FL

Jed S. Hand
Iowa City, IA

Philip J. Hanes
Augusta, GA

Bruce S. Haskell
Louisville, KY

Steven L. Hechler
Overland Park, KS

Robert J. Henry
San Antonio, TX

Thomas M. Henson, II
Athens, GA

H. Pitts Hinson
Columbia, TN

Charles W. Hoffman
North Palm Beach, FL

Sidney A. Holleman, Jr.
Fort Worth, TX

Robert L. Holt
West Palm Beach, FL

Ronald H. Honeycutt
Clinton, NC

James C. Hove
New Berlin, WI

Robert M. Howell
Morgantown, WV

Richard A. Huot
Vero Beach, FL

Bruce R. Hutchison
Centreville, VA

Gregory K. Ingalls
Arvada, CO

Russell W. Ingram
Diboll, TX

Roger L. Isaacs
Indianapolis, IN

Harold W. Jablon
Columbia, SC

Allan Jacobs
Waterford, MI

Brett J. Jaffrey
Oak Ridge, TN

William C. Jaques
Irvine, CA

Spencer S. Jilek
Pasco, WA

David C. Johnsen
Iowa City, IA

Georgia Kay Johnson
Iowa City, IA

William T. Johnson
Iowa City, IA

Owen K. Jones
Brooklyn, NY

Frederick H. Kahn
New York, NY

Don C. Kalant, Sr.
Aurora, IL

Wayne B. Kaldahl
Lincoln, NE

Joseph G. Kalil
Metheun, MA

Brian Kennedy
Troy, NY

James B. Killinger
Oshkosh, WI

Kenneth S. Kornblum
St. Charles, MO

Darmon D. Kuntz
Peoria, IL

William C. Kuttler
Dubuque, IA

Wallace C. Lail
Duluth, GA

John F. Laning
Little Rock, AR

Brent E. Larson
Rochester, MN

Mark A. Latta
Omaha, NE

Lawrence R. Lawton
Spokane, WA

1996 Fellowship Class

Mingway Lee
Loma Linda, CA

R. Dale Lentz
Indianapolis, IN

Jack H. Leverett
Bainbridge, GA

Howard I. A. Lieb
Staten Island, NY

Kenneth I. Lieberman
Ithaca, NY

Robert T. Lindner
Greensburg, PA

Stephen F. Litton
Golden Valley, MN

William K. Lobb
Milwaukee, WI

Rise' L. Lyman
San Antonio, TX

John F. Mac Namara
Atlanta, GA

William A. MacInnis
Halifax, NS, Canada

Gordon K. Mahanna
Omaha, NE

Stanley F. Malamed
Los Angeles, CA

Jay Marlin
Worcester, MA

Julie A. Marshall
Lincoln, NE

Thomas K. McCawley
Fort Lauderdale, FL

J. Michael McCoy
Knoxville, TN

William V. McCoy
Erie, PA

Michael K. McGuire
Houston, TX

Thomas S. McLellan
Battle Creek, MI

James E. Metz
Columbus, OH

Andrew M. Michanowicz
Altoona, PA

Michael E. Michel
Topeka, KS

David Mock
Toronto, ON, Canada

Edward H. Mohme
Norcross, GA

Michael P. Molvar
Lincoln, NE

Gerald R. Moon
Peoria, IL

Edward R. Mopsik
Washington, DC

Robert L. Morrow
Walsh, CO

Steven G. Morrow
Loma Linda, CA

J. Richard Moulton
Atlanta, GA

Leslie H. Muldorf
Poughkeepsie, NY

Dennis H. Munholand
Port Charlotte, FL

Fred A. Murphree, Sr.
Tupelo, MS

R. Daniel Nable
Atlanta, GA

Linda P. Nelson
Boston, MA

Dennis W. Newton, Jr.
West Columbia, SC

Howard L. Noonan
Amherst, NY

Kirk M. Norbo
Falls Church, VA

William T. O'Brien, III
Natchez, MS

Thomas W. Peterson
Norfolk, VA

William A. Pfeifer
Englewood, CO

Joseph F. Piecuch
Avon, CT

Eva Piehslinger
Vienna, Austria

Joffie C. Pittman
Philadelphia, PA

A. Wright Pond
Colonial Heights, VA

Harris L. Poret
Houma, LA

Jack C. Porter
Hot Springs, AR

Alvin R. Posey
Enid, OK

Steven R. Potashnick
Chicago, IL

David S. Precious
Halifax, NS, Canada

Kenneth P. Press
Morristown, NJ

Peter M. Pronych
Halifax, NS, Canada

Robert B. Raiber
New York, NY

Andrea Richman
Carlisle, MA

Michael R. Ricupito
Fremont, CA

John R. Ritchie
New Orleans, LA

Edward P. Roberson
Arnaudville, LA

Sherwin Z. Rosen
Palos Verdes Estates, CA

John E. Roussalis, II
Casper, WY

E. Kendall Roy
Ashland, KY

Steven M. Rubin
New York, NY

David A. Russell
Boston, MA

Glenn A. Ruthven
Houston, TX

Thomas S. Rypel
Milwaukee, WI

Harry G. Sacks
New Hyde Park, NY

John L. Sadowski
Manitowoc, WI

Joseph G. Samartano, Jr.
Cranston, RI

Edward G. Sarkisian
Dearborn, MI

David M. Sarver
Vestavia Hills, AL

Michael W. Schafhauser
St. Paul, MN

Paul D. Schuller
Edmonton, AB, Canada

Robert Schwartz
Rahway, NJ

Edward R. Scott, II
Tallahassee, FL

Donald L. Seago
Jackson, MS

Lloyd J. Searson
London, England

Harriet F. Seldin
San Diego, CA

Joseph C. Serflek
New Berlin, WI

Kevin D. Sessa
Boulder, CO

James C. Setterberg
Glenwood Springs, CO

David A. Sewell
Corpus Christi, TX

Guy S. Shampaine
Bowie, MD

Peter A. Shapiro
Seattle, WA

Robert A. Sharp, Jr.
Jacksonville, FL

Robert R. Shaw
Spokane, WA

Richard L. Sherman
Pembroke Pines, FL

Michael A. Siegel
Baltimore, MD

Fred F. Simmons, Jr.
Houston, TX

Denis E. Simon, III
Baton Rouge, LA

David M. Sinar
Cayahoga Falls, OH

Keith L. Small
Denver, CO

David R. Smith
Sarasota, FL

Gerald A. Smith
Concord, NH

Thomas C. Smith
Little Rock, AR

Michael K. Sonick
Fairfield, CT

Peter M. Spalding
Lincoln, NE

Larry J. Squillace
Virginia, MN

Charles F. Squire
Wichita, KS

David R. Stevens
Grand Rapids, MI

Larry R. Stewart
Plano, TX

William C. Stiefel, Jr.
Decatur, GA

Stephen Stone
Norwood, MA

Frank P. Stout
Fayetteville, NC

Stephen G. Stratton
Westfield, NY

Peter W. Stutman
Montreal, QU, Canada

John A. Suchina
Houston, TX

Raymond M. Sugiyama
Los Alamitos, CA

Joseph M. Sullivan
Troy, NY

1996 Fellowship Class

John A. Svirsky
Richmond, VA

Loren C. Swanson
Oshkosh, WI

Peter M. Tan
Mt. Airy, MD

Donald R. Tharp
Indianapolis, IN

George P. Thomas
Washington, DC

Edward D. Thornblade
Scottdale, PA

V. Roger Tibbetts
Spring Valley, CA

Joseph A. Toljanic
Chicago, IL

Calvin D. Torneck
Toronto, ON, Canada

Robert E. Towe
Stone Mountain, GA

John D. Townsend
Seattle, WA

Paul D. Tripodi
Indiana, PA

Albert T. Twesme
Las Vegas, NV

Stephanie A. Urillo
Southington, CT

Barry D. Wagenberg
Livingston, NJ

Lewis C. Walker
Jacksonville, FL

Terence E. Walsh
Metairie, LA

Robert L. Wanker
Clarksburg, WV

Lyvonne M. Washington
Indianapolis, IN

Russell I. Webb
Upland, CA

Jerome P. Wellbrock
Covington, KY

R. Dean White
Bedford, TX

Ray C. Williams
Chapel Hill, NC

Thomas P. Williams
Washington, DC

George P. Willis
Indianapolis, IN

Vaughn F. Wipf
Santa Barbara, CA

Everan C. Woodland
Blue Bell, PA

Joye D. Wright
Tuscaloosa, AL

James C. Yeargin
Daytona Beach, FL

Kenneth P. Yonan
Glenview, IL

Roy E. Ziff
Hasbrouck Heights, NJ

Mary M. Ziomek
College Park, MD

Howard W. Zuckerman
Lombard, IL

Profiles in Professionalism: 1996 ACD Awardees

William John Gies Award

The William John Gies Award was established by the American College of Dentists in 1939 to recognize Fellows for outstanding service to dentistry and its allied fields. This award embodies the highest levels of professionalism, and it is the highest honor the College confers on its members.

Charles A. McCallum, DDS

One of the few members of the dental profession who has been the president and chancellor of a major university, Dr. Charles A. McCallum, has the distinction of receiving the highest honor the ACD can bestow upon a Fellow, the William J. Gies Award. Dr. McCallum served as President of the University of Alabama at Birmingham 1987 through 1993. Dr. McCallum was the first representative from dentistry to serve on the Board of Commissioners Joint Commission on Accreditation of Health Care Organizations and served as Chairman of the Board of Commissioners 1987 through 1988.

During his tenure as President of UAB, he focused the resources of the University of Alabama at Birmingham on the problems of disadvantaged children and families in urban areas. He also focused UAB's efforts to offer more educational funding opportunities to minorities to increase the talent pool from which UAB and other institutions could recruit more faculty members. Increased educational opportunities for minorities also meant more highly educated people for professions other than academia. This program gave access to higher education at all levels, from summer internships for high school students, to undergraduate scholarships to graduate and postgraduate fellowships.

In Alabama, he is known as a "can do miracle worker" who, through all of his accomplishments, maintained a viable oral and maxillofacial surgery practice. Through personal involvement, he built bridges of significance to the community, forging relationships with every segment of society and every interest group.

Kindness is a term most often used to characterize the man. As dental dean, he stuffed his lab coat pockets with butterscotch candies, handing them out in offices across campus. At Christmas, he switched to peppermint. When Christmas fell on a Wednesday, Dr. McCallum declared the preceding Monday and Tuesday holidays for the employees, while he maintained his regular work schedule making hospital rounds. It has not been uncommon for him to drop in on or stop people on the street, just to talk, as he enjoys meeting as many of the UAB community as possible. He continues to give of himself in the community by personal involvement in many community organizations, including serving as General Campaign Chairman of the United Way of Central Alabama.

Honorary Fellowship

The ACD confers Honorary Fellowship upon persons who are not members of the dental profession, but have made outstanding contributions to the advancement of the profession and its service to the public. These contributions may be in education, research, administration, public service, public health, medicine, and many other areas.

Burton C. Borgelt

The individual who is the recipient of the Honorary Fellowship Award for 1996 began his dental industry career as a delivery boy in Ohio in 1953. Fifteen years later, the company he began his career with was purchased by Litton Industries and he was named Vice-President of Marketing. One year later, he was promoted to President of the company.

Awarded the Tomes Medal of the British Dental Association (1989), this man is the second American to be so honored. In 1990, he was honored by the Canadian Dental Association with the Special Friend of Canadian Dentistry Award. Among their blessings in life, this man and his wife count seven children and twelve grandchildren.

The individual being honored, who rose from a modest beginning to such heights is Burton C. Borgelt, retired Chairman of the Board of Directors of Dentsply International, now serving as a Director of the company. Mr. Borgelt is currently President of the National Foundation of Dentistry for the Handicapped.

Merit Award

The supporting services of dentistry are vital to the profession, providing key elements which enhance the effectiveness of dental care delivery and the growth of the profession. The ACD's Award of Merit was established by the Board of Regents in 1959 to recognize unusual contributions in dentistry and its service to humanity by persons who are not Fellows of the College.

Martha S. Phillips

Respected throughout the country as an unflagging supporter of organized dentistry, Ms. Martha Phillips is this year's Award of Merit recipient. Ms. Phillips' constant goal during her distinguished career as Executive Director of the Georgia Dental Association is ensuring dentistry receives all the respect and consideration it is due.

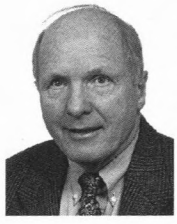
Ms. Phillips is being so honored because of her commitment to the profession, her invaluable contribution to the growth and activity of the GDA, her esteem and reputation as a state association executive, her influence and success as dentistry's lobbyist and representative in state legislative activities, as well as the admiration and respect she has enjoyed in her work with ADA. Ms. Phillips, as part of a coalition of health care providers, was a main impetus behind the passage of patient protection, anti-gag rule, and point-of-service legislation this year in Georgia.

Ms. Phillips has just been elected Secretary/Treasurer of the American Association of Constituent Dental Executives and has been asked to serve on the ADA's Executive Directors Advisory Committee.

Service Award

This award is presented to recognize outstanding efforts of a Fellow of the American College of Dentists for exceptional and distinguished service to the College or to humanity through his or her professional service.

Jeremiah J. Lowney, Jr., DDS



Dr. Jeremiah Lowney, this year's recipient of the Service Award, is the oldest of eleven children, born in an Irish neighborhood in Massachusetts. Dr. Lowney served a three-year tour of duty as a Navy Dental Officer, where he attained the rank of Lieutenant Commander. He is the father of four children and the grandfather of two boys. Dr. Lowney has practiced orthodontics in Massachusetts since 1966.

For the past twenty-eight years, Dr. Lowney has been very involved in professional, church, and civic activities. His professional affiliations include being an Associate Clinical Professor of Orthodontics at the University of Connecticut. Dr. Lowney's civic affiliations and individual honors are numerous.

In 1982, Dr. Lowney began working in makeshift slum clinics in Haiti, where he was eventually joined by Mother Teresa's Sisters. In 1985, he formed the Haitian Health Foundation and has been its President since starting the tax-exempt foundation. The Haitian Health Foundation has built a medical, dental, nutritional clinic complex that now serves over four hundred of the hemisphere's poorest people each day. A liaison has been formed with the University of Connecticut Health Center. Faculty and students provide their skills and learn Third World health care. Adults and children have received reconstructive facial surgery for cleft palate and facial deformities by surgical teams from this health center. The clinic has been designated by U.S. Ambassador Alvin Adams as the finest health care facility in Haiti.

Dental Managed Care in the Context of Ethics

The Officers and Regents of the American College of Dentists

Definitions

Managed care is a market mechanism for distributing oral health care resources. There are four essential features which together define managed care:

1. It is a secondary market; dental health care opportunity, not care itself, is brokered in the managed care market. In this fashion it might best be termed "brokered care" since future dental visits are actually bought and sold rather than oral health itself.
2. It is a four-party system; there are (a) patients, (b) dentists [together comprising the primary market], (c) brokers, and (d) purchasers [the latter two comprising the secondary market].
3. Costs and benefits are calculated in the aggregate; not on an individual basis. Plan purchasers buy a package of benefits. Third parties work on an actuarial basis. Dentists cannot use conventional per-procedure accounting to figure their return; only aggregate marginal analysis works.
4. Some of the dental health care dollars are shifted from providing care to managing the market.

There are eight characteristics of managed dental care that seem to be emerging, which although they do not define managed care, are usually the focus of discussion:

1. Income of providers tends to be lowered
2. Income of brokers tends to rise
3. Cost to purchasers tends to be lowered
4. Risk is spread more evenly across the four parties
5. Access to care among the marginally served tends to be increased
6. There are pressures for standardizing dental care
7. Large databases on care delivery are being assembled by third parties
8. More opportunities for ethically based decisions are created for dentists

The aspirational statements of the American College of Dentists are a voluntary set of ethical guidelines that all Fellows of the College hold as goals in their professional lives.

A Fellow of the College will ...

1. Value truthfulness as the basis for trust in the dentist-patient relationship (**Veracity**)
2. Treat all individuals and groups in a fair and equitable manner (**Justice**)
3. Recognize the dignity and intrinsic worth of individuals and their rights to make choices (**Autonomy**)
4. Respect the rights of individuals to hold disparate views in ethics discourse and dialogue as these views arise from diverse personal, ethnic, or cultural norms (**Tolerance**)
5. Be sensitive to and empathizes with individual and societal needs for comfort and help (**Compassion**)
6. Strive to achieve the highest level of knowledge, skills, and ability within his or her capacity (**Competence**)
7. Be committed to involvement in professional endeavors that enhance knowledge, skills, judgment, and intellectual development for the benefit of society (**Professionalism**)
8. Act in the best interests of patients and society even when there are conflicts with the dentist's personal self-interest (**Beneficence**)
9. Incorporate core values as the basis for ethical practice and the foundation for honorable character (**Integrity**)

It is the position of the American College of Dentists that ethical practice takes precedence over features of any particular system of delivering or paying for care. Managed care can be viewed in the context of ethics; the opposite is not meaningful. The core aspirational values of the College are identified in bold in the following analysis of managed care.

Managed Care per se

Managed care is a market mechanism. Dentists and patients participate out of the same motivation as purchasers and carriers — economic advantage. Although ethical abuses might be caused by participants in such a system, in theory, the system is neither good nor bad. However, to protect against moral risk, the following principles are considered primary:

A. *The ethical and professional aspects of dentistry must always take precedence over its economic ones. The market nature of managed dental care must always be evaluated in an ethical and professional context; whereas the reverse is not meaningful.*

Although managed care per se might be regarded as ethically neutral, it does confront the profession with increased levels of ethical risk. Increased vigilance is necessary in order to avoid the ethical compromises associated with maintaining different standards of care for patients on different payment systems, passing the costs of bad business decisions on to patients, and failing to fully disclose pertinent information to patients, for example. The principle of **justice** would be violated if it were found that managed care distributed oral health care in an inappropriate manner or that it lowered the overall level of care provided (as would be the case if chronically low levels of compensation undermined the research foundation or reduced the number of care providers).

The most serious of the ethical risks to which managed care exposes the profession concerns **autonomy** of the patient, the dentists, and to some extent the purchaser. Autonomy encompasses individuals' free choice of their own futures, subject to not causing harm to others. It remains to be determined by ethical analysis whether the restructuring of large segments of the health care system based on aggregate patient characteristics is in conflict with the ethical principle of autonomy. Coercion — forced choices between avoidable undesirable alternatives — and withholding or distorting information are factors contributing to limited autonomy. **Veracity** is also a related ethical risk.

B. *It is unethical to participate in managed care programs that require the dentist to knowingly coerce patients or limit the information available to them for making informed decisions about their care.*

Obligations of Dentists Who Participate in Managed Care Systems

The dentist-patient relationship is often altered in managed care arrangements, and incidents have been reported of attempts to justify substandard dentistry based on terms imposed by managed care contracts. At this time there is no conclusive evidence that dental care delivered in managed care settings is different in quality from care delivered in traditional systems. The potential for undertreatment represented by selection of care based on coverage rather than need, failure to diagnose, use of inferior materials or performing careless work, rationing access to care, or delegating to unqualified support staff is real. But this risk is not inevitable — it is always mediated through the dentist's personal choice of standards of care. Economic self-interest should not be placed higher than the aspirational goals of **compassion, justice,** and **beneficence**.

C. *The standard of care must be the same for all patients regardless of the means of reimbursement available to patients.*

It is possible that dentists may discover themselves in contractual arrangements that force a choice between compromised patient care and personal economic loss to the dentist. If this situation arises because the dentist was mislead or defrauded by a carrier, appropriate legal action against the carrier should be followed, always with the help of competent legal advise and the support of the profession (**professionalism**). If the unsound contractual arrangement resulted from the dentist making a decision that was not fully informed, both the dentist and his or her patients have been put at risk by the dentist's negligence. The concept of **competence** in dentistry extends to the safety, personnel, financial, and other areas of dental practice, as well as to technical matters. Because the dentist assumes personal responsibility for providing care under the terms of all reimbursement systems accepted in the office, diligence in selecting such programs is also the dentist's responsibility.

D. *It is an ethical obligation to fully explore and understand all terms of contractual arrangements and their implications for practice prior to committing to them.*

Managed care cannot be used in any way to shift responsibility for patient care from the dentist. The basic tenants of **veracity** should prevent one from justifying substandard care by pointing to other's rules. Especially disturbing would be any attempt to involve or use others in such a system.

E. *Employing or directing underqualified individuals in order to profit from a lower standard of care offered to patients in a managed care system is inherently unethical.*

Obligations of Dentists Who Do Not Participate in Managed Care Systems

The emergence of managed care has created division within the profession. Differences in the relative importance of values intrinsic to the profession, actual and perceived competition among practitioners, and uncertainty about how the profession should respond collectively have caused undesirable tensions among dentists. While the choice to participate, the nature of participation, or the choice of not participating in managed care systems is a personal matter, there are some ethical obligations that apply to dentists not involved with managed care.

