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Lawyers & Dentists

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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.

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FROM THE EDITOR

Growing Leadership

The famous American philosopher Lily Tomlin has a two liner that might be of help to the American College of Dentists in its current search for identity. She used to say "When I was young I always wanted to be somebody. But now I realize that was a little vague."

Who would deny that the American College is in the leadership business; but who would step forward to say we know all about it?

In the leadership market, our niche is recognition of significant and often lifelong accomplishment. While this is a worthy and noble activity, it certainly is a crowded niche. Omicron Kappa Epsilon, the International College of Dentists, and the Pierre Fauchard Academy all have profiles of activities that closely match those of the American College. The ADA, the American Association of Dental Schools, the International Association for Dental Research, the American Dental Trade Association, and every specialty and hopeful specialty, to say nothing of state associations and component societies, are also in the business of recognizing leadership. As Associate Dean for Academic Affairs in a dental school, my office manages the awards program for graduating seniors. This year we will present ninety-three of them. One of our graduate programs has more awards than residents. Some of the awards carry a notable cash prize; others involve a plaque and a year's supply of something-or-other. Since the sponsors have no contact with the recipients, I often wonder whether they consider this to be a form of advertising, increasing their own name recognition.

The American College of Dentists is in the leadership business.

In all but a few cases, the citations for awards mention leadership. The market for leadership recognition is saturated. But more can be done in the name of leadership than recognize it after it has occurred. We might pay more attention to developing it.

In addition to having a leadership conference for new officers, why not a leadership conference for new Fellows? Organized dentistry already knows a good bit about leadership training; why not a partnership at the local level where the College conducts a program for new officers of state and component societies on ethical issues? Or perhaps the College could sponsor student leaders for brief internships at the state association level. Some sections do this now, and more could fund student participation in section activities. Semi-formal mentoring relationships are another possibility.

The journal of the American College also has potential for leadership development. It is a respected forum for discussion of the emerging policy issues facing the profession — exactly the kind of thing that leaders and potential leaders should be studying. One section of the College gives a student prize of cash and a year's subscription to our journal. Honorable mention is a year's subscription to JADA. For the total prize money spent, and considering the difference between subscription costs and production costs, this section could give a year's subscription to the *Journal of the American College of Dentists* for one year to every student graduating from the dental school in its state. Perhaps a section would want to sponsor annual subscriptions to the journal for officers in state and component dental societies who are not Fellows of the College. Another opportunity for investment in leadership is the editor of component dental societies. Frequently, this is the point of entry into organized dentistry for many future officers. Perhaps a section could sponsor participation by one or more new editors in the annual editors' workshop conducted by the American Association of Dental Editors.

The market for leadership recognition is saturated.

There are three characteristics of the leadership development initiatives I have just enumerated. First, they are targeted to individuals who show potential for great leadership, specifically at the beginnings of their leadership paths. Second, they are cooperative activities. Leadership development requires the combined efforts of numerous groups within the profession; it cannot be accomplished by one group trying to outbid the other in terms of the prestige of its prizes. Finally, these leadership initiatives are all situated at the section level. Leadership development is inherently a grass roots activity.

As an instructive exercise, the officers of sections might wish to itemize their annual budget in four categories. What proportion of the monies spent are used by officers? What percentage goes to the fellowship generally? What percentage is specifically targeted to grow newly inducted Fellows — say those who have joined the College within the past five years? And finally, what proportion of the annual budget goes to developing the potential fellowship of the College? It is impossible to determine the correct distribution of resources without being arbitrary. But this might make an interesting agenda item for an executive committee meeting. The goal would be to shift some resources away from those who are already in leadership positions towards those who will lead the profession in years to come.

Let's look, for a minute, at the scientific foundation for making awards. It is universally known that rewarded behavior increases in likelihood. But we are not very effective if we must wait for the behavior we want before we can reward it. B.F. Skinner, the Harvard professor who devoted his career to studying this effect, recommends that we reward every successive approximation to the desired behavior. We need a system of rewards spanning the leadership development path of professionals, and every award along the way should be as prestigious as the "grand prize."

Leadership development is inherently a grass roots activity.

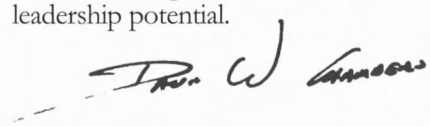
Another psychologist who has studied rewards is Edward Deci. His research involves the relationship between intrinsic rewards (those things we do for the love of it) and extrinsic rewards (those things we do because they are approved by others). Deci has been able to show that people who engage in activities for their own sake tend to lose that intrinsic motivation when someone else decides to reward that behavior extrinsically. This thought always runs through my mind on the Friday of convocation at the American College of Dentists. Several speakers that day will feel the need to remind the new class of Fellows to guard against losing their intrinsic motivation.

Before creating an impression that this editorial is campaigning against professional awards, let me say I am in favor of such awards and have declined only a few. The most cherished of these is honorary fellowship in the American College. This is the only certificate I have framed and mounted on the wall in my office; this is the only rosette I wear. I have found some things I can do as an individual to pave the way for future leaders. I bring student guests to College-sponsored functions. I have written all new fellows in our section and those across the country whom I know. I have arranged for fellowship for three people — not an easy task since I must find both the candidate and the sponsor. Every manuscript submitted to the *Journal of the American College of Dentists* is reviewed by at least one Fellow who has joined the College within the past two years.

There is one final point about giving awards that must be considered, and that is an ethical issue. Awards are good for the recipient and good for the sponsor. Let's make certain in the College that the interests of the recipient are foremost. If we are recognizing an individual for a lifetime of volunteer service on an Indian reservation, for example, let's send press releases to the dentist's home town paper, the reservation authorities, the

dentist's dental school. Let's also have a picture of the dentist in shirt sleeves doing what he or she loves and not a picture of the ACD representative giving the award.

The American College of Dentists is in the leadership business. Our awards are as prestigious as anyone else's and about as widely recognized. It is time to consider additional strategies for developing leadership. Resources should be allocated more evenly along the career paths of professionals rather than concentrated at the end. More programs are needed to help individuals realize their leadership potential.



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

Letters to the Editor

Dear Editor,

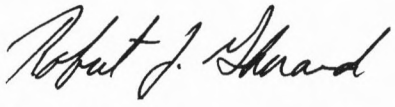
The manuscript in the Spring issue, "Dentists' HIV-related ethicality: An empirical test," was interesting, but left many questions unanswered. While I agree 100% that the dental profession should treat HIV+ patients, I also strongly feel we should be free to treat them, and other patients with infectious diseases, on our terms and following standard infection control measures.

The data in the table are revealing. Surprisingly, 42.1% of the dentists who don't agree that dentists are ethically obliged to treat HIV+ patients still are willing to treat these patients in their offices. However, only 