Professionalism and **tolerance** are clearly established principles in dentistry. The American Dental Association Principles of Ethics and Code of Professional Conduct lays out guidelines for criticizing the work of colleagues. The aspirational principle of **tolerance** applies in such cases as well.

F. *Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Action is required because the patient's oral health is being threatened and not because of the nature of the reimbursement system.*

Patients have a right to know why their dentists choose not to participate in managed care systems. It is as important to carefully think through one's position to avoid managed care as it is to evaluate offered contracts. This is the essence of

integrity. It may even be appropriate to present this professional position in writing. A personalized variant of the following position would convey a professional respect for patients' health and dignity without maligning managed care.

G. I believe in providing the highest level of care possible to my patients. After carefully studying the plans available as supplements for patients' responsibility for their own health, I have not found any which permit me to offer the level of care I believe my patients are entitled to. I would be pleased to discuss various plans and alternatives with you.

Obligations of the Profession

Managed care is an issue facing the profession as well as individual dentists. While single practitioners cannot be relieved of their personal responsibility in patient care, there are several aspects of an altered economic system for allocating oral health care that can only be addressed at a larger level. In fact, one of the characteristics of managed care is its emphasis on aggregate rather than individual markets. Another feature of managed care is the involvement of four parties in place of the customary dentist-patient dyad.

The economic interest of carriers and purchasers call for one kind of regulation of quality while health concerns of dentists and patients call for a different type. The principles of **integrity** and **competence** require that dentists retain full responsibility for defining, monitoring, and enforcing technical dental standards of care. **Professionalism** can be used to justify the obligation that the profession as a whole engage in cooperative evaluation of the economic and patient satisfaction aspects of care.

H. Organized dentistry and other groups concerned with oral health should actively engage managed care carriers and purchasers to create systems for ensuring appropriate economic and patient satisfaction outcomes and develop or enforce existing regulations to protect the quality of oral health of patients.

Managed care is based on a number of assumptions about the relationship between oral health and cost factors that have not so far been supported with adequate data. Specifically, the following hypotheses stand in need of verification (**veracity**):

a. The cost of introducing a market intermediary is less than the improvement in overall oral health that such an intermediary introduces.
b. It is possible to reduce variation around the least expensive acceptable alternative sufficiently to avoid the damage caused by random undercare.
c. Market-driven reimbursement patterns across the range of service, including diagnosis and prevention, match the optimal allocation of care.
d. The benefit of aggregate decrease in overall level of excellence of care to acceptable levels will be offset by greater aggregate utilization rates.

I. *The profession should both focus issues critical to the evaluation of managed care and gather, interpret, and disseminate research bearing on these questions.*

The emergence of managed care is heightening the importance of several issues already recognized as being especially important to the profession and the patients it serves. There is a history of progress in each of the following areas:

a. Valid and interpretable information about the outcomes of treatment.
b. Standards of care that are uniform enough to provide guidance and flexible enough to accommodate patient individuality.
c. Training of dentists in business and interpersonal skills sufficient to support practices based on quality dental care for patients.
d. Advocacy for patient oral health at the individual and group levels.
e. Training of dentists in the ethics of the dental profession.
f. Forums for the presentation and debate of issues critical to the oral health of America.

J. *The profession should refocus on the traditionally important roles of serving dentists through treatment outcomes data, standards of care, business training, advocacy for patient oral health, training in ethics, and forums for policy issues in order to improve oral health of patients.*

References

1. Beauchamp R, Childres. *Principles of biomedical ethics.* Oxford, UK: Oxford University Press, 1994.
2. Etheredge L, Jones S. Managing a pluralist health system. *Health Affairs,* 1991;10:93-105.
3. Henikoff LM. Purchase-driven reform: who is at the wheel? *Frontiers of Health Services Management,* 1993;9:7-41.
4. Iglehart JL. The struggle between managed care and fee-for-service practice. *New England Journal of Medicine,* 1994;331:63-7.
5. LaPuma J, Schiedernmayer D. Ethical issues in managed care and managed competition: problems and promises. In Nash DB (ed). *The physician's guide to managed care.* Gaithersburg, MD: Aspen, 1993. Pp 31-60.
6. Ozar DT, Sokol DJ. *Dental ethics at chairside: professional principles and practical applications.* St Louis, MO: Mosby, 1994.
7. Peligrino ED. Healthcare: reform, yes; but not *a la* Lamm. *Cambridge Quarterly of Healthcare Ethics,* 1994:3:168-72.
8. Priester R. A values framework for health system reform. *Health Affairs,* 1992;11:84-107.
9. Rule J, Veatch R. *Ethical questions in dentistry.* Chicago, IL: Quintessence, 1993.
10. Schlackman N. The impact of managed care on clinical practice. In Bloomberg MA, Mohlie SR (eds). *Physicians in managed care: a career guide.* Tampa, FL: The American College of Physician Executives, 1994. Pp 27-43.
11. Shortell SM, Gillies RR, Anderson DA. The new world of managed care: creating organized delivery systems. *Health Affairs,* 1994;13:46-64.
12. Stoline, AM, Weiner JP. *The new medical marketplace: a physician's guide to the health care system of the 1990s.* Baltimore, MD: The Johns Hopkins University Press, 1993.
13. Volpe FJ. Types of managed health care organizations. In Bloomberg MA, Mohlie SR (eds). *Physicians in managed care: a career guide.* Tampa, FL: The American College of Physician Executives, 1994. Pp 7-26.
14. Weinstein BD. *Dental ethics.* Philadelphia, PA, 1993.

Alternative Approaches to Ethics

Ethical analysis is not a closed procedure; living as an ethical professional is more than learning and applying a set of rules. In this section, seven thinkers knowledgeable in the subject were asked to present alternative approaches to ethical analysis and to apply them to a common case involving managed care in dentistry. The writers are presenting the basic approaches assigned to them; these do not necessarily represent the preferred nor the only way they approach ethical issues.

Readers are also invited to try their hands with this case. It is clear that even the experts haven't said the last word. Send your responses to the editor.

Managing Carefully

Hal, Jerry, and Ross had become fast friends in dental school in the '60s and started a scratch group practice together right after graduation. It worked because they put in the hours, treated their patients with great respect, provided excellent quality care, and established their practice in a growing community.

They were sitting in the staff room debating the merits of a managed care proposal. The staff had left a half an hour ago. The three dentists appeared more tired and tense than usual. They had developed a thriving practice, one patient at a time. They managed their practice very carefully. Slightly more than half their patients had insurance coverage; only Jerry saw the occasional Medicare patient.

"I just don't like it on principle," Hal was saying. "We have always agreed that the basis of this practice — the basis of any quality practice — is the patient. We provide quality because we have quality patients. The patient comes first ..."

Ross continued the thought, "and second, and third ... We have done so well because we selected our patients to be the ones who want and can afford excellent oral health care. That's what distinguishes us from some of the other practices in town; we have worked to build up a true family of patients who appreciate the quality of the care we provide."

"That's precisely my point," returned Hal. "I object to managed care on the theoretical grounds that it destroys the doctor-patient relationship. These companies tell the patients who they can see, for what, when, and all that. There is no freedom for the patient, no choice. Managed care focuses so much on controlling cost that it reduces everything to a commodity. They buy and sell patients. They look at averages; not real people."

Jerry, who seemed to be absorbed in the financial analyses the office manager and accountant had provided, interjected without looking up, "If our patients were on managed care programs, do you know what our practice would be worth on the market? Zip! A few thousand for the equipment, maybe. Probably less because of that ugly sofa in your office, Ross. You are right, Hal. The measure of any practice is the patients — whoever owns the patients owns the practice."

"I wish it were that simple," said Ross. "Times change; this is not the '60s. These are not the same patients we started with. More and more, everybody is focused on price. We are in a different market now. There certainly are no more dentists in town than there were ten or fifteen years ago when you consider the number of

patients, but our 'so-called colleagues' are different too. We all used to be professional: only internal marketing, everyone belonged to the ADA, comparable fees, no bad-mouthing your colleagues. Now it's all competition, cut-rate care, advertising, over-billing the insurance companies to get even, and unethical practices that the state board won't do anything about because of threats of law suit over 'contract rights.' Virtue is fine — in a virtuous society. I hate managed care as much as any dentist does, but let's be realistic, we're talking about survival. Either we get the patients or somebody else will get them and make a living off poor quality care. We have already lost several families on that teacher contract. They say they would like to stay with us, but they can't afford to."

Jerry, still buried in the financial reports, added, "Of course you are right. I hate to reduce this to a money thing, but there really is always a 'bottom line.' The way I read these figures, on this plan from the computer assembly plant deal, we could break even with a cap rate of $13."

"Excuse my French, but 'no way!'" Hal was adamant. "We've been through all those calculations about marginal contribution, excess capacity, co-payments, and utilization rates. I don't care what the accountant says, I don't care what the spreadsheet analysis from the ADA says, I don't care what anyone says ... There will always be patients under the capitation systems on whom dentists will lose money if they provide the care the patient should have. And that is moral entrapment of the dentist on the part of these companies. They are tempting young dentists and others with weak ethics to abuse these patients."

"Exactly," was Ross's reaction. "It is economic exploitation. The dentist has to take all the risk. Some of these insurance executives are making three and four million dollars a year. And it's coming right out of the hide of the dentist. Our free market system, which is what this country is built on, is being eroded. What we need is some laws that have real teeth in them that limit what these companies can do."

Jerry finally looked up from his papers. "Is there such a thing as free-market socialism? Somebody, and I don't know who it is, seems to be pushing for the idea that everyone ought to have top quality dental care whether they can afford it or not. The patients who can afford it and the dentists are being asked to subsidize the care of a lot of patients who don't even want dental care and don't know how to maintain what they get. And the insurance companies are getting rich off this system. I have no problem with seeing some Medicare patients every once and a while or volunteering for school screening, but that should be my choice. If doing something in the public good is required, it's no longer an ethical choice."

"Jerry, you're too much of a philosopher," said Hal. "Listen, you guys do what you want, but I'm not going along with this contract. My self-concept as a professional is just incompatible with the notion of inserting disinterested third parties between me and the patient."

"Count me out, too," added Ross. "If the profession will just stick together, if all the facts are known, this thing is going to blow over. Dentistry is not like medicine."

"I guess that makes it unanimous," said Jerry. "There are too many 'ifs' in these numbers. I owe it to my family not to compromise the economic viability of the practice."

Principles of Dental Ethics and the Ethics of Managed Care

Thomas K. Hasegawa, Jr., DDS, FACD
Merrill Matthews, Jr., PhD

Dentists Hal, Jerry, and Ross are faced with a dilemma that at first glance might appear to be a financial dilemma affecting their patient load and income from their practice. However, a closer examination reveals that they are faced with an ethical dilemma that challenges some of their most basic assumptions about how patient care should be delivered. Their dilemma: whether to stay with their current fee-for-service arrangement or to participate in a managed care program.

For these three dentists, this choice is not just about managed care and its risks, benefits, and burdens. Rather, it raises more fundamental questions — questions faced by all of us, regardless of our situations, at some point in our lives. Should our decisions be guided by what we think is right, or by what will yield the best outcome? Should our actions be guided by our personal or professional principles or by the search for the best consequences?

Identifying How We Approach Ethical Decisions

When faced with an ethical dilemma people tend to fall into two distinct categories. Some people believe that there are principles which are always right, and so should be followed regardless of the consequences. We shall call them "principlists." By contrast, there are others, many of whom may believe strongly in certain principles, but who are willing to put their principles aside if they believe the consequences of a situation demands it. We will call them "consequentialists."

Much of the history of ethics — and what is often at the center of any ethical dilemma — is the debate over whether people should be guided by principles or consequences. There are strong feelings on both sides of the question.

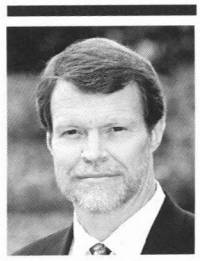
Since principlists believe there are absolute rights and wrongs, they often accuse consequentialists of being immoral because they have no principles they value as absolute, that is, that cannot be set aside. Thus, we have the motto, often delivered with a sneer, that the ends never justify the means.

Consequentialists, on the other hand, are not looking for what is "right" so much as what is "good", i.e., what maximizes pleasure or, conversely, minimizes pain. They identify with the old rancher in Ogden Nash's play "The Rainmaker", when he grabs the pistol away from his outraged son who intends to shoot the rainmaker for making love to the rancher's daughter in an effort to restore confidence in herself. The rancher knows adultery is wrong, but as a consequentialist he is willing to set that principle aside because he thinks in this case the adultery may be beneficial. "Noah, you're so full of what's *right*", the old rancher exclaims to his son, "you can't see what's *good*" (Emphasis added).

In fact, many consequentialists believe that, if the truth be known, principlists are only putting up a moral sham. While they may talk principles and absolutes, when faced with a serious ethical dilemma, one that could have a substantial impact on the principlists' lives or finances, they will set their principles aside and be guided by the consequences of their actions. The principlists may even try to rationalize their actions to others by pointing to some fundamental principles they embrace. But if you scratch them, you will find a consequentialist underneath.

However, though principlists believe there are actions which are always right or always wrong, that does not mean that they agree on which actions are right and which ones are wrong. Even the source of these absolute moral principles

Dr. Hasegawa is a Professor and Interim Associate Dean of Clinical Services at the Texas A&M University System -- Baylor College of Dentistry, Dallas, Texas.



Dr. Matthews is Vice President of Domestic Policy for the National Center for Policy Analysis in Dallas, Texas, and IRB Consultant for the University of Texas -- Southwestern Medical Center at Dallas, Texas.

can be disputed, with some principlists seeking their absolutes internally, e.g., conscience, and others looking to some external source of authority, such as the Bible, the U.S. Constitution or, for our purposes, the ADA Code of Ethics.[1]

Likewise, though consequentialists agree that ethical decisions should strive to achieve the greatest good, they often do not agree what the greatest good would be or whether the object of that good should be the individual making the decision (known as ethical egoism) or as many people as possible (utilitarianism).

While it is probably fair to say that the majority of academic philosophers — and, indeed, most individuals for that matter — take a utilitarian approach, the professions have largely taken a principlist approach. That's why they create codes of ethics which members of the profession are expected to adhere to. Do members of the various professions sometimes set their professional codes aside when they believe the consequences of an ethical dilemma demand it? Yes, at least for some principles in the code, but not for all. Principled journalists have gone to prison rather than reveal their sources to an inquiring judge. Principled attorneys will refuse to divulge privileged information under the attorney-client relationship. Editors may resign before they give up their principle of the freedom of the press. And principled health care providers will never reveal information subject to the physician-patient relationship.

Unfortunately, however, one principle sometimes comes into conflict with others. As a result, professionals are forced to examine their conflicting principles in an effort to determine which principle or principles are paramount.

Principles in Conflict

The philosopher W.D. Ross has proposed a theory of "prima facie duties" that explain the relationship between moral duties and obligations and how we prioritize our principles. Philosophers have identified four approaches meant to help us sort through the issues when principles come into conflict.

Nonmaleficence. Nonmaleficence is common to our understanding of health care ethics and associated with the maxim, *Primum non nocere:* "Above all (or first) do no harm".[2] There are two ways to understand the importance of this principle. First it focuses on the priority of restraining actions that would harm another. For example, you have assessed that your patient is at high risk for surgical extractions even after you have received a family physician's release to proceed, so in order to avoid harming the patient you feel compelled to secure a second opinion from a cardiologist or to call the physician to discuss your concerns. However, if emergency care was necessary and time was of the essence, the additional time needed for the consultation may result in harming the patient.

The professions have largely taken a principalist approach.

A second way to understand this principle is that obligations not to harm patients are different from obligations to help the patient. Competent dentists make this decision when they refer patients to specialists because the patients' needs may exceed the skills of the clinician.[3] Some philosophers believe this is the only true principle of ethics, or as the philosopher William Frankena contends, that nonmaleficence takes precedence over beneficence.[4]

Beneficence. A second principle is referred to as beneficence, or benefiting others. The benefit of the patient has long been held as a central value in the dental profession's ADA Codes of Ethics.[1] The daily practice of the competent dentist includes removing harmful conditions such as infective teeth and carious tooth structure, preventing harm through home care instructions and dietary counseling, and benefiting patients through community service such as by oral cancer screenings or even electing to provide some indigent care in the office. The principle of beneficence refers to a moral obligation to act for the benefit of others by helping them further their important and legitimate interests.[2]

Autonomy. Respect for patient autonomy is the third principle on the list. Respect for autonomy refers to the fact that the patient is a moral being and therefore deserves our respect. For example, the philosopher Immanuel Kant (one of the most famous philosophical principlists) has argued that people (in our case, patients) have unconditional value and we should value them as an end in themselves, and not as a means to an ends. A dentist may, for example, make a judgment that a patient is unable to afford extensive dental care based on the way that patient may be dressed, or that they have a low dental "IQ." As a result, the dentist may then propose extractions and complete dentures rather than the more costly and complicated periodontal and restorative care followed by fixed or removable partial dentures. Such a decision ignores the patient's right to patient involvement, as the ADA Code strongly supports.[1] To respect patient autonomy means that we acknowledge in action and attitude the person's right to make choices based on his or her own values and beliefs.[2] Patients do not leave their values at the operatory door any more than health care professionals do (or should).

Justice. Justice is explained by various philosophers in terms such as fairness, dessert (what is deserved), and entitlement (that to which one is entitled).[2] For example, some issues relate to procedural justice such as who should be treated first, and, if your 8:00 a.m. patient is twenty minutes late, is it fair to treat the late patient if it would make all of the other morning patients wait? Or should you replace a fixed partial denture because the porcelain fails under normal usage after six months? Other issues touch on what is known as distributive justice, or how we should distribute rights and responsibilities in society. Who should have access to care, the person with the most money or the one with the most need? Or is there a right to health care?

Thus, to say a dentist is committed to a principled ethical approach does not narrow that person's ethical options. In many ways it expands them as he or she tries to determine which principles are most important and how to resolve those principles which appear to be in conflict.

Principled Dentistry and the Dilemma of Managed Care

The clinicians in the case at hand do not really know whether they are principlists or consequentialists — but, then, most people don't. They are simply trying to talk through the issue to discover where their individual and collective values lie.

As the discussion progresses, they look at their past, their training, their practice, their patients, their commitment to quality care both in the past and in the future, their financial future, and the dilemma imposed on them by the trend towards managed care. The financial incentives in managed care, i.e., a capitated rate for each patient which gives the dentist a financial incentive to not provide quality care if that is the most expensive care — is at odds with their training and basic professional principles.[5,6] Hal refers to it as "moral entrapment" and Ross as "economic exploitation." These incentives are often viewed as creating problems of overtreatment in fee-for-service dental care and undertreatment in capitation practices.[7] For medicine, the incentives may result in the exclusion of sicker patients, rationing by inconvenience, burdensome micromanagement of clinical decisions, or denial of beneficial but expensive care to some patients, either by micromanagement or by perverse incentives to providers.[8]

As they grope for an ethical solution to their dilemma, they consider the consequences of their actions. Jerry points out that while he hates to bring up the financial element, "There really is always a 'bottom line.'" But it is Hal who sets the tone when he makes the statement "I just don't like it on principle." The principle he identifies is that managed care "...destroys the doctor-patient relationship." Now, the dentists could base this principle on the ADA Code of Ethics, but they don't. Rather, they associate this principle with their training back in the 1960s and thus tie their principle to an external source (as discussed above).

All three recognize that the nature of the practice of dentistry is evolving, and it may be moving away from fee-for-service care to managed care. All three also recognize that they could be financially harmed by the encroaching managed care element, but all three also recognize that they could be financially harmed if they stay in a fee-for-service system because they could lose a number of patients. They don't know the future (as the principlist Kant liked to point out). They might make more money or less money if they shift to a managed care arrangement, but they feel fairly confident they will be making less money if they don't. Thus, if they were consequentialists, the financial role would probably be paramount in their decision, and they would join managed care.

But while the financial element plays a strong role in their decision-making process, all three eventually come to the conclusion that the quality of care — the element they have staked their dental practice and reputation on — is the paramount value at stake. Though unarticulated, all three eventually recognize that they are principlists and that the principle they refuse to set aside is the quality of care which they think could be threatened under managed care. The three dentists agree that they shall reject the seduction of managed care and opt for quality of care regardless of the consequences.

Conclusion

As the health care system moves forward toward the next century, it must come to grips with two "needs": the need to control health care spending and the need to maintain — if not improve — quality. If managed care is to remain a viable method of reimbursement, it must become compatible with the highest quality of care. Many dentists are understandably skeptical that managed care and quality care can coexist. If managed care is to remain with us, the burden must fall on those who run managed care systems to establish policies and capitation rates that ensure quality care.

In response to both ethical issues about managed care, the ADA Council on Ethics, Bylaws and Judicial Affairs published the following statement:

The dental profession is challenged today to maintain its high ethical standards in the face of changes in the dental marketplace and the growth of managed care. The ethical statements subscribed to by the profession place the patient's welfare above any other consideration. Although the method of health care delivery may change, the overriding duty of the dentist will always be to provide quality care in a competent and timely manner.

Dentists who enter into managed care agreements may be called upon to reconcile the demands placed on them to contain costs with the needs of their patients. Dentists must not allow these demands to interfere with the patient's right to select a treatment option based on informed consent. Nor should dentists allow anything to interfere with the free exercise of their professional judgment or their duty to make appropriate referrals if indicated. Dentists are reminded that contract obligations do not excuse them from their ethical duty to put the patient's welfare first.[9]

References

1. ADA principle of ethics and code of professional conduct. Chicago, IL: The Association, 1996.
2. Beauchamp TL, Childress JF, eds. Principles of biomedical ethics. New York, NY: Oxford Press, 1994.
3. Hasegawa TK, Matthews M. Knowing when you don't know: the ethics of competency. Dent Abstracts 1996;41(5):218-220.
4. Frankena W, ed. Ethics. Englewood Cliffs, NJ: Prentice Hall 1973.
5. Guay AH. Understanding managed care. J Amer Dental Assoc 1995;126(4):425-33.
6. Zatz M. Dental capitation programs: key decision factors. J Amer Col Dent 1995;62(2):17-20.
7. Atchison KA, Schoen MH. A comparison of quality in a dual-choice dental plan: capitation versus fee-for-service. J Pub Health Dent 1990;50(3):186-93.
8. Clancy CM, Brody H. Managed care: Jekyll or Hyde? J Amer Med Assoc. 1995;273(4):338-9.
9. ADA Council on Ethics, Bylaws and Judicial Affairs. Defining managed care ethics' primary ethical duty — to put the patient's welfare first. ADA News 1995;26(3):12.

Virtue Theory and a Dental Managed Care Case

David Ozar, PhD

The aim of the moral theorist is to articulate sets of concepts about the elements of human moral life at its best that will help others do their moral thinking more clearly and effectively. The tradition of moral theorizing that is today called "virtue theory" was developed extensively by Plato, Aristotle, and other ancient, medieval, and Renaissance thinkers and by others since then. It was out of favor among English-speaking academic moral theorists during much of the twentieth century, but has been undergoing a major resurgence in recent years. The elements of human moral life that virtue theories try to articulate are part of the fabric of daily life so the following brief summary of the role of virtues in our moral life should sound familiar.

Much of recent Western moral theory has focused on *actions*, trying to articulate the specific characteristics of our actions that make them right or wrong, morally acceptable, required, optional, or prohibited, and so on. The long tradition of virtue theory, on the other hand, has focused its attention on the characteristics of *persons*. Moral theory that focuses on actions can assist us when we are perplexed about how to behave in a particular situation. Those who stress action-oriented ethics generally think that being told to act like a particular kind of person who is possessed of certain virtues is not concrete enough guidance. But action-focused theories often overlook how much of our conduct is shaped, not by self-conscious deliberation about how to act, but by the habits we have built up — both good habits (virtues) and bad ones (vices). The moral life is, to an important degree, a matter of becoming a certain kind of person with certain kinds of habits. It also has, therefore, an important developmental aspect. Both action and virtue theories are needed for an adequate account of human moral life and reflection.

What characteristics of persons are morally admirable, are worth imitating, worth recommending to one another, and worth teaching to our children? How do these characteristics relate to the rest of a human personality and to our interactions with one another? How do humans come to develop and solidify these characteristics within their own personalities and how can we help others to do so? These are the kinds of questions that thinkers in the virtue tradition have focused on.

But before we examine these matters, we need first to ask: What is a virtue? Aristotle's answer to this question in the *Nicomachean Ethics* has stood the test of time: a virtue is a complex, *habitual* pattern of human life concerned with some human *excellence*. First, it is a complex, habitual pattern of life which includes not only a pattern of acting in a certain way, but also an ease of acting this way and the ability to identify when acting this way is appropriate. Second, it is a pattern of life that concerns some human excellence.

But what is to be counted as human excellence? Ancient, medieval, and Renaissance virtue theorists often described truly admirable human beings in terms of such virtues as temperance, fortitude or courage, justice, friendship, and prudence, to name the most important. (It is deserving of note that the term, "prudence," which is often used today to refer to a skilled ability to protect oneself from loss, was used differently by the virtue theorists of old. When they spoke of prudence, they meant something much more significant and complex; namely, the experience-based ability to discern in each situation a course of action most in accord with the virtues a person already possesses and those other virtues towards which he or she should be actively growing.)

These characteristics of admirable humans, and other virtues we might list, are no less important in describing human excellence today. But when the emphasis in a particular discussion is on persons who fulfill an important social role, as in

Dr. Ozar is Professor and Co-Director of Graduate Studies in Health Care Ethics in the Department of Philosophy and Director of the Center for Ethics at Loyola University of Chicago. He was the founder and served as first President of the Professional Ethics in Dentistry Network (PEDNET).

the case presented here for comment, then it is essential to ask if there are habits of conduct, valuation, and perception that are particularly associated with the proper fulfillment of that social role. The aspects of human excellence that concern us here are the virtues of the excellent dentist. So we must turn our attention specifically to those.

The Excellent Dentist

I have argued elsewhere *(Dental Ethics at Chairside: Professional Principles and Practical Applications* by David Ozar and David Sokol; St. Louis: Mosby-Yearbook, 1994) that the full explication of the ethics of any profession requires answering eight sets of questions about that profession's practice. Three sets of these questions are principally relevant to the case under consideration here. (a) What is the proper relationship, especially regarding treatment decisions, between the dentist and the patient? (b) What are the central values, especially those secured for patients, that should direct dentists' practice decisions, and how are these values ranked? (c) How much sacrifice of their own interests for the sake of patients' interests do dentists commit themselves to when they enter this profession?

In the vast majority of circumstances, our dental community gives its answer to each of these questions by its actions rather than by words. That is, the characteristics of excellent dentistry that respond to these questions are expressed for the most part in habitual actions rather than in careful, self-conscious deliberations and the words that would express them. In the same way, the larger community gives its support of the dental community's answers to these questions by its actions, i.e., by continuing in many ways, overt and subtle, to support the independence of this profession and to trust its members, both individually and collectively, to practice according to its ethic. (I take it for granted that both the existence of a profession, and the current contents of its ethic, are the product of an ongoing, sometimes nearly invisible dialogue between the larger community and the members of the professional group. Both the profession and its ethics are complex social systems and both parties to this dialogue are essential for their existence.)

But so long as the content of these patterns is left inarticulate, we will be unable to use them to guide us in facing new situations and answering new questions about ethical practice. What then is the current state of the dialogue between dentists and the larger community about proper conduct in these three areas? What does excellent dental practice look like in these three respects?

The characteristics of excellent dentistry are expressed for the most part in habitual actions.

The sketch that follows can only serve to highlight some of the most important features of these matters.

A. The Ideal Relationship. There was a time not so long ago when the notion of "doctor's orders" was quite descriptive of the dentist-patient relationship. But for over a generation now, dentists have aspired to a collaborative model of decision-making with their patients. Most are concerned enough about patient understanding and self-determination, as well as the therapeutic and legal advantages of well-informed patients, to aim for treatment decisions that are the product of a shared judgment about what will be best and a shared choice to do it. Of course, many patients are not fully able to participate to this degree and some who are able nevertheless opt to be much more passive than this. But this is the accepted ideal for dental practice.

Clearly, this ideal identifies all managed care contracts with "gag clauses" to be simply unethical, for such contracts unethically prohibit the dentist from fully informing the patient of all clinically appropriate treatments. Clearly, too, this ideal will often add to the dentist's work, in comparison with fee-for-service or more traditional forms of dental insurance, because the patient often understands little of the managed care contract's limits on treatment or treatment managers' refusals to cover any but the least costly appropriate treatment. It will fall to the dentist to explain these matters.

More complex is the insertion of an active third party, the managed care organization, into what has traditionally been viewed by dentists as a simple two-party relationship between dentist and patient. The truth is, of course, that patients have always brought their financial constraints to their conversations with dentists. If managed care organizations and their treatment managers are viewed as essentially more of the same — more aggressive now than their previous counterparts were about controlling costs, but still setting the limits on patients' ability to receive treatment — then a genuinely collaborative treatment decision by dentist and patient can surely remain the ideal. At least in theory, moreover, the patient has freely chosen the particular managed care contract that he or she brings to the dental office. Even so, however, there will often be fewer treatments to choose from than in the past. But this need not affect the collaborative nature of the relationship either; it need not interfere with the ideal of a shared judgment and shared choice.

Nevertheless, as sharply constraining the range of alternatives does in any area of human choice, the new situation will surely *feel* much more constrained, unfree, not-in-our-control than did the old, at least until we all become more accustomed to the new limits. The challenge will be for dentist and patient both to continue to work towards a shared judgment and a shared choice in this environment of fewer alternatives, and so to maintain *their* two-person relationship even though they are each forced to be more conscious of the third party's role than before.

B. Central Values of Dental Practice. The managed care situation has done nothing to seriously challenge dentistry's commitment to the highest ranking values of dental practice: the patient's life and general health, the patient's oral health (defined as appropriate and pain-free oral functioning), and the patient's autonomy to choose between clinically appropriate treatments offered by the dentist. Obviously, dentists have not suddenly been authorized by the rise of managed care to perform treatments that are inappropriate from the point of view of patients' oral or general health. Here again, however, the new situation will often require additional work by the dentist to advocate actively with a managed care organization for a patient when it is denying treatment that the patient truly needs or it is proposing treatment insufficient for the patient's condition.

But managed care's most serious challenge to dentistry's central values lies in the core initiative of managed care as a social institution, i.e., its efforts to reduce health care costs by opting for the least costly appropriate treatment whenever several treatments are appropriate for the clinical situation. Several generations of dentists have been trained to recommend — exclusively if a dentist's practice can support it fiscally or, more often, whenever it is financially feasible for the patient — the very best treatment for the presenting condition, even though less expensive, appropriate treatments are also available. Many, probably most dentists today, have well-formed habits of focusing patients' and their own attention on *the best* treatment, and now the managed care companies are telling dentists and patients that the best care is too costly and *adequate* care will have to do unless the patient wishes to add further personal resources.

For many dentists, even if they can intellectually affirm that adequate care is indeed adequate, a requirement imposed by a managed care organization that a patient accept such adequate care as the negotiated benefit in their contract *feels* like a requirement to practice unethically. It feels unethical because it flies in the face of a deeply established professional habit to always recommend — and in the case of some dentists, to personally provide only — the best treatment for the situation.

In truth, if adequate care is indeed adequate for the patient's needs in the situation, then there is nothing unethical in providing it. As was already mentioned, patients must be fully informed of the range of treatments available and the dentist may choose to — may even be professionally obliged to — reveal his or her judgment that the adequate treatment supported by the managed care organization is not the best form of treatment that is possible. But so long as the treatment offered and performed is adequate, the dentist's feeling of acting unethically must be viewed as misrepresenting the situation. (Of course, if the managed care organization will support only treatments that are *inadequate* to the patient's condition, then, as was mentioned, the dentist must become the patient's advocate to get him or her the appropriate treatment.)

The challenge will be for dentist and patient both to continue to work towards a shared judgment and a shared choice.

Dentists who have been in the habit of referring to other dentists those patients who would opt for less than the best treatment, on the basis that it is part of their philosophy of dental practice to personally perform only the best treatments, will probably find the new situation under managed care even more distressing. It will now be much more likely that patients referred away for these reasons will likely not return, since the best treatment will rarely be available to them and they might as well stay with a dentist who is willing to offer them the treatments that their managed care organization will support. For these dentists, the shift in American health care away from supporting the costs of routinely providing the best treatment to supporting only the least expensive treatment adequate for the patient's condition will feel like a slide away from professional standards altogether. This certainly seems to be the gist of the reasons given in the case before us for this group of dentists declining to participate in a capitation contract or, apparently, in any managed care contract that might be offered to them in the future.

Provided that patients are not thereby denied access to dental care (because, for example, there are no other dentists available), there is nothing unethical in a dentist or group of dentists refusing to offer anything but the best treatments (provided, as already noted, that they fully inform their patients of the whole range of adequate treatments). But obviously there will be a severe financial price to pay for trying to do this if and when managed care comes to dominate the dental market place. Still, dentists whose habitual patterns of practice are likely to place them in this situation should not misrepresent what is going on. So long as the managed care organizations are supporting adequate dental treatments for patients' dental needs, they cannot be properly accused of trying to force dentists to practice unethically. These dentists' feelings that unethical practice is being required of them, because their long-standing habits of practice are being challenged, are understandable, but probably inaccurate. They should reflect on the whole situation from an ethical point of view much more carefully.

C. Sacrifice and Its Limits. Every professional accepts an obligation to some measure of sacrifice of his or her own interests for the sake of those whom he or she serves. This is in the nature of professional commitment. The difficult questions concern how much sacrifice is

required, for whom, and when. It is commonplace, for example, that a dentist may be obligated to accept some or even great loss for the sake of a patient in need of treatment that the patient cannot afford. Dentists are also constantly weighing sacrifices of time and energy for the sake of their patients. Dentists vary in how much sacrifice they make, and very likely some of them do not do enough. But as a group, dentists clearly recognize this obligation and try to give it effect — although, as in most such matters, far more often in habitual patterns of appropriate deeds than in articulate statements of what they do.

But if such sacrifice appears to be mandated through the actions of third parties (employers, managed care organizations, etc.), the ethical requirements in this area become much less clear and the sense of impropriety on the part of the third party much greater. What should the partners in this case do, for example, about accepting the capitation contract? There will always be individual cases where the average-per-patient cap allotment is exceeded in rendering appropriate care. May such sacrifice be mandated by a third party, sacrifices that might well be outside the types or limits of sacrifice the group has committed to?

This is an important question, and one that each dentist (and group of dental partners) must address forthrightly. But it is important to remember that capitation arrangements look at patients in *groups,* not individually. The relevant question about degree of sacrifice therefore concerns the whole *group* of patients when a capitation contract is being considered. Even though, in treatment decisions, the ideal dentist-patient relationship remains a one-to-one collaboration, when a dentist is considering entering a capitation program, the dentist must think about financial matters in terms of the covered pool of patients. If the terms of the arrangement cannot support appropriate treatment for the whole group (with or without appropriate measures of fiscal sacrifice), then the dentist should not enter into the contract. On the other hand, if a dentist makes a bad prediction and finds that the contracted group is requiring a loss by the end of the year, this is essentially a bad business judgment of the dentist rather than a question of whether some measure of professionally required sacrifice is owed. Nor is it proper to see it — if it is indeed a bad business decision — as an unethical imposition by a third party on decisions about sacrifice that rightly should be the dentist's own.

Managed care may well make dentists' decisions about appropriate sacrifices and about the proper limits of such sacrifice much more complex, and dentists may have to be much more forthright with patients about their judgments about when and how much to sacrifice. But it is essential, in weighing these matters, not to mistake the facts of the situation, as for example by mistakenly judging the financial arrangements for capitation patients as if they were to be considered on a one-by-one basis.

Conclusion

The statements of the three dentists in the case are grounded to a great extent in habits of perception, valuation, and conduct that are truly admirable for dental practice. Their statements are, in other words, grounded in their virtues as dentists. But like most habits, these dentists' professional ethical habits are not well articulated, and so the relevant elements of their habitual practice contain both custom and virtue mixed together, and in a few cases, custom that is mistaken for virtue, e.g, looking at the capitation patients individually for treatment but then failing to look at them as a group when finances are the question.

Articulating and distinguishing the professionally excellent from the non-essential (and from the mistaken, when necessary) is an important task and one without which it is extremely difficult to address the new situations that arise in life. One moral of this story, then, is "Do not rest satisfied that our inarticulate virtues will surely guide us well." The members of the dental profession must continue to work to communicate with one another and with the larger community, as clearly and articulately as possible, about the content of their professional commitments and their ongoing efforts to respond properly to the new circumstances which life in a complex, changing society keeps bringing to them.

Casuistry in Dental Ethics: A Case for Cases

Gerald Winslow, PhD

Anyone who has taught ethics to dental students soon learns at least one thing: Cases are more interesting than abstract principles and their associated theories of ethics. Grappling with the specific details of a complex case appeals to most students, especially if the case has the ring of reality. Recitations of professional codes or general norms risk immediate boredom. Taken alone, this obvious difference in interest levels might not provide sufficient argument for the priority of case-based ethics, also known by the technical name *casuistry*, whether in dentistry or any other field. In recent years, however, those who would revive casuistry have extended compelling arguments for a return to this once honored approach to moral judgment.[1-3] In this article, I address some of these arguments and add a few of my own in order to make a case for dental casuistry.

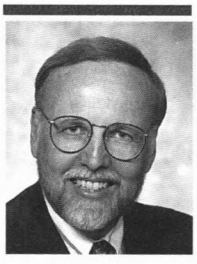
Casuistry, as used here, refers to a method of moral judgment that attends first and foremost to decisions about specific cases. Rather than approaching ethical questions with a full-blown theory or a sleek set of principles, the casuist insists on giving priority to the messy business of resolving concrete cases of conscience. Through analogical reasoning, casuistry proceeds from one case to another. General principles, if they emerge, do so through the accumulation of careful observations about particular circumstances, and such principles are always subject to revision in the light of new occasions.

Contending for casuistry in dental ethics might seem entirely unnecessary. Today's leading texts on dental ethics are significantly devoted to discussion of specific cases.[4-6] Nevertheless, casuistry requires explicit defense for at least two reasons.

First, both the label and the method have earned a dubious reputation in Western thought. Consulting nearly any English dictionary will quickly reveal the problem. Mine, for example, offers two definitions for casuistry.[7] The first refers, innocuously enough, to "a resolving of specific cases of conscience, duty, or conduct. . . ." The second, however, reveals the baggage of some unfortunate history: "specious argument, rationalization."

How did a method of careful moral discernment about particular cases get twisted into something synonymous with weaseling out of moral duties? According to Jonsen and Toulmin, whose work on casuistry has been most influential in reviving interest in this approach, casuistry reached its zenith in the 16th and 17th centuries. Many of the arguments and conclusions of the casuists during the period of "high casuistry" may now strike us as odd or unacceptable. But the method contained critical elements of self-correction that prompted the emergence of new moral paradigms as changing social conditions required them. Jonsen and Toulmin acknowledge from the beginning that there may be "good casuistry, which applies general rules to particular cases with discernment, and bad casuistry, which does the same thing sloppily." Sadly, the latter made it easy for critics, especially 17th century French philosopher Blaise Pascal, to pan the method. Pascal's critique was so scathing and so clever that casuistry has been viewed with suspicion ever since. The goal of Jonsen, Toulmin, and other "new casuists" is to rehabilitate casuistry so that its best elements are again available.

A second problem with casuistry is that many of us who are educated in philosophical or religious ethics are uneasy if moral discourse is thin on theory or fails to proceed from an enunciation of broad principles. The grand theories of ethics are the pinnacles of our craft. Honed statements of principles are the power tools of our lore. Case-based ethics can seem the lowest form of ethics — mere casuistry. In this regard, ethicists may need more rehabilitation than does casuistry. And health care, including dentistry, may be providing the remedy.



Dr. Winslow is Professor of Ethics, Loma Linda University in Loma Linda, CA.

In recent decades, the ethical issues in health care have become sufficiently interesting, novel, and pressing to attract the attention of many in academic ethics. (The creation of new jobs, teaching ethics to students of the health care professions, has also had attention-getting power.) Analyzing the deeper meanings of moral concepts, so characteristic of much ethics in this century, began to take second place to the earnest work resolving the specific ethical issues at hand. Typically, as in the Seattle case of allocating scarce, life-saving renal dialysis or the case of stopping artificial life-support for Karen Ann Quinlan, the questions were practical, immediate, and dramatic. Most of the recent ethical issues in dentistry appear less sensational and less discontinuous with the traditional ethics of the profession. But one has only to think of the controversies over treating patients with AIDS, or the independent practice of dental hygienists, or the response of the profession to managed care to see that dentistry, too, is facing pressing, practical issues, case after case.

Making this observation need not imply disdain for conceptual clarity or theoretical sophistication. But there are strategic implications. The method of casuistry asks that we begin with the details of a case, the particular set of circumstances. No matter how much attention must then be given to moral norms, to the clarification of moral concepts, and to reflection on moral theory, the goal of the process is to secure guidance for a case. The dream of a grand, unifying theory of ethics is relinquished in favor of the practical task of finding current moral direction. "The heart of moral experience," Jonsen and Toulmin aver, "does not lie in a mastery of general rules and theoretical principles, however sound and well reasoned those principles may appear. It is located, rather in the wisdom that comes from seeing how the ideas behind those rules work out in the course of people's lives."[1]

My own disenchantment with a theory-first or principles-first approach to ethics has grown, in part, from attempts to teach ethics to dental students. I have already mentioned that cases are more engaging, and more effective in enticing the students' participation in the subject. But there is more. Time and again I have watched students or colleagues in the profession who have learned to speak a little ethics. I have grown increasingly uneasy, even weary, as I listen to people who apparently feel obligated to use the language of ethical theory (e.g., natural law, utilitarianism, Kantianism, contract theories, or virtue ethics) or the current language of ethical principles (e.g., beneficence, justice, autonomy, or fidelity). Those who have learned a little of this language often seem compelled to display it and to impose it on others, as if, somehow, these words and these categories were tantamount to "doing ethics." This approach also appears to give the user of the words special authority to decide matters of ethics. I have asked myself: Did we, who specialize in the study of ethics, require people to dance in these hip boots? Did we believe that another cursory recitation of the favored terms of our trade would actually improve moral discourse? What had become of the native moral language which these able minds might better have brought to the case at hand?

The method of casuistry asks that we begin with the details of a case.

Looking at the Case

It would, however, be ironic to dwell more on the need for dental casuistry. In order to experience directly some of the critical steps of casuistry, we need a case. And our editors have provided one: the case of three dentists, Hal, Jerry, and Ross, "debating the merits of a managed care proposal." We sense that the stakes, both ethically and economically, are high. A decision may lead down a one-way street. And the historical precedents are unclear. What strategies from the history of casuistry may we bring to this case? Space permits mention of five.

1. *Describe the Case Richly.* The first requirement of case-based ethics is a thorough description of the circumstances. One commentator on casuistry has suggested that we proceed best with actual rather than hypothetical cases.[8] He adds that our case studies should be detailed: "If the purpose of moral education is to prepare one for action in the real world, the cases discussed should reflect the degree of complexity, uncertainty, and ambiguity encountered there." We need answers to the orator's traditional set of questions: who, what, where, when, why, how, and by what means. Typically, we also need to know about the feelings of the key participants, how their relationships are likely to be affected by the alternatives, and who has the authority to decide the matter under question.

Of course, we nearly always wish to know more. In the case at hand, for example, does the proposed contract contain so-called "gag rules" that would prohibit the dentists from discussing alternative treatment plans with their patients if the treatments were not covered under contract? What sort of bonuses or other financial incentives, if any, will be offered the participating dentists for holding down costs? Is the remuneration provided by the plan so small that the dentists will face overwhelming pressure to under treat? How might the managed care contract affect others, including the hygienists, who work in the practice?

2. *Relating the Case to Model Cases.* A key strategy of casuists is to begin with "paradigm cases" about which there could be little doubt concerning a moral decision. Once such model cases are settled, it should be possible, through analogy, to extend lines of reasoning about more questionable cases. In this way, an orderly classification of cases can be developed. We should know, for instance, that it is plainly wrong for a dental student to lie to a patient about a diagnosis or proposed treatment plan in order to earn enough points so the stu-

dent can graduate. This would be an obvious breach of a fiduciary relationship. As Hal, in our case, says, "The patient comes first. . . "

One of the perplexities facing dentistry today is uncertainty about where to place cases involving managed care in a taxonomy of cases. For example, are managed care contracts akin to fee splitting that has traditionally been prohibited? Can the patient still come first in managed care? Are the potential conflicts of interest that might lead to under treatment in managed care more dangerous than those in fee-for-service care that might lead to excess treatment? If managed care is ethically dubious, is this mainly because of potential conflicts of interest? Such concern would explain a statement in the American Dental Association's most recent edition of its code of ethics: "Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first."[9] Of course, if the ADA had deemed all managed care contracts to be inherently unethical, the code could certainly have forbidden members from entering into to such contracts.

3. *Appealing to Ethical Norms.* The fact that casuistry begins and ends with the specificity of cases does not rule out the use of ethical rules and principles. The three dentists appeal directly or indirectly to a number of norms and values, some in conflict with others. In addition to "the patient comes first," Hal claims that managed care "destroys the doctor-patient relationship" and removes "freedom for the patient." He objects to managed care's buying and selling of patients and the tendency to "reduce everything to a commodity." But he does not object to Jerry's statement that "whoever owns the patients owns the practice." Ross complains that "Our free market system which is what the country is built on is being eroded." But this statement is made (ironically) just moments after Ross recalled wistfully a time, prior to cut-throat competition, when there was limited marketing and dentists had "comparable fees." The three dentists also appeal to the values of high quality dental care, professional identity, non-exploitation of patients and dentists, family loyalty, and survival.

This mishmash of free-market ideology, professional tradition, and prudential calculation might tempt us to search again for a unifying theory of ethics that would clean up the clutter. For example, utilitarianism might be called to the rescue. The case would be settled by determining what course would produce the greatest good for the greatest number.

The three dentists appeal directly or indirectly to a number of norms and values, some in conflict with others.

But when we returned to the case, theory in hand, we would find that the same tangled considerations must be addressed in order to settle what the greatest good would be or who would comprise the greatest number. We would still need to ponder such matters as whether increased accessibility to basic dental care or decreased costs of dental care would amount to enough good to offset some loss of freedom. In other words, we would be back to casuistry.

4. *Weighing Multiple Considerations.* Careful casuistry requires that many factors be assessed and given relative influence in the final decision. It seldom occurs that one consideration overpowers all the others. Rather, the cumulative weight of numerous reasons usually tips the scales in one direction or another.

Although casuistry typically uses case material for the edification of analysts other than actors in the case, this fourth point will be explained from a perspective within the case. In the case at hand, the three dentists bring forth many different reasons for rejecting the managed care contract. No single reason in favor or against the contract seems sufficient by itself, not even "survival." Thus, despite the apparent messiness of their conversation, including its contradictions, the three dentists are engaged in a process that is typical of casuistry. They are introducing and pondering a wide variety of considerations with accompanying reasons in order to arrive at their conclusion.

5. *Reaching a Probable Resolution.* There is a feeling of urgency in the deliberations in the case of the three dentists. Like all casuists, they do not have forever to reach a decision. And, like all casuists, any decision is unlikely to carry total certainty. Good casuistry must always include a "counsel of humility." Most decisions, on further reflection and with more information, could turn out to be wrong. The ethically correct decision, from the perspective of casuistry, is the one that has the weightier arguments in its favor at the time the decision is made. Given the reasons adduced by the three dentists in this case, it is probable that they made the correct decision. Their fears about maintaining their fiduciary relationships with their patients and about preserving their personal integrity seem sufficient to rule out the managed care contract that they were considering. The high value that the dentists place on their freedom and the freedom of their patients adds further heft to the arguments against the contract. It is difficult to imagine ethical arguments that would be sufficient to outweigh the negative arguments for these dentists at this time. It would be difficult to believe, for example, that the dentists' decision not to sign the contract would unfairly injure others or lead to a decrease in needed dental care.

Still, using the same method of casuistry, another partnership of three dentists, in different circumstances, might properly arrive at exactly the opposite decision. Indeed, it would be a useful exercise in casuistry to examine a similar case in which other dentists might be justified in signing a managed care contract. What protections would need to be ne-

gotiated? What shifts in values might be implied? We might imagine, for example, that three other dentists would embrace a managed care contract because they would be freed from the corrosive influence of having increases in their incomes tied to doing more procedures. We might imagine that they have distinctive moral commitments borne of shared religious faith or philosophical reflection. These dentists might celebrate the fact that managed care was holding down costs so that more people could receive basic dentistry. And if the managed care contract did not provide for the highest quality of dental care, the dentists might insist on being able to point this out to their patients, thus giving the patients the opportunity to decide if they are able to pay for top-of-the-line care out of their own resources. But this would be a different case.

Dentistry is just now learning to apply the moral maxims of its ethical tradition to managed care. It is far from clear how this will turn out. Dental codes of ethics, which only a few years ago were written primarily with the fee-for-service model in mind, are now being revised in light of new paradigms. Such a time should provide rich opportunities for thoughtful dental casuistry. Those of us who care about the profession's ethics should see this as an invitation to put our pre-cooked doctrines in the background and join the issues of the day at the level of practical cases. We should bring to bear on these cases all of the moral insights and arguments that fit, carefully weighing each. And we should do this in humble fashion, without the pretense of special expertise or theoretical superiority.

References

1. Jonsen AR, Toulmin S. The abuse of casuistry: a history of moral reasoning. Berkeley, CA: University of California Press, 1988.
2. Keenan JF, Shannon TA, eds. The context of casuistry. Washington, DC: Georgetown University Press, 1995.
3. Miller RB. Casuistry in modern ethics: a poetics of practical reasoning. Chicago, IL: University of Chicago Press, 1996.
4. Ozar DT, Sokol DJ. Dental ethics at chairside: professional principles and practical applications. St. Louis, Mo: Mosby, 1994.
5. Rule JT, Veatch RM. Ethical questions in dentistry. Chicago, IL: Quintessence, 1993.
6. Weinstein, BD. Dental ethics. Philadelphia, PA: Lea and Febiger, 1993.
7. Webster's ninth new collegiate dictionary. Springfield, MA: Merriam-Webster,1987.
8. Arras JD. Getting down to cases: the revival of casuistry in bioethics. J Med Phil 1991;16:29-51.
9. American Dental Association. Principles of ethics and code of professional conduct. Chicago, IL: American Dental Association, 1996.

Ethical Analysis from the Perspective of Rational Self-Interest

Salvatore J. Durante, DDS

Should you go to work this morning or loaf around home? Should you carefully consider entering into that business partnership with the prosperous doctor down the hall whom you've just met or should you "just do it" because your gut feeling is that he's probably a nice guy? And if you do, should you tell him that you actually do not know anything about treating TMJ disorders, even though he considers that an important part of your purported skills? Maybe you should lie, attempt to fake reality; for a short while, just until you get your foot in the door. None of these questions comes with automatic answers, yet you must act.

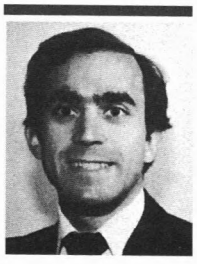
Wouldn't it be wonderful if there were a field of study that looked at "the nature of man," what it takes to live *as man*, and then set guidelines based on the results of that study? That is what ethics is supposed to be: the purpose of ethics is to guide men and women in choice and action, for a successful life.

Unfortunately, that is not how ethics is viewed today. The standard view on ethics is that an act is moral if the intended beneficiary of the action is someone other than yourself, and you receive "moral credit" to the extent that an action requires you to sacrifice. The standard of value here — the ultimate value toward which all your actions are aimed — is not your own life or happiness. It is not even your neighbor's life, because he too must sacrifice for the good of others. The standard here is actually suffering itself. Sacrifice enough, make the total sacrifice of your own life, and you would be declared a saint by modern society. The more undeserving the beneficiary of your sacrifice, the more you would be honored. If enough people practiced this, or were convinced by someone to practice this, the result would be mass suffering and death. Whatever can be said about the moral code of self-sacrifice, one cannot say that it is a guide for successful living.

In contrast to the standard view of morality as self-sacrifice, Ayn Rand offers her reality-based morality of rational self-interest: "The objectivist ethics proudly advocates and upholds rational selfishness — which means: the values required for man's survival qua man — which means: the values required for human survival — not the values produced by the desires, the emotions, the 'aspirations,' the feelings, the whims, or the needs of irrational brutes. . . . The objectivist ethics holds that human good does not require human sacrifices and cannot be achieved by the sacrifice of anyone to anyone. It holds that the rational interests of men do not clash — that there is no conflict of interests among men who do not desire the unearned, who do not make sacrifices nor accept them, who deal with one another as traders, giving value for value."[1]

Let's take one step back to grasp a key point of the objectivist ethics of rational selfishness. Ayn Rand started her study of ethics by assuming nothing and taking nothing for granted. She did not begin by asking "What should man value?" She began by asking what gives rise to the need for the concept of *value* in the first place. That is where one will find the standard of value, the proper ultimate goal of all one's actions. Life is what leads to the concept of value, because it is only living entities that can and must act to sustain their existence. What promotes their life is a value; what hurts their life is a disvalue. Reason is man's basic means of survival, and that which is proper to the life of a rational being is the good; that which negates or destroys it is the evil. So man must use his faculty of reason to its utmost — to see reality as it is — and must selfishly respect that same faculty of reason in others.

Ayn Rand has developed a systematic, objective philosophy, which includes ethics.[2] In examining the "Managing



Dr. Durante is in private practice at 589 Metropolitan Avenue, Brooklyn, NY 11211.

Carefully" scenario, I can only hope to provide a glimpse of what she has accomplished. In looking at any ethics scenario, such as we are doing here, the primary question is, Are the actors thinking or are they evading? Do they use their minds to see reality or do they strive to evade facts? Do they try to connect and integrate their knowledge to everything they observe, or do they actively try to disintegrate their knowledge and avoid making connections in their minds? To be sure, thinking is not the only objectivist virtue, but it is the most fundamental. Derivative virtues include independence (in thought as well as action), integrity, honesty, justice, productiveness, and pride, some of which we will see on display as we look at "Managing Carefully."

An Objectivist's Analysis of the Case

Our three dentists want to provide high-quality care and choose to be the best they can be. They join together in this common goal. They understand that not everyone wants the level of quality they wish to provide, so they carefully choose the neighborhood in which they will establish their practice. As a result of their careful thought and planning, they succeed. Our dentists have developed a practice they are proud of. Now, they believe they may need to alter their original plan for reasons we will look at in some detail. But before we look at the apparent dilemma presented in "Managing Carefully," let's stop and look at the situation to this point. On the road our three dentists have traveled, every step of the way involved choices and thus can be morally scrutinized.

The purpose of ethics is to guide men and women in choice and action, for a successful life.

Let's look at the essentials. First, our dentists acted ethically in that each individually decided to support his existence through productive work. Staying alive and furthering one's life requires effort. Immorality at this level would be exemplified by the freeloader or human parasite who avoids productive activity and attempts to defy his own nature as man, i.e., to deny that productive activity is required to sustain one's life.

Second, our dentists consciously chose to focus on the fact that their patients are individuals seeking a service. "The patient comes first ... and second and third. . . " "I object to managed care ... [because] it destroys the doctor-patient relationship. There is no freedom for the patient, no choice." Immorality at this level would be exemplified by denying the individual and rational nature of man and, instead, trying to render dental services to one's patients on some other basis, e.g., some collective standard: "They [managed care plans] look at averages; not real people." Another irrational standard would be "How much can I sell these patients, whether they need it or not?"

Third, our dentists recognize that what they have achieved is good: they have worked rationally, honestly, and diligently, and they have prospered. They value their achievement and are properly proud of themselves. Immorality at this level would be exemplified by the practitioners who approach life and work mindlessly, somehow barely getting by from year to year. Another example of immorality at this level would be the truly and honestly successful dentists who are willing to sacrifice their achievement for something they value less or should not value at all because it is, in fact, a threat to their life. An example would be the successful practitioner who joins a managed care plan from a sense of duty to society even after realizing that such an action would hurt his or her practice and livelihood.

Up to this point, our dentists are fine examples of moral people: they support themselves through honest, productive activity, and they show no tendency to sacrifice — neither themselves to others nor others to themselves. *This is the moral life.*

Our three dentists are now faced with what they think is a dilemma: stay with their original goal of high-quality dental care for those who want it, or join a managed care plan (MCP). As with their approach to establishing and maintaining their practice thus far, their approach in this matter is moral. They approach the matter rationally: they focus on the facts, including the values they rationally hold, explore all the angles they can think of, and arrive at a definite course of action aimed at preserving their lives and the rational values they hold. To be sure, they are not professional philosophers or even explicitly philosophical. They accept several false moral, economic, and political premises, but they do think independently enough to arrive at the moral course of action.

Whatever can be said about the moral code of self-sacrifice, one cannot say that it is a guide for successful living.

Let's look at how they approach their dilemma. They value the business they have developed and wish to see it prosper, but a new form of competition has emerged: managed care. All MCPs aim to control costs ultimately by reducing a practice's fees and controlling patient options. But if managed care translates into lower fees and more bureaucratic control, why are our three dentists even tempted to join a MCP? Two main reasons are given:

1. *Half of their patients now have insurance and many of those patients may become part of managed care plans.* What basis is there for this fear? There is a genuine risk that many patients will at least try the assigned or available dentists in their plan. Some may be satisfied and never return to our dentists' office. Some may be dissatisfied with the MCP but get the idea that

shopping around for a new dentist would not be a bad idea. The fact is that even if a provider decides to join as many MCPs as possible, there is always the risk that one's present patients will become members in another MCP and they will leave the practice. MCPs are a new form of competition and they will draw some of our dentists' patients away, at least initially.

2. *The market is changing: price is becoming paramount in patients' minds.* Is this true? Dentistry is a service that has always been price sensitive. Even those who have insurance are subject to some price discipline through deductibles, co-payments, and yearly limits. MCPs that promise no deductibles or co-payments will attract some patients. Our dentists' fees have always provided a sort of threshold over which some potential patients would not pass. However, if the dentists want patients who primarily care about the quality of the work they receive, then this should not be a consideration.

The dentists reject the plan for the following reasons:

1. *They believe it will not be possible to maintain the level of quality they want to provide.* This is true if they intend to maintain the level of profit they have maintained in the past. When income gets cut, quality and profit are under pressure. If they refuse to lower their standard of living, then quality will have to suffer. The attempt to maintain income levels while cutting the quality provided would result in a downward spiral of both income and quality until our dentists have neither the income nor the quality practice they started with.

Managed care can be said to work only if one thinks collectively.

2. *Patients lose the ability to choose.* This is true in some respects. If patients' present dentists are not in the new MCP, they must choose another dentist if they want the benefits of the MCP. Also, some dental procedures may not be covered by the new MCP. So, compared to fee-for-service insurance, there are more restrictions. However, patients are certainly free to stay with the dentist of their choice if they are willing to pay the fee.

3. *Doctors treat patients almost as wards of the MCP, rather than as sovereign individuals.* Managed care reduces the sale value of the practice because the plan would, in a sense, own the patients. Is this valid? Yes. As just one example, consider that some MCPs include "gag clauses" that forbid doctors from telling patients about treatment options beyond the plan's coverage. At the same time, more and more patients would come to our dentists' practice mainly because the plan sends them there.

4. *The insurance administrators come between the patient and the doctor, in an attempt to control their expenses.* "They look at averages, not real people." This is true, and at root, what makes MCPs potentially immoral constructs. Managed care can be said to work only if one thinks collectively, i.e., the care of the collective patient pool would be "satisfactory" even as some patients suffer. All the health care provided is viewed as belonging to the group rather than to the individuals. The healthy pay but don't seek care, while the ill use the resources provided by others. This is welfare — "free market socialism" as one of our dentists put it — applied to dentistry: the healthy subsidize the ill while bureaucrats make the rules and gain power over others' lives.

In summary, our dentists make the *moral* choice. They act to preserve their practice in its original well-considered form; they reject the lure of destructive MCPs. And they do it primarily for selfish reasons, as an act of self preservation. Immorality, in the "Managing Carefully" scenario, would have to involve irrationality at some level. An immoral trio of dentists might decide to join the MCP in question for any number of irrational, self-destructive reasons: they might evade the evidence against MCPs, they might decide that they owe a debt to society because of the wealth they have produced, they might decide that the crowd knows best and the crowd is moving toward managed care. Each case of immorality would involve some instance of irrationality, evasion, or lack of intellectual independence.

However, our three dentists' decision is far from firm: it was not reached with moral conviction and could change under severe enough pressure. They make their choice *despite* their view of morality not because of it. Of course, they hold the widespread view that self-sacrifice is moral and that selfishness, independence, is immoral. As an example of ethical behavior, one of our three dentists cites the fact that he occasionally sees Medicare patients and volunteers for school screenings. (In fact, charity is a marginal issue in ethics: charity is immoral if it involves self-sacrifice on the part of the charity giver or if the recipient is in need through some irrationality of his or her own. To provide charity in the first instance would be directly self-destructive; to provide it in the second would be unjust.) As another example of virtuous behavior, they cite acting professionally, which they say includes refraining from advertising and over-billing insurance companies, tactics that they believe are employed by their competition. Note that, in their view, both attempting to attract patients via advertising and cheating insurance companies are immoral acts. What these tactics have in common is *not* that they are dishonest but that the desired goal is to improve one's practice and income; that is, selfish motives are unprofessional and, therefore, unethical.

Each case of immorality would involve some instance of irrationality, evasion, or lack of intellectual independence.

"Virtue is fine — in a virtuous society. I hate managed care as much as any dentist does, but, let's be realistic, we're talking about survival" says one of our dentists. They are correct in calling "vir-

tue" a threat to their survival: if "virtue" means self-sacrifice, morality *is* a threat to one's survival.

The solution is not to shun morality or attempt to mix some rational life-serving elements in with the irrational ideal of self-sacrifice. For the same reason one would not temper a healthful diet with a little bit of arsenic and glass shards now and then. Rather, our three dentists must learn what morality is, rationally understood. It is a tool, a method for living successfully, and the more irrational and threatening any situation becomes, the more crucial it is that one live virtuously — as a matter of self-preservation. Then they will understand that there is nothing morally appealing about sacrificing oneself to one's patients, with or without a MCP. Also, they will understand that there is nothing rationally selfish about joining a MCP as a matter of expediency while sacrificing the long-term health of their practice. And perhaps most importantly, they will see that their decision to shun MCPs is virtuous and the only choice possible for them.

References

1. Rand A. The virtue of selfishness. New York, NY: New American Library, 1964.
2. Peikoff L. Objectivism: the philosophy of Ayn Rand. New York, NY: New American Library, 1991.

Looking for Virtue in a Virtuous Society — Discursive Ethics and Dental Managed Care

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

The essence of discursive ethics is using language to create relation ships.[1-2] What is right and what is good do not exist outside of human nature to be discovered by rational processes or revelation; they emerge as part of the process in which communities are created. The unethical individual is one who would be described by the Yiddish word *schnorrer* — one who seeks the benefits of participating in a moral community but is quick to find personal exceptions to excuse his or her own self interests.

Sometimes language is descriptive, and sometimes it performs functions.[3] Think of the relationships that are created through the following words: "I take thee to be my wife," "The jury finds the defendant guilty," "By the authority vested in me, and upon the recommendation of the faculty, I confer upon this class the degree, Doctor of Dental Surgery," or "I will be your dentist."

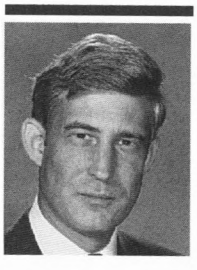
In each case, a relationship is created through these words that carries with it mutual expectations about future behavior.[4] Individually vulnerable people come together by discussing the implications of their cooperation and agreeing to abide by their common expectations for promised behavior.

To participate in a moral community means to make and honor promises that have been freely agreed to by all participants.[1,5] It is to *profess* both a relationship and the means of creating it. In this sense the phrase, "professionalism and ethics" is redundant.

Jurgen Habermas[1,2,5], a German philosopher and leading contributor to the theory of discursive ethics, underscores the belief that ethics arises in communicative action rather than within the isolated individual or abstractly in nature to be later discovered by individuals. "Ideas of the good life are not something we hold before us as an abstract 'ought.' Rather, they shape the identities of groups and individuals in such a way that they form an intrinsic part of culture or personality."[2, p. 108] This view is similar to the hermeneutic tradition or the constructionism of American pragmatic philosophy.[6]

Shortcomings of the "Golden Rule." Habermas launched his philosophical argument concerning ethics from the work of the last great modern Western philosopher, Immanuel Kant. Kant's famous categorical imperative ("I am never to act in any way other than so I could want my maxim also to become a general law")[7] is a restatement of the Golden Rule: do unto others as you would have them do unto you. Habermas believes that this popular principle is an inadequate guide to the moral life. A psychopath who believes all prostitutes should be murdered could easily generalize this belief. Hitler admired Kant's work. The "Golden Rule" too easily lends itself to paternalism as captured in the cynical "Rule of the Gold" — he who has the gold makes the rules.

The principle of discursive ethics states that "only those norms can claim to be valid that meet (or could meet) with the approval of all who are affected in their capacities as participants in a practical discourse."[2, p.66] This means that dentists, without coercion, must actually agree to all of the consequences likely to follow from participation in managed care contracts. It means that patients, without coercion, must actually agree to all of the likely consequences of participation in fee-for-service dental care or to any of its alternatives. It is not good enough to perform a thought experiment along the lines, "If everyone else were like me, they would agree that what I am about to do is right" or for a group of dentists to decide what is best for patients.



Dr. Chambers is Professor and Associate Dean for Academic Affairs, University of the Pacific School of Dentistry, 2155 Webster Street, San Francisco, CA 94115.

Communicative vs Strategic Action. It is clear that many significant and real debates in health care fall outside the moral bounds of discursive ethics. Dentists complain they are the victims of raw economic power in some managed care markets or of bureaucratic aloofness in the application of multiplying government regulations. These same dentists would be alarmed if patients became over questioning or attempted to negotiate their fees. This kind of discussion — I will stack my self interests and my power up against your self interests and your power — have nothing to do with ethics. They are called "strategic action," and their aim is to produce specific, desired results. The alternative, communicative action, involves agreement on reasons and consequences of action among free and informed participants. There is nothing inherently "evil" in strategic communication; the danger to be guarded against is dressing up strategic communication in ethical trappings and attempting to pass it off as morality.

The Objectivity Trap. There is something humanistic in discursive ethics; both in the sense that the good, the true, and the beautiful can be found in human nature and that there are no morally privileged positions. So-called objectivity is just a mental game of pretending to have a perspective other than one's own. It is an attempt to know something without participating in the act. In its most dangerous form, this pretended external truth (with no human fingerprints on it) turns out to support the personal beliefs of those who discover it, often resulting in a system of self-righteousness that is not open for discussion by others.

A more modest and defensible position about which beliefs support life devoted to the good, as well as the true and the beautiful, is intersubjectivity. There is much to be said for living in communities where our behavior is intelligible and predictable to others and where we advance each other's good because we recognize it as our good as well. Thomas McCarthy puts this humanism in the following terms. "Members of our species become individuals in and through being socialized into networks of reciprocal social relations, so that personal identity is from the start interwoven with relations of mutual recognition. This interdependence brings with it a reciprocal vulnerability that calls for guarantees of mutual consideration to preserve both the integrity of individuals and the web of interpersonal relations of which they form and maintain their identities."[9, p. x] This web is the moral community.

So-called objectivity is just a mental game of pretending to have a perspective other than one's own.

Interchangeable Perspectives. The intersubjectivity of members of a moral community is more than a club of individuals who speak and act the same or share common self interests. Lawrence Kohlberg is a psychologist who has studied moral development[10] and believes that the highest levels of ethical standing include recognition that one's perspective is interchangeable with the perspectives of others in the community. Interchangeable perspectives mean that we can see things from other's points of view, we know that others understand our motives, and that the same actions cannot simultaneously be appropriate for us and inappropriate for others. That is what it means to speak in the first person plural — "we."

The Emotional Test. One way to test ethical perspective is by analyzing emotions. Ethical philosophers usually have *none* because they are engaged in an exercise of rational analysis rather than moral analysis. The popular definition that ethics is the study of right and wrong leaves the matter in the hands of a few "professional ethicists."[11] A sense of *moral superiority* comes from a pseudo ethics or an objective view that brackets one's own perspective out of consideration. Common forms of this include the "naturalistic fallacy" that just because something exists and has for some time is reason to believe it ought to exist. This is what Voltaire panned so cleverly in *Candide* ("This is the best of all possible worlds" — because it is the only one). A more dangerous form of this argument is the "ethnocentric fallacy" which mistakes my own prejudices as an adult, white, well-educated, Western male as some how being important moral principles. The emotions that more accurately signal ethical danger are a combination of *resentment, indignation, and sadness.*[12] These are the emotions that lead to considered public action. *Anger and defensiveness* are another kind of emotion and usually indicate a threat to self interests rather than to moral community.

Post-Modern Philosophy. Although discursive ethics may seem attractive for organized dentistry or for professional groups such as the American College of Dentists, most dentists find it foreign and just a little out of reach. Dental education is grounded in the objective sciences that can be "seen" (experts must have slides) and an old pedagogy of "right and wrong" answers (picked from a short list of alternatives). Dental practice cherishes the image of the rugged individualist and presumes an inherently unequal relation between dentist and patient.

Dentistry is a thoroughly modern art and science, being born in the early 1700s with the help of Pierre Fauchard. Philosophers call this period from 1650 through 1850 the modern age, or the era of objectivity. Most of the theories of ethics being considered by dentistry today were developed well before that period. All of them share the assumption that it is possible to create an ethical system that is complete and rationally defensible and that the remaining ethical questions are largely matters of discovering the true principles and ensuring their implementation.

Linguistic analysis, communicative action, pragmatism, and the other philosophical underpinnings of discursive ethics are all examples of post-modern phi-

losophy. There is no clear definition of post-modernism, but post-moderns seem to agree that explanations can be complete or consistent, but not both simultaneously and to favor theories which lead to useful consequences over those purporting rational truth. The social sciences and physics, mathematics, and computer artificial intelligence have already moved beyond modernism. The biological sciences and medicine have not. Douglas Hofstadter's Pulitzer Prize winning *Godel, Escher, Bach: An Eternal Golden Braid*[13] offers a semi-popular introduction to post-modernism.

For the post-modern, there is no rational escape from the tangle of inconsistency, incompleteness, and personal perspective. Referencing a moral principle that is consistent with one's actions is not convincing evidence of acting ethically. It is often an act of ethical justification. The principles either do not cover all situations sufficiently (incomplete) or several might apply (inconsistent), and there is no "superior" perspective from which completely defensible choice is possible. The same criticisms could be applied in other forms to most currently popular approaches to dental ethics.

Post-moderns reverse the usual order between reasoning and moral action. The ethical imperative is to seek moral community through action, not to seek personal certainty as a precondition for action. We find out who we are and what we stand for at the table; not before we go there. As the founder of American pragmatism, Charles S. Pierce, expressed it: "But above all let it be considered that what is more wholesome than any particular belief is integrity of belief; and that to avoid looking into the support of any belief from a fear that it may turn out rotten is quite as *immoral* as it is disadvantageous."[14, p. 111]

At the Table

The case "Managing Carefully" is only superficially about ethics. It is principally a discussion among three dentists about their economic self interests with occasional references to the suspect motives of others. The only promise that is made in the case is to continue to treat patients as they have been treated in the past, despite the acknowledgment from Ross that "times change, this is not the 60s. These are not the same patients we started with" and "they say they would like to stay with us, but they can't afford it."

Many would applaud the decision of these three dentists. If it doesn't exactly fit the Golden Rule, there are certainly many dentists who believe with Ross that "If the profession will just stick together, . . . this thing is going to blow over."

What is missing in these dentists' conversation is a sense that the moral community — those effected by their decisions — might also include purchasers such as the teachers union and the computer company referred to in the case, patients themselves, and the dentists' "so-called" colleagues who have different perspectives on the issue. They are not at the table; they are not part of the moral community envisioned by these dentists. Although the dentists are in dialogue with the managed care broker through the contract, there is little specific discussion about it and Hal is clear that he "doesn't care what anyone says [about it]." The dentists are presuming to speak for the patients and the purchasers without specifically inviting them to participate.

Perhaps dentists' deciding what is in patients' best interests can be defended on scientific ground, but it cannot be defended ethically. For example, consider the issue of professionals advertising which the three dentists find objectionable in their colleagues. This has historically been considered an ethical issue involving the relationship between professionals who advertise and those who do not. It can also be considered an issue between dentists and patients. The historic prohibition against "selling" on the part of professionals may actually stem from the relationship that this creates between the professional and the patient. "Sellers" are in relationship to "buyers," and buyers have the power of saying yes or no. If dentists are not considered "sellers," patients cannot claim the rights of "buyers." When dentists seek to dominate the dentist-patient relationship and limit treatment alternatives to those that are professionally most favored, the communication is strategic rather than communicative. As Habermas points out, "The argument made possible by discourse depends on two things: the individual's inalienable right to say yes or no and his overcoming of his egocentric viewpoint."[2, p. 202]

The fight over managed care is largely at the strategic level, working out whose self interests will be served. As Jerry observes, "The measure of any practice is the patients — whoever owns the patients owns the practice."

The fight over managed care could become an ethical discussion if the verb is shifted from "control" to "communicate." There are signs that the dental profession is taking the lead over third-party brokers in communicating with both patients and purchasers. If such communication is sincere — if there is open listening — the dentist-patient and the dentist-purchaser relationships will be preserved. If it is nothing more than competition for patients and whether dentists will be able to maintain their historic monopoly on defining value in oral health care, the profession can well anticipate several decades of compromise. The future of the profession will be significantly influenced by whom it chooses to talk with. Either dentistry must find a way to talk with patients and providers as autonomous in-

No ethical community can be created for those who do not recognize that the rules they use to judge others must be the rules they use to judge themselves.

dividuals, or dentistry will increasingly find itself talking with the lawyers for third-party brokers.

We must look at Hal's contention that managed care companies "look at averages; not real people." The French, post-modern philosopher Michel Foucault takes the position that all practice that reduces individuals to norms or averages is inherently unethical because it robs them of their unique identity.[15] The debate over treating or accounting based on individual patients *or* aggregates is a misstatement of the issue. A significant challenge facing the profession in the next few years will be to discover ways of thinking and talking about the delivery of care and the management of practices that combines understanding of both the individual *and* the group. Dental science is made stronger by this double vision — an SNA angle can only be fully interpreted by knowing the age group from which the measurement comes. The same might be true of business practices.

At least since Biblical times, there has been an argument whether intentions or motives could be unethical. "Whosoever shall kill shall be in danger of the judgment: but I say unto you that whosoever is angry with his brother without a cause shall be in danger of the judgment." (Matt 5:21-22.) Today we are principally concerned with actions as being unethical. But the proponents of discursive ethics would have us pay more serious attention to how we talk. Not only are lying and making false promises outright unethical, negligence in speech damages relationships as well.

R. Alexy, a student of Habermas, has drawn up a little list of rules for how to talk in ethical discussions.[2] For example, one of Alexy's rules is that "Every person with the competence to speak and act is allowed to take part in a discourse." This is how we know immediately that the discussion between Hal, Ross, and Jerry is not an ethical discussion of what is best for patients. There are no patients present; the dentists speak for the patients. Another discourse rule is that "Every person may assert only what he or she really believes." There is no way to get inside Jerry's head, but I have heard many professional men and not a few career women justify the workaholic lifestyle they have chosen by saying they "owe it to their family." Most would be horrified at the thought of having a frank discussion with their families on this matter.

Of the other rules proposed by Alexy, one more will serve to illustrate the ethical confusion in the case being analyzed. This rule states that whatever is said about a particular situation must also be held to be true for all similar situations. It is the "What is sauce for the goose is sauce for the gander" rule. Hal, for example, condemns managed care brokers who "buy and sell patients." Twenty seconds later, Jerry asks the question what their practice would be worth if they sold it. Ross vilifies his "so-called colleagues" for "badmouthing" other dentists. Ross traces the success of the practice to selecting patients who want and can afford the type of care they offer (and presumably excluding others) while Hal damns the managed care brokers for reducing patient choice. Later Jerry uncovers a conspiracy that "somebody, and I don't know who it is" is pushing for a single standard of care. Insurance company executives who make money in the dental care market are chastised; dentists who do the same are not. In one sentence, Ross decries the erosion of free-market enterprise and in the next sentence calls for government protection of dentists' interests.

The problem in each of these situations is the dentists' blindness to interchangeable perspectives. No communication is possible and no ethical community can be created for dentists such as these who do not recognize that the rules they use to judge others must be the rules they use to judge themselves. Perhaps the most damaging of these linguistic fallacies is the claim by Hal that managed care is "tempting young dentists and others with weak ethics to abuse patients." Being young does not place one in the category of having weak ethics. ADA statistics show that the number of managed care patients per dental practice is the same regardless of the age of the practitioner. How can the profession have an honest discussion in the face of attitudes such as these?

Ethics emerges in honest discussion — not with those who already have the same self interests we do — but with everyone who is effected by our actions. It is a community activity characterized by free expression. The historic concern of the American College of Dentists with ethics is almost self explanatory: it is a group striving to become an ethical community. And the communications activities of the college are the principle vehicle for this. It seems only natural that one would look for virtue in the virtuous society.

References

1. Habermas J. The theory of communicative action. Vol 1. Reason and the rationalization of society. Boston, MA: Beacon Press, 1984.
2. Habermas J. Moral consciousness and communicative action. Cambridge, MA: MIT Press, 1993.
3. Austin JL. How to do things with words. New York, NY: Oxford University Press, 1965.
4. Chambers DW, Abrams RG. Dental communication. Sonoma, CA: Ohana Group, 1992. [Chapter 1: Characteristics of communication and Chapter 11: Treatment plan and informed consent].
5. White SK, ed. The Cambridge companion to Habermas. New York, NY: Cambridge University Press, 1995.
6. Dewey J. Reconstruction in philosophy. Boston, MA: Beacon Press, 1920/1962.
7. Kant I. Metaphysical foundations of morals. In Friedrich CJ, ed. The philosophy of Kant. New York, NY: The Modern Library, 1949.
8. Bernstein RJ. Beyond objectivism and relativism: science, hermeneutics, and praxis. Philadelphia, PA: University of Pennsylvania Press, 1983.
9. McCarthy T. Introduction. In Habermas J. Moral consciousness and communicative action. Cambridge, MA: MIT Press, 1993.
10. Kohlberg L. Essays on moral development. San Francisco, CA: Jossey-Bass, 1981.
11. Moon JD. Practical discourse and communicative ethics. In White SK, ed. The Cambridge companion to Habermas. New York, NY: Cambridge University Press, 1995.
12. Strawson PF. Freedom and resentment. London, UK: Oxford University Press, 1974.
13. Hofstadter DR. Godel, Escher, Bach: an eternal golden braid. New York, NY: Vintage Books, 1979.
14. Pierce CS. Values in a universe of chance. (Wiener PP, ed). Garden City, NJ: Doubleday Anchor, 1958.
15. Bernauer J, Mahon M. The ethics of Michel Foucault. In Gutting G. ed. The Cambridge companion to Foucault. New York, NY: Cambridge University Press, 1994.

Moral Problem-Solving in Managed Care

E. Haavi Morreim, PhD

The approach to moral analysis presented here does not appear on standard lists of ethics methodology. I think of it as "moral problem-solving," with an emphasis on practical considerations that are crucial for someone who wants to resolve a problem in a morally credible way.[1-2]

If we are trying to do the right things, theoretical agonizing is not always necessary, nor is it necessarily the best thing to do. Various schools of moral philosophy can help on the most profound, intractable issues, but as a matter of practical fact, many of our moral challenges are neither profound nor intractable. Our moral lives are normally comprised of complex situations whose constituent elements are often amenable to considerable alteration. Our moral aim should be, not to make dramatic choices that honor one value at terrible sacrifice to some competing value, but to invent a resolution that honors all the important values as well as possible. Sometimes terrible priority choices are unavoidable. But with a bit of ingenuity, those occasions can be much rarer than we might think. And such ingenuity is our moral obligation.

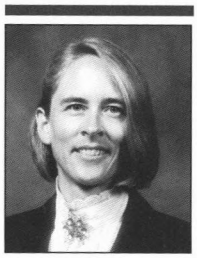
The first task in any morally problematic situation is to figure out what — really — is going on. In my own experience doing ethics consultations in a medical setting over the past sixteen years, I would estimate that in 70% - 80% of requests for consultation the real problem turns out to be a communication mix-up or a need for further factual information.

In other cases the problem stems from fallacies in reasoning. An example from my experience in medicine concerns a middle-aged lady with asthma who asked, during a routine check-up, how her lungs sounded. The physician judged that in fact they sounded somewhat poor, though not unusually bad for this particular patient. He was reluctant to say so, however, because the last time he did, her immediate anxiety reaction precipitated an asthma attack that led to three days in the hospital. He seemed on the horns of a dilemma: either be honest with her and possibly cause harm or avoid harm via some form of deception. But this analysis represents a false dichotomy, because it fails to uncover a major assumption. The physician implicitly presumes that for this lady, there is an unbreakable connection between hearing bad news and becoming highly anxious. That assumption must be questioned. Why does a mildly negative report about her lungs trigger such panic? Perhaps she cannot afford her medications or maybe she mistakenly believes that her condition is just like that of a relative or friend who recently died. The apparent ethical dilemma disappears when the problem can be reframed to address the fundamental issues, not their superficial manifestations.

In other words, moral problem-solving is often a "gum-shoe" fact-finding and problem-clarification effort. When done well, ethics dilemmas can sometimes be made to disappear. Two of the cardinal rules in such detective work are to seek primary sources of information and to avoid making unwarranted assumptions or relying on others' assumptions.

Some apparent moral dilemmas are real ones, of course, not resolvable by further information and clarification. Here, the key step is to identify the important values at stake. This requires identifying the people or groups who have a significant stake in the dilemma's resolution. Beyond that, identifying the important values will require thinking about the things that human beings cherish: wellbeing, freedom and autonomy, honesty, justice, compassion, and assorted others. In ordinary life, ethical challenges are usually entangled with a host of factors: political battles, logistic obstacles, emotional entanglements. But if the problem is to be resolved, all of them must be acknowledged to whatever extent they play an important role.

The final step is creative problem-solving. In many cases, the most obvious options may not be the ones that can best honor all the important, competing values. In that case, one's challenge is to invent new options that will do better. Traditional indemnity insurers, for in-



Dr. Morreim is Professor in the College of Medicine, University of Tennessee, Memphis at 956 Court, Box 11, Memphis, TN 38163. The author gratefully acknowledges the very helpful assistance and comments on earlier drafts provided by Fred Heros, DDS.

stance, tended until recently to reimburse a number of procedures only when performed in a hospital. The result was sometimes perverse and costly: a patient who would prefer to be at home, and who could be cared for much less expensively there, nevertheless might languish in a hospital. Finally recognizing the need to do better, many insurers and MCOs (managed care organizations) have installed case management systems that can sometimes develop more satisfactory alternatives.

Dentistry and Managed Care

If dentists are to address the problems of managed care, they must first understand them. That understanding must not be based on prevailing fashionable ideology, but rather on a clear, accurate, factual understanding. This is the gum-shoe step in moral problem-solving, and often it is the most important. Dentistry is significantly different from medicine, and these differences shape in significant and perhaps surprising ways the issues dentists actually face.

This section explores several common concerns about managed care, as captured in the conversation between Ross, Jerry, and Hal, and in the College's White Paper on managed care and ethics. The concerns listed here overlap somewhat, but each merits attention.

Managed care can force the dentist to provide poor-quality care. This concern arises from both of managed care's principal tools: controls and incentives. Utilization controls are used, partly because health care practices are based in incomplete science. Indeed, the White Paper inquires whether there is an ethical risk in allowing practice to get so far out ahead of its factual foundations. Fee-for-service practice, combined with generous insurance coverage, encourages a quick proliferation of technology, often before it has been adequately tested. Studies now reveal wide variations in health care practices that are not supported by much more than local habits, ideologies, and fashions.[3-22] The problem is profound in medicine, but not absent in dentistry.

While lavish funding has fueled proliferation of unevaluated treatment, aggressive cost containment has fueled rapid proliferation of unevaluated guidelines. In some cases these guidelines are not founded on science at all, but only on the consensus of a limited number of people disposed to favor conservative care. Other guidelines are based on outcomes studies carried out by MCOs, insurers, manufacturers of drugs and devices, and others with a significant conflict of interest in the outcome of the research.[23-27] Even a well-constructed guideline, if enforced by personnel who do not understand when exceptions are needed, can be pernicious. Dentists are understandably reluctant to follow them blindly.

Incentives likewise can leave the dentist in a difficult predicament. In regions where solo and small-group practices predominate, individual practitioners may have very little power to bargain over the terms of a managed care contract. Particularly for recent graduates with debts, or where an adequate fee-for-service practice is difficult to build, dentists may feel they have little choice but to accept managed care contracts, and on terms they find distasteful if not unethical.

If dentists are to address the problems of managed care, they must first understand them.

Realities, however, are more complex. For one thing, dentists are considerably more free than physicians to deliver appropriate care even when discouraged by incentives or other constraints. Physicians commonly must use costly technologies such as computed tomography or magnetic resonance for diagnosis, or even costlier drugs, devices, surgeries, and hospitalization for treatment. And usually these tools are owned, controlled, and paid for by other parties. If an insurer or MCO refuses to pay, or if a hospital refuses to let the physician use these tools without funding, the physician may have limited options.

Dentists, in contrast, rely almost exclusively on their own professional knowledge and skill, and on the tools they own in their offices. Hence, even if a third party refuses to pay for a particular intervention, the dentist can usually provide it, albeit at a personal expense in time and perhaps also materials. Rather than arguing that they are literally forced to provide poor care, dentists' more correctly stated claim is that they are placed in the unfair position of having personally to make up for payers' refusals to meet their obligations. Furthermore, while care that is foregone in medicine can mean death or major disability, this is rarely the consequence in dentistry where there is often more time to consider one's alternatives.

Moreover, inappropriate utilization decrees can often be appealed. Here, the real problem is that such appeals can cost precious time and aggravation, particularly when the insurer or MCO systematically installs such obstacles as part of its cost containment strategy.[28-30] At this point, the real ethical challenge is to identify at what point this constant fighting represents an undue "hassle-factor" that is above and beyond the call of ethical duty.[31]

Managed care forces the dental profession to reduce the standard of care. This concern, a variant of the one above, reaches deeper into philosophical issues because it inquires whether dentists should provide a single standard of care. The legal system, for instance, presumes that there is a basically uniform standard of care to which dentists and physicians can be held. Although the courts accept variation for reputable minorities, differing schools of thought, and to some extent different local practices, nevertheless there is an expectation that these varying styles should still lead to a comparable quality of care.[32-33] Alternatively stated, the standards question asks whether there is some minimal level of care, below which the dentist or physician should not dip. The very notion of professionalism seems to suggest an affirmative response.[34]

The traditional expectation of a single standard of care based on prevailing practices may have made sense in an era when health care providers had little to offer beyond their knowledge and skill, and it may have been reasonable so long as lavish funding meant that virtually everyone could have access to the latest and greatest developments. However, rapid proliferation of costly techniques, now combined with the urgent need to contain costs, opens the door to major questions regarding which interventions are worth pursuing, at what cost.

Some of the most obvious examples come from medicine: one clotlysis drug for patients with heart attack may provide a 1% improvement in mortality risk, but at ten times the cost of the leading alternative.[35-37] In most cases the tradeoffs are not clear choices among defined outcomes, but simply a change in risk, as when a costlier antibiotic brings a somewhat greater chance of curing or avoiding infection.[38] Dentistry carries its own comparable tradeoffs. A crown might be the ideal treatment in a given case, but in light of its higher costs, some patients would opt for extraction or an amalgam buildup.[39]

Such value choices should not be camouflaged under such notions as "medically necessary," "unnecessary," "standard," or the like. To judge, for instance, that the costlier drug is "necessary" implies that all patients must agree with this particular cost-value trade-off. More important, it presumes that all health plans must include this level of care. By implication, such coverage means that patients should have no alternative but to purchase this level of coverage, regardless of whether they might like to use that money for other ways to improve their health or reduce their risk of injury or illness or pursue other life goals.

When dentists insist that they must not be forced by managed care to change their style of practice, *the dentists* may be engaging in coercion of patients. To refuse to acknowledge that sometimes there is more than one acceptable way to solve a problem, and further that sometimes even a suboptimal treatment can still be acceptable, is to force patients to accept dentists' values about what prices are worth paying.

Encouragingly, the legal system is beginning to recognize the legitimacy of such variation. Courts have long acknowledged that health plans can legitimately differ in the level of resources they provide.[32,40] Recently courts have begun a trend away from a "judge-made insurance" that awards broad benefits to patients and toward upholding health plans' contractual limits more firmly.[40]

Managed care infringes patients' autonomy. Like the others, this concern has a very real basis. In many instances, patients who may previously have had indemnity insurance with an open choice of providers suddenly find themselves in a managed plan with limited provider and treatment options. They may not be informed about treatment restrictions and almost certainly have not been told about provider incentives such as capitation. Clearly, autonomy appears to be infringed.

Closer analysis, however, suggests that the managed care plan does not necessarily create this infringement. Suppose that a private citizen, fully informed about all a plan's provider and treatment limits and even about its incentive structure, made a judgment that, for the money he or she wants to spend on dental care, this plan suited his or her needs better than any other option. In that case, enforcement of the plan's limits would not represent any suppression of autonomy whatever. It would simply be implementing this person's own choices — an honoring of the autonomy owed to an adult who is competent to make his or her own decisions.

The real coercion may happen at the level of employers. Although employees often regard health care benefits as a "freebie" added to their wages, medical and dental insurance is in fact part of that compensation. Between 1970 and 1989, "employer expenditures ... for wages and salaries increased only 1% [while] employer spending for employee health benefits increased 163%."[41] When employers take their workers' money and make unilateral decisions about what health benefits to buy with little or no input from those whose money they are spending, they act coercively. In the case of medical care, once a health plan is chosen — and 84% of businesses that provide health care offer only one choice[42] — the employee has little alternative but to accept it, with whatever restrictions that entails.

Equally important, medical services are so costly that few people can directly pay for many of them out of pocket. A significant illness or injury bodes bankruptcy. In this respect, dentistry is different. Most people can directly pay for routine care. Even the costliest treatments, such as root canals, crowns, bridges, and implants, are within most people's reach if given a reasonable payment schedule. In this sense, employer-selected dental benefits do not leave employees nearly as helpless to pursue their own values as in the case of medical insurance. The restrictiveness might in some cases be unfair or improper, but the employee's autonomy has not been obliterated.

Managed care assaults professionalism, turning dentists' professional services into a mere commodity. Many MCOs throughout health care are attempting to standardize care, partly because, as noted above, so much of the variation in providers' practices has no scientific basis. Unfortunately, the guidelines themselves are often equally unscientific, stemming more from obvious cost savings than from care considerations. Such guides may amount to an "assembly line" care that ignores important differences from one patient to the next. The situation poses a significant problem because professions are in part defined by the fact that sophisticated judgment and individuality of care are required.

Though true and important, this argument should not be overrated. Patients are indeed individual, but if dentists or any other health-care providers were to claim that every patient is absolutely unique they would be denying that their profession is based on science. Science, after all, seeks pattern and regularity in the world. The real question, therefore, is not whether greater orderliness might

beneficially be brought to the practice, but whose order, based on what. As argued above, it is time to recognize that health care, including dentistry, involves not just scientific regularities, but also myriad cost-value tradeoffs about which people may legitimately differ.

Consumers normally have power of the purse. They command respect because, if their needs are not met, they can seek services elsewhere. In some more ideal world, it might be preferable for patients to seek care without worrying about financial matters. However, so long as resources are limited for the many goals to which human beings aspire, it is better to acknowledge prices and opportunity costs than to ignore them. Only when the economic dimensions of care are openly acknowledged can we begin to make intelligent decisions that assign proper priorities among our values.

Dentists like Ross in the hypothetical case may perhaps decry the emergence of a more vigorous marketplace in health care, and it must be conceded that a certain crudeness almost inevitably accompanies such changes. And yet the "good old days" in which there was "only internal marketing, ... comparable fees, and no bad-mouthing your colleagues" was marked by a high degree of control by the profession, not only over itself, but over those it served. As recent developments in antitrust law emphasize, when health care providers forbid each other to advertise, the result is higher prices.[43] Another predictable result is reduced choice: so long as costs are not part of the deliberation, it is easy for professionals to insist that they can only provide one level of care — the best — and that surely others are misguided if they dare suggest lowering that standard.[44] Many patients shared this view as long as widespread availability of lavish insurance, particularly for medical care, encouraged them to think that health care is free, and that one should never have to pay when it comes to health.[45] A greater room for patients to choose what they want in dental care will require an openness of discussion in which all parties acknowledge that good care is not free, that more economical approaches to care may be entirely acceptable, and that if one chooses a plan with limits, one must live with the consequences of the limits chosen.

Managed care places dentists in conflicts of interest. This problem has been widely discussed. On the one hand, it is well-recognized that fee-for-service financing creates a conflict of interest, namely to increase the volume and intensity of services in order to reap higher earnings. Conversely, capitation financing and other managed care incentives reward the dentist for limiting care. Perhaps the key moral worry is that while the former conflict is fairly obvious to patients who see that the more things the dentist does, the higher the bill goes, the latter conflict is not at all evident unless it is explicitly disclosed. Equally important, patients may never know which treatment options are being withheld unless they are extremely savvy.

Health care, including dentistry, involves . . . myriad cost-value tradeoffs about which people may legitimately differ.

The problem must not be underrated, because it can be deeply corrosive to the dentist-patient relationship. Perhaps the most damaging element is secrecy. Somewhat like marital infidelity, the patient may suspect that the dentist is not being fully candid, yet a reluctance to confront the issue may sow seeds of distrust that are never adequately addressed. The remedy for this, however, is well within the dentist's control. Honest discussion of the nature and limits of the patient's health plan, combined with a good-faith effort to deliver the best possible care within those constraints can at least restore communication that is the indispensable substrate for trust.

Managed care can adversely affect access to dental care. Access concerns need to be subdivided. Sometimes this refers to patients' ability to gain access to any care at all ("general access") and sometimes to their ability to use the particular providers and treatments of their choice ("specific access").

In medicine, some sort of health plan is necessary for most people to have general access to health care. Although in many cases the move from indemnity insurance to managed care is prompted by businesses' need to contain costs, the implications go further. In some cases it is the only way in which an employer can continue employee health benefits, or perhaps even to add them where they were not already provided.[46] Thus, some specific limits on provider and treatment choices may be the only way to broaden general access to care.

In dentistry, however, managed care cannot be analyzed in quite the same way. The cost of dental care is not financially prohibitive for most Americans, and even a serious dental problem does not ordinarily bode economic ruin. Thus, managed dental care cannot be seen as crucial to access in the same way it may be for medical care. In some situations it may actually enhance general access, though in most cases managed dental care probably represents an employer's attempt to limit its outlays for a benefit its workers have been receiving.

Against this background, it becomes important to assess what effects financial subsidies have on access to care and on the relationship between dentists and patients. In some ways, the effect of indemnity insurance — the direct payment of incurred costs — is perverse. Although insurance makes it much easier to see a dentist, with a wide range of treatment and provider choices, two side-effects are sobering. First, widespread insurance coverage can actually hinder access for those who lack coverage. Once patients are economically insulated from the costs of their care, fees tend to rise, along with volume and intensity of services. Such a rise in the cost of care can make access considerably more difficult for those who pay out of pocket. Sec-

ond, a rich level of coverage may inhibit an optimal relationship between dentist and patient. The less the patient needs to think about costs, the less reason he or she has to discuss carefully the care that the dentist recommends. As long as there is not some other cost, such as pain or time away from work, the patient may be inclined to say "let's just do whatever you think is best, Doctor; my insurance will cover it."

Typical dental insurance, however, may provide something of a check on this pattern. Since many plans require a substantial copay, patients still have a significant financial interest in careful conversations with their providers. And providers have an ongoing reason to ensure the satisfaction of people who can take their business elsewhere.

Managed care, in contrast, tends to insulate patients almost entirely from the costs of their care. On one level this enhances access, since there are no financial barriers to care. And managed plans do not tend to raise the fees, volume, or intensity of services, so they do not have the perverse effect of chilling access for the people who pay out of pocket. However, the patient's ease of agreeing to a recommended treatment is counteracted by the necessity, within managed plans, to restrict the treatments to be recommended. Furthermore, this economic insulation can also impede relationships, possibly even more so than in indemnity insurance.

Fortunately, in the case of dental care the constraints are not unmanageable. The option to seek care out of plan or out of pocket is genuinely available for most people. Accordingly, a crucial moral task is to ensure that patients understand enough about their managed care plan to make intelligent decisions about when to stay within it and when to move on.

Deeper Issues and Moral Problem-Solving in Managed Care

The real moral challenges of managed care are a bit different than commonly envisioned. Dentists are not often literally coerced to provide bad care; standards of care may rightly be more flexible than some observers presume; the curtailment of patients' autonomy may sometimes come more from the employer than from the MCO; even under restrictive plans, patients retain considerable freedom regarding dental care because it is generally much more affordable than medical care; and regarding health care as a service subject to cost-value tradeoffs may be a salutary development.

But some very real problems remain in three major areas. First, patients need greater freedom to act on their own cost-value priorities, especially in choosing among plans and in making choices within plans. This may require revising the connection between employment and health care. Patients may also be inadequately informed by employers, plans, and providers alike about the limits and incentives built into their chosen or assigned dental plan. And patients may be so economically insulated that employers or payers who incur the economic risks of dental care may be unwilling to permit them the freedom to make unfettered treatment choices.

A crucial moral task is to ensure that patients understand enough about their managed care plan to make intelligent decisions about when to stay within it and when to move on.

Remedies could take a variety of forms, which can only be briefly suggested here. A greater diversity of choices among plans might be achieved by the kind of purchasing pools that are emerging for medical plans. The federal government, for instance, contributes a defined amount to enable each employee to choose among several hundred plans, with employees paying any difference between the government subsidy and the actual premium if they choose a higher-cost plan.[47] A number of purchasing pools in the private sector, some for large employers and some for small companies, achieve a similar result.[48-51] In many of these pools, independent agencies gather factual information to help subscribers choose knowledgeably among the plans. Those who create such pools can, if they wish, require eligible plans to submit detailed information about their rules, procedures, financial condition, and a host of other factors. Patients can be brought into economic contact with their care either by retaining a significant copayment or, if it is thought desirable to avoid any financial barriers to care, by a variant of medical savings accounts in which copays are made from a dedicated fund of money whose remainder is kept by the patient at the end of the year.

Second, dentists may need better opportunities for fair negotiation with health plans. If solo practitioners find themselves unable to avoid morally, economically, or professionally distasteful contractual arrangements, then a better bargaining leverage needs to be created. Dentists need to find ways to mitigate the conflicts of interest that arise under various payment systems and to disclose appropriately those that cannot be avoided.

In fact, dentists may be able to arrange greater flexibility in contracting than they might suspect. Individual practitioners need not regard a contract as written in stone. With the assistance of good legal counsel, a number of provisions can be modified in many cases. Further, dentists need not necessarily act alone. Although antitrust problems arise immediately if otherwise-independent dentists collaborate regarding the terms and rates to which they'll agree, some kinds of associations can create a numerical strength that may permit substantial leverage in negotiation. Physicians have been creative in this area, forming

independent practice associations, group practices without walls, traditional group practices, and even unions. Dentists may need to construct new associations of their own.

Third, if utilization guidelines are too often based on little or no scientifically acceptable research, dentists need to find ways to fill that gap, and they need to figure out how to manage inappropriate utilization verdicts in the meantime. As noted in the White Paper elsewhere in this issue, such research is growing rapidly among managed care providers. Further, once it is recognized that there can be more than one acceptable way to treat a variety of conditions — including some that are less optimal because they are less costly — dentists as a profession need to decide just what they will consider to be the minimum quality of care that any member can provide. Such standards need to be based, not on customs or on a concern to preserve practice revenues, but on a thoughtful philosophical dialogue about what the profession means.

References

1. Morreim EH. Philosophy lessons from the clinical setting: seven sayings that used to annoy me. Theoretical Medicine 1986;7:47-63.
2. Whitbeck C. Ethics as design: doing justice to moral problems. Hastings Center Rpt 1996;26(3):9-16.
3. Burnum JF. Medical practice a la mode. The New England J Med 1987;317:1220-2.
4. Wong ET, Lincoln TL. Ready Fire!...Aim! J Amer Med Assoc 1983; 250:2510-3.
5. Grimes DA. Technology follies: the uncritical acceptance of medical innovation. J Amer Med Assoc 1993;268:3030-3.
6. Garber AM. No price too high? New England J Med 1992;327:1676-8.
7. Weinberg JE. Which rate is right? New England J Med 1986;314: 310-1.
8. Chassin MR, Brook RH, Park RE, et al. Variations in the use of medical and surgical services by the Medicare population. New England J Med 1986;314:285-90.
9. Wennberg JE, Freeman JL, Culp WJ. Are hospital services rationed in New Haven or over-utilized Boston? Lancet 1987 1;1185-8.
10. Chassin MR, et at. Does inappropriate use explain geographic variations in the use of health care services? J Amer Med Assoc 1987;258:2533-7.
11. Wennberg JE. Outcomes research, cost containment, and the fear of rationing. New England J Med 1990;323:1202-4.
12. Leape LL, Park RE, Solomon DH, Chassin MR, Kosecoff J, Brook RH. Does inappropriate use explain small-area variations in the use of health care services? J Amer Med Assoc 1990;263:669-72. 13. Leape LL, Park RE, Solomon DH, Chassin MR, Kosecoff J, Brook RH. Relation between surgeons' practice volumes and geographic variation in the rate of carotid endarterectomy. New England J Med 1989;321:658-7.
14. Wennberg JE. Unwanted variations in the rule of practice. J Amer Med Assoc 1991;265:1306-7.
15. Cleary PD, Greenfield S, Mulley AG, et at. Variations in length of stay and outcomes for six medical and surgical conditions in Massachusetts and California. J Amer Med Assoc 1991;286:73-9.
16. Fisher ES, Welch HG, Wennberg JE. Prioritizing Oregon's hospital resources: an example based on variations in discretionary medical utilization. J Amer Med Assoc 1992;267:1925-31.
17. Greenfield S, Nelson EC, Subkoff M, et at. Variations in resource utilization among medical specialties and systems of care: results from the medical outcomes study. J Amer Med Assoc 1992;267:1624-30.
18. Welch WP, Miller ME, Welch HG, Fisher ES, Wennberg JE. Geographic variation in expenditures for physicians' services in the United States. New England J Med 1993;328:621-7.
19. Miller MG, Miller LS, Fireman B, Black SB. Variation in practice for discretionary admissions. J Amer Med Assoc 1994;271:1493-8.
20. Detsky AS. Regional variation in medical care. New England J Med 1995;333:589-90.
21. Guadagnoli E, Hauptman PJ, Avanian JZ, Pashos CL, McNeil BJ, Cleary PD. Variation in the use of cardiac procedures after acute myocardial infarction. New England J Med 1995;333:573-8.
22. Pilote L, Califf RM, Sapp S, Miller DP, Mark DB, Weaver D, Gore JM, Armstrong PW, Ohman M, Topol EJ for the GUSTO-l investigators. Regional variation across the united states in the management of acute myocardial infarction. New England J Med 1995;333:565-72.
23. Task Force on Principles for Economic Analysis of Health Care Technology. Economic analysis of health care technology: a report on principles. Ann Intern Med 1995:122:61-70.
24. Kassirer JP, Angell M. The Journal's policy on cost-effectiveness analyses. New England J Med 1994;331:669-70.
25. Evans RG. Manufacturing consensus, marketing truth: guidelines for economic evaluation. Ann Int Med 1995;123:59-60. 26. Gerber AM. Can teaching assessment control health spending? Health Affairs 1994;13(3):115-26.
27. Kessler DA, Rose JL Temple RJ, Schapiro R, Griffin JP. Therapeutic-class wars — drug promotion in a competitive marketplace. New England J Med 1994;331:1350-3.
28. Grumet GW. Health care rationing through inconvenience: The third party's secret weapon. New England J Med 1989;321:607-11. 29. Light DW. The practice and ethics of risk-rated health insurance. J Amer Med Assoc 1992;267:2503-8.
30. Light DW. Life, death and the insurance companies. New England J Med 1994;330:498-500.
31. Morreim EH. Balancing Act: The New Medical Ethics of Medicine's New Economics. Washington DC: Georgetown University Press, 1995.
32. Morreim EH. Rationing and the law. In: Strosberg MA, M. Wiener JM, Baker R, Fein IA, (eds). Rationing America's medical care: The Oregon Plan and beyond. Washington, DC: Brookings Institution, 1992, 159-84.
33. Morreim EH. Stratified scarcity: Redefining the standard of care. Law, Medicine and Health Care 1989;17(4):356-67.
34. Pellegrino E, Thomasma D. A philosophical basis of medical practice. New York: Oxford University Press, 1981.
35. The GUSTO investigators. An international randomized trial comparing four thrombolytic strategies for acute myocardial infarction. New England J Med 1993;329:673-82.
36. The GUSTO investigators. The effects of tissue-plasminogen activator, streptokinase, or both on coronary-artery patency, ventricular function, and survival after acute myocardial infarction. New England J Med 1993;329:1615-22.
37. Lee KL, Califf RM, Simes J, Van de Weft F, Topol EJ. Holding GUSTO up to the light. Ann Int Med 1994;120:876-81.
38. Eddy DM. Applying cost-effectiveness analysis: the inside story. J Amer Med Assoc 1992;268:2575-82.
39. Bernard v. Char, 903 P.2d 667 (Hawaii 1995), 903 P.2d 677 (Hawaii 1991).
40. Morreim EH. Moral justice and legal justice in managed care: the ascent of contributive justice. J Law Med Ethics 1991;23:247-65.
41. Report to the Board of Trustees, AMA Direct contracting with employers: a strategy to increase physician involvement in the current health care market. Report 27-A-95, p 1.
42. Blendon RJ, Brodie M, Benson J. What should be done now that national health system reform is dead? J Amer Med Assoc 1995;273:243-4.
43. Virginia Pharmacy Bd. v. Va. Consumer Council, 425 U.S. 748 (1976).
44. Havighurst CC. Health care choices: private contracts as instruments of health reform. Washington, DC: American Enterprise Institute, 1995.
45. Morreim EH, Redefining quality by reassigning responsibility. Amer J Law Med 1994;20(1-2):79-104.
46. Mirvis DM, Chang CF, Hall CJ, Zaar GT, Applegate WB. TennCare — health system reform for Tennessee. J Amer Med Assoc 1995;274:1235-41.
47. Butler SM, Moffit RE. The FEHBP as a model for a new Medicare program. Health Affairs 1995;14(4): 47-61.
48. Shewry S, Hunt S, Ramey J, Bertko J. Risk adjustment: the missing piece of market competition. Health Affairs 1996;15(1):171-81.
49. Robinson JC. Health care purchasing and market changes in California. Health Affairs 1995;14(4):117-30.
50. Luft HS. Modifying managed competition to address cost and quality. Health Affairs 1995;15(1):23-38.
51. Schauffler HH, Rodriguez T. Exercising purchasing power for preventive care. Health Affairs 1996;15:73-85.

A Moral Development Perspective Applied to a Case on Dental Managed Care

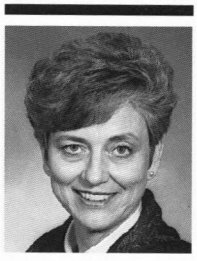
Muriel J. Bebeau, PhD, FACD

Moral psychology is interested in understanding how people come to make and implement defensible moral decisions. To address this question, the psychologist first asks why people tend to act unethically. Are they just plain bad? Actually, a great deal of improper conduct is committed by fundamentally decent people who believe in and are committed to ethical values. When Midwest Savings and Loan President Hal Greenwood was convicted on multiple charges of fraud, some jurors commented that Greenwood was a basically good person who just got caught up in a series of questionable activities. A review of psychological research[1] would support that possibility. There appear to be four fundamental reasons why people sometimes fail to do what others consider moral:

One is a problem of *moral blindness*, the failure to perceive all the ethical implications of conduct. Imagine a dentist who believes he has achieved consent for dental treatment, but fails to recognize that the sweet little lady in the dental chair is seriously cognitively impaired. The dentist may be well intentioned, but blind to the symptoms of impaired decision making. Or, imagine the dentist who fails to see the moral implications of a "gag order" included in the managed care contract he signed.

A second problem is *defective reasoning*. History is replete with shocking instances of crooked thinking. Remember how Nazi officers defended killing millions of Jews on the basis of their duty to obey authority? Or Nazi physicians' justification of the use of concentration camp prisoners for lethal experiments? Although one needn't rely on history for examples of defective reasoning, the reasons advanced by Nazi officers and physicians during the Nuremberg Trial served as a catalyst for psychologist Lawrence Kohlberg's pioneering efforts to understand how reasoning processes developed, how education inhibited or promoted development, and how the capacity to "think like a philosopher" related to moral judgment and action.

After thirty years of research, there appears to be pretty convincing evidence that there are conceptually different problem-solving strategies used by people to handle moral problems.[2] The strategies form a developmental hierarchy. What we mean is that some strategies are more adequate than others, in the same way that some conceptual frameworks for handling math problems are more adequate than others. For example: Persons who know calculus can handle more complex problems than people who only know algebra. Persons who know long division can handle more complex problems than persons who can only add and subtract. As the demands of the problem increase, these mathematical systems can be applied with greater efficiency. For many of the math problems one encounters in day to day life, addition and subtraction work just fine. We may rarely need to use algebra or calculus to handle day to day problems. Likewise in the moral life, most of the problems we face in day to day life are covered by existing laws and rules. Our decision is whether to *do* what we should, not what we *should* do. While it is helpful to understand the rationale behind existing rules or laws, and helpful to have developed the capacities to apply conceptually adequate moral frameworks to new or old moral problems



Dr. Bebeau is professor in the department of Preventive Sciences at the University of Minnesota School of Dentistry; Director of Education for the Center for the Study of Ethical Development; and Faculty Associate with the Center for Biomedical Ethics at the University of Minnesota. She was inducted as an Honorary Fellow of the College in 1986 for her work in ethics.

(i.e., to "think like a philosopher"), it is not essential for leading a moral life. But in the professions, one is likely to encounter new moral problems, ones that haven't been adjudicated. In such instances, competence in moral reasoning becomes a necessary survival skill. Professionals are expected to distinguish among competing values, to prioritize conflicting rights and develop a morally-defensible course of action.

The psychologist first asks why people tend to act unethically.

But, knowing one's moral responsibility is, of course, no guarantee that one will do it. A third problem occurs when an individual fails to give *priority to moral concerns*. A few years ago the dental profession worried about an oversupply of dentists and a decreasing incidence of disease, conditions which could stress the professional's commitment to put the patient's interests first. Today the profession is concerned about the proliferation of managed care arrangements that tempt the dentist to cut corners on patient care in order to maintain a profitable practice. The potential for such a problem to have far reaching consequences for the profession and the public becomes even more apparent when we consider human nature. Daniel Goleman,[3] in his book *Vital Lies, Simple Truths: The Psychology of Self- Deception*, highlights our capacity for developing elaborate and internally persuasive rationalizations for prioritizing nonmoral values over moral ones. As an example, Goleman cites John Dean's confession in his book "Blind Ambition," wherein Dean stated that his actions as special counsel to President Nixon during Watergate were motivated by a desire to succeed, and that questions of morality and justice were set aside.

Michael Josephson[4] notes that rationalizations for assigning priority to nonmoral values seem to be related to three kinds of selfishness: *self-indulgence* — the belief that one is entitled to the "good life" because one has suffered to achieve one's professional status; *self-protection* — the desire to avoid unpleasant and embarrassing confrontations through lying, concealment, blame shifting, and even document destruction; and *self-righteousness* — the tendency to judge ourselves in terms of our best and most noble virtues and motivations. Because self-esteem and self-respect depend on a positive assessment of one's own character, most of us believe we are ethical, even when an independent assessment of personal actions might prove otherwise.

Finally, moral failings can result from an *inability or unwillingness to implement* an effective plan of action. Poor interpersonal skills and poor problem solving abilities interfere with effective resolution of a problem. Likewise, fatigue and lack of ego strength contribute to ineffectiveness. For professionals, lack of impulse control or ego strength are less likely to account for failure to implement effective plans than are ineffective negotiation and interpersonal skills. Research on self-regulation processes shows that persons who think a task is enjoyable, or challenging, are more likely to persist in their efforts to resolve a problem.[3] Conversely, persons who approach a problem with dread, are less likely to persevere. Practice in resolving difficult problems of the profession — such as responding to an apprehensive or angry patient, or discussing a quality issue with an offending peer — can change the expectation of efficacy which is likely to change behavior.

Perhaps you can see that failure to behave morally isn't just a matter of scrupulous vs. unscrupulous moral character, but actually relates to deficiencies that can be overcome through carefully designed educational experiences. This is not to suggest that ethical reflection can transform scoundrels into saints (it is not even clear that intensive psychotherapy can accomplish that), but it is to suggest that ethical action is the product of a number of integrated abilities.

We can provide practice (a) interpreting situations, (b) formulating a morally ideal course of action, (c) prioritizing personal and professional values, and (d) developing practical and effective plans of action. In my view, the goal of ethics education should be to help participants examine their competence with respect to these abilities and then to strengthen them.

Perhaps you can see why ethics education needs to expand beyond the content of courses in philosophy. Even though this content is the very foundation for moral argument, the ability to construct a well-reasoned argument alone will not result in effective ethical *action*. In fact, the development of the ability to reason, in isolation from related abilities and implementation skills, often leads to the kind of cynicism we sometimes see in young professionals — professionals who haven't yet worked out ways of integrating what they ought to do morally with what they can do practically.

There are conceptually different problem-solving strategies used by people to handle moral problems.

But, is there evidence that practicing these abilities improves them, and more importantly, translates to professional behavior? Much of our work at the Center for the Study of Ethical Development over the last fifteen years has focused on understanding the effects of applied ethics education on professional ethical decision making. Recently Center colleagues Rest and Narváez[2] drew together studies from a variety of professions, including dentistry[5], that show that practicing the abilities we define improves them, that major ethical develop-

ment occurs after adolescence, and that improved reasoning predicts clinical performance.

The Case from a Developmental Perspective

With this brief overview of the components of morality, what would the psychologist look for in a case such as the case presented here. First, one must add the disclaimer that the psychologist could not make reliable judgments about the ethical development of the story characters based on this simple narrative account. Nonetheless, the account offers some insight into the participants' *sensitivity* to issues. We can examine what the participants seem to attend to and what they seem to ignore. Clearly, if they fail to see a moral issue, it will not be reflected in the rationale offered in defense of their decision. By listening to the *rationale* participants offer, one can gain insight into whether the person consistently applies a conceptually coherent moral framework to decision making. The philosopher may be interested in the *particular* moral framework the person brings to decision making; the psychologist looks to *whether* the person brings a coherent moral framework to decision-making, or bases decisions on some less adequate framework. For example, a person might develop a line of argument that focuses on maintaining self-interest at the expense of the interests of others; or an argument that considers only the interests of persons with whom one is affiliated; or an argument that exhibits an unreflective obedience to existing law, religious dogma, or other source of moral authority. Psychologists tend to make much more gross-grained distinctions than the philosopher, distinctions that reflect life-span development. Finally, by examining the decision participants make, one can infer how they prioritize moral concerns.

Ethical action is the product of a number of interrelated abilities.

Based on the information provided in the case, let's examine evidence for each of the processes involved in moral decision making. To what extent are these practitioners aware of the moral issues embedded in the case? How do they appear to be reasoning about these issues? How do they appear to conceptualize their role and responsibility as professionals? What appears to be their commitment to the ethics of the profession? What personal qualities and implementation competencies are reflected in their decision?

Moral Sensitivity. These dentists seem well-versed in the variations on managed care contracts and the ethical implications of signing contracts that interfere with their ability to make a profit at the expense of quality care to the patients. They have developed their business acumen and are using available resources, such as the ADA contract analysis service, to analyze the contracts so they don't make financial mistakes that would jeopardize their profit, and in turn, tempt them to cut corners at the patient's expense. On these grounds they are to be commended.

Moral Reasoning and Judgment. These dentists provide little insight into the moral considerations that guide their decision making. Aside from a reference to putting the patient first and a belief that they ought to provide quality care and treat patients respectfully, we have little information about the conceptual framework they bring to reasoning about moral issues. At one point they consider consequences of their action, but they seem to focus only on consequences to themselves (loss of income), possibly to patients (poor quality) in their practice, possibly consequences to undeserving managed care executives who are enriching themselves at the expense of the profession, and possibly to a perceived overall diminishing of professional authority as dentists lose power to third parties. Self-interest reasons seem to predominate, though there are also appeals to maintaining professional autonomy and patient autonomy. One could scarcely argue that these dentists are arguing from a fully-formed consequentialist perspective.

Moral Motivation and Commitment. How do they appear to conceptualize their role and responsibility as professionals? Although there is clear reference to an obligation to "put the patient first," there is little reference to a professional role that goes beyond serving those who can afford and want their services. Only one of the dentists, Jerry, occasionally takes on a Medicaid patient, and he does not regard "doing something in the public good" as ethically required. There is no discussion of the role of the practice or the individual dentists within the larger community, either as advocates for the oral health of the community or as advocates for the just distribution of oral health care resources. In fact, these dentists seem to be reacting to changes in the financing of dental care, rather than becoming engaged proactively with their community. They seem not to consider that someone buys these dental plans, that it might be possible to influence the purchase of dental benefit plans, either directly through organized efforts, or indirectly through discussions with their patients. Although Jerry seems to consider that it might be virtuous to do something for others, none of his partners seem to seriously consider that they may have a responsibility for the oral health of their community.

Ethics education needs to expand beyond the content of courses in philosophy.

Moral Character and Competence. What personal qualities and implementation competencies are reflected in their deci-

sion? Each of the dentists agrees to stand by his conviction to avoid signing contracts that potentially compromise patient choice and professional autonomy. We might argue that these individuals are true to themselves, are not waffling, even in the face of losing their patient population and their income. They demonstrate ego strength as their actions are consistent with their convictions. At the same time, we witness expressions of helplessness — feelings that they are eternally controlled by forces that are beyond their influence. They complain about unprofessional colleagues, about the ineffectiveness of the Board of Dentistry, about the unregulated power of third parties, about diminishing standards of care. Such feelings of helplessness seem to be instrumental in their final decision to hunker down and maintain their current course of action. We fail to see the kind of optimism that would inspire them to take up the challenge presented by these external forces and to respond proactively.

In sum, although we applaud their strength of conviction and their moral commitment to put their patients' interests before self-interest, we nonetheless are disappointed in the outcome of their deliberation. Why the disappointment? These are not newcomers to the profession -- indeed they are moving into the ranks of elder statesmen. We are disappointed because we expect leadership — moral leadership. Why the moral failing? Their narrow conception of their role as a professional interferes with their interpretation of the moral issues embedded in the problem. Failure to see the moral issues interferes with reasoning about what to do. But even if these dentists conceptualized the moral problem differently, one wonders whether they have the conceptual tools to formulate a morally defensible course of action. We see their capacity for developing elaborate and internally persuasive rationalizations for limiting their sphere of obligations to those who want and can afford their services. We wonder if challenging these rationalizations and challenging the narrow conception of their role and responsibility would result in decisions and actions that would benefit them as well as the larger society. Evidence from efforts to influence the processes that give rise to morality suggests that it will.[5]

References

1. Rest, JR. Morality. In: Mussen P (ed). Manual of child psychology. Vol. 3, Cognitive development, Flavell J and Markham E (eds). New York, NY: Wiley, 1983. 556-629.
2. Rest JR, Narváez DF. Moral development in the professions: psychology and applied ethics. Hillsdale, NJ: Lawrence Erlbaum, 1994.
3. Goleman D. Vital lies simple truths: the psychology of self- deception. New York, NY: Simon and Schuster, 1985.
4. Josephson M. Teaching ethical decision making and principled reasoning: easier said than done. Ethics 1988;1:27-33.
5. Bebeau MJ. Influencing the moral dimensions of dental practice. In Rest, JR, Narváez, DF. Moral development in the professions: psychology and applied ethics. Hillsdale, NJ: Lawrence Erlbaum, 1994. 121-146.

Professional Ethics in Dentistry Network (PEDNET)

John G. Odom, PhD

An attempt to decipher the acronym PEDNET might produce the image of a person walking (ped) on a fishing net. Indeed, founding members felt very much like they were walking on a net and frequently stepping into open spaces. However, a few dedicated people believed that a Professional Ethics in Dentistry Network was worth the occasional awkward intervals of organizational development. PEDNET is still a young association, but it is approaching maturity and needs more involvement from dental practitioners to achieve its growth potential. What PEDNET is, its historical development, its activities, and why practicing dentists should become members will be briefly described.

PEDNET, established in 1982, is a nonprofit association comprising two hundred and fifty members from the Unites States and Canada. Membership includes dental educators, dental practitioners, dental association officers, dental hygienists, ethicists, and social scientists who are concerned about professional and ethical issues in dentistry and about improving the ethics education of aspiring dental professionals. Prior to 1987, the network primarily served to provide a newsletter to members. In 1987, the association held its first annual meeting and currently meets twice each year. A constitution establishing an executive committee, officers, and responsibilities was adapted in 1991. There have been five presidents of PEDNET, two of whom have been practicing dentists.

What does PEDNET do? Some of the association and member activities are described below:

1. PEDNET program meetings are held within larger organizations including the annual meetings of the Society for Health and Human Values, the American Association of Dental Schools, and the American College of Dentists. This provides members with an opportunity to also participate in program activities of other organizations vital to ethics and dentistry. Local dental association members in the host city receive an invitation to send representation to PEDNET meetings.
2. In 1993, PEDNET collaborated with the American College of Dentists to develop and present a national bioethics course for dentists. The course was held at the Kennedy Ethics Institute at Georgetown University.
3. In 1996, a bioethics course was held at Loyola University in Chicago and a third is being planned for Loma Linda University.
4. The Ohio State University College of Dentistry annually offers a Dental Ethics Institute which is an elective course for dental students. The course involves dental faculty, dental practitioners, ethicists, and consumers in a two-day program. PEDNET members frequently serve as the featured speaker or attend to communicate to students the importance of ethics in their profession. The institute is financed by Omicron Kappa Upsilon.
5. PEDNET has approved sponsorship of an annual ethics essay contest for dental students which will begin in 1997.
6. The authors of three textbooks currently used to teach ethics in dental schools are members of PEDNET. Other members wrote chapters in one of these books.
7. PEDNET is working with the California State Board of Dental Examiners to develop a testing mechanism for professional ethics that is separate from the jurisprudence examination.
8. PEDNET members participated in the most recent rewriting and restructuring of the ADA Principles of Ethics and Code of Professional Conduct.
9. PEDNET members provide remediation courses for dentists who have been sanctioned by dental boards for ethical violations.

10. PEDNET members serve as consultants to the ACD Task Force on Ethics and the ADA Council on Ethics Bylaws and Judicial Affairs.
11. Dental journal editors, dental schools, and dental organizations have invited PEDNET members to write, speak, or arrange dialogues about professional ethics.

Why should practicing dentists become members of PEDNET? PEDNET is composed of very active and dedicated members who strive to assist the profession of dentistry as new ethical challenges to the profession occur almost daily. Among the reasons to join are the benefit of new friendships among persons who hold the same high ideals for the profession that you do. You will have opportunities to attend meetings where open discussions of challenging ethical issues are addressed in a serious and rigorous manner. As you participate and learn you will better be able to serve as a resource to your local, state, or national dental organizations as well as dental schools. Because PEDNET values the talents of all of its members, there are unlimited opportunities to become active in the governance of the association and to help chart the future of PEDNET.

More importantly, PEDNET can benefit from your membership. An association such as PEDNET must develop close ties to organized dentistry and to dental practitioners if it is to be effective. Each practicing dentist brings a wealth of practical knowledge about the challenges facing the profession and adds immensely to the strength of the association. Membership is $25 per year. One would have difficulty receiving more for one's money in any professional association. Further information is available by contacting the President or the Executive Director of PEDNET:

President:
Donald E. Patthoff, DDS
300 Foxcroft Avenue, Suite 320
Martinsburg, WV 25401
(304) 263-0411

Executive Director:
Richard D. Stevens
Professional Ethics in Dentistry Network
PO Box 1301
Charleston, WV 25325
(304) 344-5246

Looking for Moral Heroes

Drs. Jim Rule and Muriel Bebeau, both Fellows of the College, are working on a project interviewing and telling the story of people who have made exceptional moral commitments. Do you know someone they should be talking to?

The criteria for being a moral hero include:

- A sustained commitment to moral ideals or principles that include a generalized respect for humanity or sustained evidence of moral virtue
- A disposition to act in accord with one's moral ideals or principles, implying also a consistency between one's actions and intentions and between the means and ends of one's actions
- A willingness to risk one's self-interests for the sake of one's moral virtues
- A tendency to be inspiring to others and thereby to move them to moral action
- A sense of realistic humility about one's own importance relative to the world at large, implying a relative lack of concern for one's own ego

If you know of anyone who fits these criteria (including yourself), please write a letter of no more than two pages in length to Dr. James Rule, 325 Hawthorn Road, Baltimore, MD 21210. Alternatively, you can phone Dr. Rule at (410) 889-8764 or Dr. Bebeau at (612) 625-4633.

The First P -- Product

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

The marketing mix is the complete offer a seller makes to any potential buyer. In classical marketing theory it is composed of four parts: the product, its price, channels of distribution (colloquially called place in order to have a term beginning with the letter P), and promotion which includes incentives, public relations, and advertising. These are the four Ps which every MBA student must master.

Sometime within the past ten to fifteen years, dentistry entered the marketing age. No one asked permission of dentists to make this change. It just happened; largely because of changing consumer habits and dramatic developments within the profession, especially the range of services that can be provided to patients. In the product category, patients no longer go to the dentist primarily for the relief of oral pain through surgical means which are themselves quite painful. Less than half a dentist's time is now spent in restorative procedures. Patients go to the dentist for a multiplicity of reasons, including prevention, replacement of work done by previous dentists, enhanced esthetics, and even habit. And when they go, they expect more choices and better service.

Price has also become an issue in dentistry as never before. Even before the introduction of managed care, patients were showing signs of price sensitivity. The Federal Trade Commission has made it clear that dentistry enjoys no special privilege as a profession and will be treated as a "trade" in which price competition is expected as a presumed public good.

Dentistry is now reeling under new channels of distribution. Brokered care and capitation reimbursement systems have stimulated the growth of clinic chains who intend to compete on price and convenience. They offer accessible locations, extended hours, and short wait times.

And, yes, all of this is accompanied by a rising chorus of advertising.

Traditional, fee-for-service dentistry cannot opt out of the marketing game. What it has done is to choose a marketing mix that places almost all of its emphasis on the first P — the quality of a product. The competition within the oral health care market is coming from groups which use a different marketing mix, with greater attention to the other three Ps. What segment of the market traditional dentistry maintains will depend entirely on how successfully it analyses the market and whether it can differentiate its product in a fashion that overwhelms the other three components of the marketing mix.

Market Differentiation, Segmentation, and Positioning

A *differentiated* product or service is one that has characteristics consumers recognize as being different from other product offerings in the same category. An amalgam restoration can be differentiated in terms of its technical quality, how diagnostically convincing it was to the patient, gentleness and speed of delivery, and professional manner of the dentist and the staff. Differentiation is the reason for going to one dentist instead of going to another. Products and services that cannot be differentiated by consumers are called commodities. Salt, gasoline, and parking lot attendants are examples. From a marketing perspective, differentiation is critical because commodities must compete on price.

Market *segmentation* refers to identifying naturally occurring subgroups with distinct needs and purchasing characteristics. The shops along Michigan Avenue in Chicago are not for everyone; neither are Walmart or the second-hand outlets run by philanthropic organizations. The dental needs in rural communities are different from those in affluent suburban neighborhoods. Dental specialties can be considered attempts to address segmented markets with discipline expertise.

Market *positioning* means offering a differentiated product to identifiable market segments in an attempt to meet the organization's mission. Beverly Hills dentists do not offer the same product to their demanding and image-conscious clientele that GIs get in boot camp. (Professionalism would demand, however, that the technical quality of, say, amalgam restorations should be identical in both settings.) Dental schools have historically served a market niche of individuals who are willing to trade their time for reduced fees.

Market positioning is more than catering to a niche where the competition is minimal. First, it is necessary to be able to achieve meaningful differentiation. The farmers I grew up with as a child would be unimpressed with the "down town" accouterments of up-scale practices. Significant segments of the American population are dentally undeserved

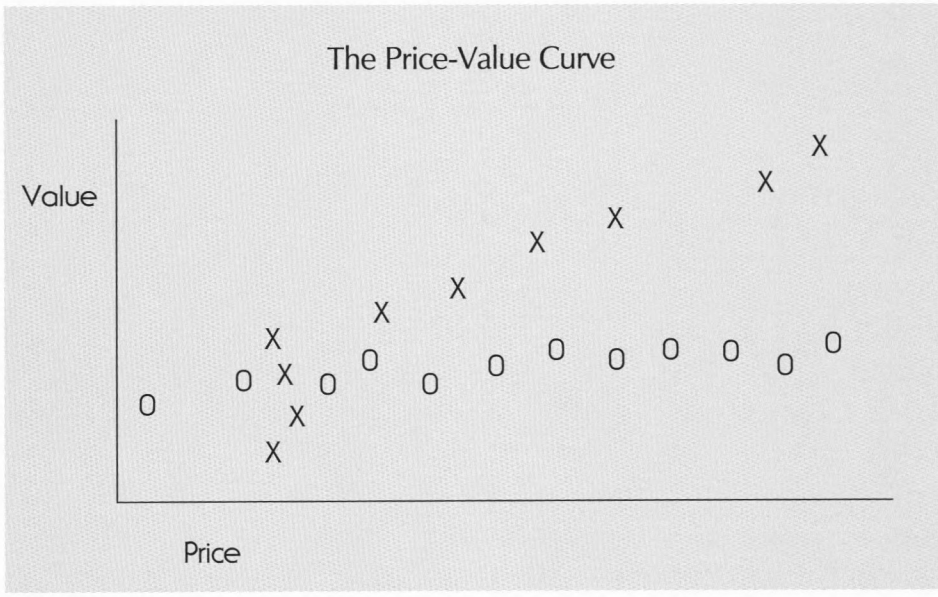
because they are not an attractive market. They lack the resources to pay for even minimal care, and their personal habits of commitment and follow-through add cost to the delivery system. Most dental graduates have an intuitive sense of market positioning when they choose a practice location. Some of the goals they are seeking to maximize are other than economic.

The Whole Product

Dentists who intend to compete on more than price must find some method for differentiating their product. A good way to do this is to consider multiple product levels. At the foundation, customers are motivated to seek *core benefits*. In the case of dentistry, this used to be the relief of acute tooth ache. When that was almost the entire extent of patients' needs, dentists were in competition with each other and prohibitions against advertising made good sense. Now the core benefits that dentists serve include prevention; pro-health lifestyles; the nurturing and "good citizen" postures of purchasers such as parents, the federal government, and employers; and self-image and esthetic considerations. The competition for the dental dollar is now largely outside the profession and includes counseling and self-help, aerobics equipment, other elective surgeries, clothes and cars and other image enhancers, and alternative components in employee benefit packages that might be offered by employers.

Dentists who intend to compete on more than price must find some method for differentiating their product.

The *generic product* is the minimal offering that meets the core needs of consumers. A haircut in the army is still a haircut. An inner city bus terminal is still a place to catch a bus. And rice is rice. The *expanded product* is a generic product with added features, specifically those features the typical customer is expecting. In dentistry this is the "standard of care." The *augmented product* is an expanded one plus those features which differentiate it. This is the convenience of the office, the courtesy of the staff, the professional manner of the dentist; the alternative treatment plans provided; the listening, caring attitude; and all the other features which differentiate one dental experience from another. To really learn the features of an augmented dental product, one would have to eavesdrop on patients as they explained to a friend or neighbor why they like going to the dentist they have chosen.



The Price-Value Curve

By now it may be apparent that the technical quality of dental care has not figured prominently in the discussion of quality of the dental product. It is one of the ironies of the profession that boards of examiners test on the initial licensure examination only those things which patients cannot judge and take for granted as being a part of the product. But the issue runs deeper as dentistry comes into closer contact with market entities such as managed care that favor a different marketing mix. The profession seems to want to draw the line in terms of technical quality of care. They have retreated to defend the fundaments of good tooth fixin'. The risk here is that product differentiation will be lost and dentistry will be converted back to a commodity defined in objective technical terms. Managed care brokers would favor this approach because it permits competition on price. If they could get dentistry to define their product exclusively in technical terms (and even set and measure the product standards for them), dentists would be converted to "providers." Reducing dentistry to technical quality justifies "the least expensive acceptable alternative treatment."

For dentistry to avoid this marketing trap, it must relinquish its obsession with its own criteria for quality in oral health care based on technical features. Dentists must become responsive to the criteria patients use in making market decisions.

The patients' perspective is captured in the price-value curve. An example of such a curve is shown above. The horizontal axis is the cost patients incur in receiving a product such as oral health care. The vertical axis is their perception of the value they receive. The xs on this graph represent hypothetical patients or market segments. Some are willing to pay more for what they perceive is greater value. Others find their optimal

relationship to be at a point of lower cost and lower received value. One could think for example of the market for cars where one segment prefers expensive luxury cars, and the other segment is comfortable with more modestly priced and less impressive vehicles. Medicine, and to some extent dentistry as well, have been justly criticized for their attempts to constrict the market and to demand that all services be at the high end of the curve. Many managed care plans deserve equal criticism for their attempts to constrain the market at the low end.

In a free-market economy, it should be possible to service market segments all along the price-value curve. It would not be possible to position oneself to the right or below the curve since patients will not willingly continue to pay for more than what they perceive they are getting. In a similar fashion, areas to the left or above the curve make no sense for providers. Of course there are exceptions to this free market model in the form of government subsidies, licensing and other restrictions of trade, and planned or socialized systems.

In order to better understand the price-value curve, it is useful to inquire a little more deeply into what constitutes price and what constitutes value. Dentists and third-party brokers will never get a clear understanding of the oral health care market as long as they confuse price with the fee dentists charge or the level of reimbursement dentists receive. From the patients' perspective these numbers make no sense and may not even be known. Even in the fee-for-service model, the fee paid the dentist is only part of the cost. Other components include out-of-pocket costs such as hiring a babysitter, gas for driving, and a parking fee — which may in some cases total more than the dentist's charge. There are also opportunity costs associated with seeking oral health care. For example, a self-employed individual such as a lawyer or a farmer forgoes the opportunity to earn income while getting to the dentist's office and waiting there. A union employee with a generous benefits package may actually find a trip to the dentist a pleasant distraction for which he or she receives the same compensation received while working. There are also psychological costs such as embarrassment, physical discomfort, and the anxiety of participating in an unfamiliar social structure which serve as significant deterrents to some patients' seeking care. There are probably a substantial number of Americans who would not seek dental care if it were free and if all incidental and opportunity costs were paid. These individuals would have to receive a stipend for visiting the dentist. Effective marketing would require that all the components of cost be factored into the marketing mix.

It is the patients' calculation of received value which drives the market.

The vertical dimension of the price-value relationship refers to the patients' subjective impression of what they are receiving. Marketers might have a generic, expanded, or augmented product in mind, but it is the patients' calculation of received value which drives the market. As with cost, value can be decomposed into several components. In the case of oral health care, it is convenient to identify three: One is technical quality of the dentistry rendered. In the accompanying figure, this is represented by the string of os. I have made the assumption of a single standard of care, the ethical minimum technical quality to which every patient is entitled. Below that standard, value drops precipitously. Perhaps it could be argued that some dentists significantly exceed the technical minimum, but it is uncertain how this is reflected in patients' perception of value. It is likely that the more operative components of the value dimension reflect the core benefits of health, image, sense of responsibility, and esthetics which motivate patients to seek dental care in the first place. Service features of the care patients receive — courtesy, convenience, professionalism, respect, predictability, freedom from hassle, etc. — are also likely to play a significant part in the value dimension.

It is evident from examining the price-value curve that third party brokers would welcome dentistry being reduced to issues of technical quality. This would have the effect of driving the price-value curve down and to the left; reducing the differentiation dentists can provide in their services and making dentistry a commodity. The appropriate marketing strategy for commodities is downward price competition.

Dentists who understand marketing will resist this pressure by augmenting and differentiating their product in ways that meet the patients' needs for value.

Recommended Reading

* Collier RA. *Profitable Product Management: Powerful Techniques for Improving Products and Maximizing Profits.* Oxford, UK: Butterworth-Heinemann, 1995. ISBN 0-7506-1888-4; 254 pages; about $33.

The title is slightly misleading. This is a book about managing product lines, as, for example, all of the dental products from P&G. The basics of the marketing mix are covered in solid fashion, but the emphasis is on balancing the multiple offerings of a firm rather than developing and selling a single product. The examples are for the most part from the UK and the continent. In contract to the other summarized references which were written for students, Collier writes for on-the-job managers.

* Kotler P. *Marketing Management: Analysis, Planning, Implementation, & Control.* Englewood Cliffs, NJ: Prentice-Hall, 1991. ISBN 0-13-552480-6; 756 pages; about $90. [Only the chapters dealing with differentiation, segmentation, positioning, and products are summarized.]

This is the one virtually all MBA students study as part of their required marketing classes. Areas covered include the marketing concept, consumer behavior, marketing research, market strategies, the marketing mix, and control (practical management) of marketing efforts. The book is huge — 750, 8 and ½ x 11 inch pages and the work is now in its ninth edition. It reads like a text book, with examples, definitions, exercises, etc.

* Kotler P, Clarke RN. *Marketing for Health Care Organizations.* Englewood Cliffs, NJ: Prentice Hall, 1987. ISBN 0-13-557562-1; 556 pages; about $80.

A complete marketing course for health care executives. This book follows the classical structure of a marketing management course (see the Kotler reference above) but there are added chapters on organizations that are responsive to customer needs, those that are responsive to changing environments, and fine chapters on public relations, recruiting, and fund raising. The content is thoroughly adapted to the health care industry (not just illustrated with a few examples) and there is ample case material.

Levitt T. Marketing success through differentiation — of anything. *Harvard Business Review*, 1980, January-February.

Grand survey of possible dimensions on which products can be made distinctive to various market segments.

Levitt T. Marketing intangible products and product intangibles. *Harvard Business Review.* 1981, May-June, 94.102.

The "guru" of marketing — the one who first pointed out that customers buy benefits, not features — identifies practical ways that "invisible benefits" of services and intangible products such as health can be made concrete for customers.

Polli R, Cook V. Validity of the product life cycle. *Journal of Business.* 1969, October, 385-400.

Products go through a predictable cycle of introduction, growth, maturity, and decline (think of the various materials used for restoring conservative lesions). The marketing mix should be different at each stage of the cycle.

Some journals which discuss marketing issues relative to health care.

Harvard Business Review
Health Care Management Review
Journal of Marketing
Journal of Consumer Marketing
Journal of Marketing Research

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each summary is about four 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 product in the marketing mix; a donation of $50 would bring you summaries of all the 1996 leadership topics.

The Manuscript Referee Process

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

Sixteen unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentists* during 1996. Seven were accepted for publication (44%) and five were declined following peer review. Two manuscripts were returned without review because they did not fit the format or content of the Journal; two were returned with suggestions to the authors for substantial changes prior to the review process.

Fifty-three reviews were received for the twelve manuscripts reviewed (4.4 reviews per manuscript). Two were noncommittal. Among the remaining, 82% were consistent with the editor's decision. Cramer's V statistic, a measure of consistency of ratings was .663 (with 0.0 representing random agreement and 1.0 representing perfect concordance). There is no way to compare the consistency of the reviews for this Journal with agreement among other reviewers because it is not customary for other journals to report these statistics. The College feels that authors are entitled to know the consistency of its review process.

The editorial "Selling Patients — The Prisoners' Dilemma" was reprinted in two other publications during the years.

Special appreciation is extended to Dr. Robert Warren of Anchorage, Alaska, for his help in organizing the theme issue on boards of dental examiners and to Dr. James Rule of Baltimore, Maryland, for his help in organizing the theme issue on alternative approaches to ethical analysis.

The College thanks the following professionals for their contribution to the dental literature as reviewers for the *Journal of the American College of Dentists* during 1996.

Ingred Arden, DDS
San Francisco, CA

R. C. Baker, DMD, FACD
University of Manitoba Faculty of Dentistry

Keith P. Blair, DDS, FACD
San Diego, CA

Ron Botto, PhD
Southern Illinois Dental School

Richard E. Bradley, DDS, MS, FACD
Lincoln, NE

William Carpenter, DDS, FACD
University of the Pacific Dental School

Paul S. Casamassimo, DDS, FACD
Columbus, OH

Jack F. Conley, DDS, FACD
Glendale, CA

Richard W. DeChamplain, DMD, FACD
Medical University of South Carolina

Henry L. Diversi, Jr., DDS, FACD
Atlanta, GA

Allan J. Formicola, DDS, FACD
Columbia University Dental School

Jack D. Gerrow, DDS, FACD
National Dental Examining Board of Canada

Jack Hadley, DDS, FACD
University of the Pacific Dental School

Jess Hayden, Jr. DMD, FACD
Eugene, OR

Bejan Iranpour, DDS, FACD
Rochester, NY

Walter N. Johnson, DMD, MS, FACD
Seaside, OR

Denise K. Kassebaum, DDS, MS, FACD
School of Dentistry, Colorado

Saul Kamen, DDS, FACD
North Hills, NY

James E. Kennedy, DDS, MS, FACD
School of Dental Medicine, Connecticut

Bruce Kinney, DDS
Yakima, WA

Daniel M. Laskin, DDS, FACD
Medical College of Virginia Dental School

Charles M Ludwig, DDS, FACD
Harrisburg, PA

Gary T. McDonald, DDS, EdM, FACD
Louisiana State University School of Dentistry

Robert E. Mecklenburg, DDS, MPH, FACD
US Public Health Service

1996 Reviewers

Cyril Meyerowitz, DDS, MS, FACD
Rochester, NY

John A. Molinari, PhD
Detroit-Mercy Dental School

Larry L. Pace, DDS, FACD
Dallas, TX

Kent G. Palcanis, DDS, MSD, FACD
U Alabama Dental School

James L. Palmisano, DDS, FACD
Toms River, NJ

Craig Passon, DDS, FACD
U Colorado Dental School

Donald E. Patthoff, Jr., DDS
Martinsburg, VA

Bruce Peltier, PhD
University of the Pacific Dental School

Ronald J. Peterson, DDS, FACD
Phoenix, AZ

Colin Price, DDS, FACD
U British Columbia Faculty of Dentistry

James E. Quinn, DDS, MBA
U Oklahoma College of Dentistry

G. Wayne Raborn, DDS, MS, FACD
U Alberta Faculty of Dentistry

Spencer W. Redding, DDS, Med, FACD
Texas, San Antonio Dental School

Peter D. Roberson, DDS, MS, FACD
Chicago, IL

James A. Saddoris, DDS, FACD
Tulsa, OK

Mario V. Santangelo, DDS, FACD
Chicago, IL

Michael R. Saunders, DDS, FACD
New Jersey Dental School

James J. Sciubba, DMD, PhD
Long Island Jewish Medical Center

R. Jack Shankle, DDS, FACD
Chapel Hill, NC

L. Donald Shumaker, DDS, FACD
Cleveland, OH

Jeanne C. Sinkford, DDS, FACD
American Association of Dental Schools

Daniel A. Shugars, DDS
North Carolina Dental School

Denice Stewart, DDS
U Pennsylvania Dental School

Galen W. Wagnild, DDS, FACD
San Francisco, CA

John N. Williams, DDS, MBA, FACD
U Louisville School of Dentistry

George A. Zarb, DDS, MS, FACD
U Toronto Faculty of Dentistry

1996 Articles

Agencies:

Ethics:

From the Editor (Editorials)

History:

Leadership:

Index

Student Views of Professional Ethics:

1996 Authors

Index

The Journal of the American College of Dentists

1996

Statement of Ownership and Circulation

The *Journal of the American College of Dentists* is published quarterly by the American College of Dentists, 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1614. Editor: David W. Chambers, EdM, MBA, PhD.

The American College of Dentists is a non-profit organization with no capital stock and no known bondholders, mortgages or other security holders. The average number of readers of each issue produced during the past twelve months was 5,090, none sold through dealers or carriers, street vendors or counter sales; 4,816 copies distributed through mail subscriptions; 4,816 total paid circulation; 196 distributed as complimentary copies. Statement filed with the U.S. Postal Service, September 25, 1996.

American College of Dentists
839 Quince Orchard Blvd., Suite J
Gaithersburg, MD 20878-1614

Periodicals Postage
PAID
at Gaithersburg, MD
and additional mailing office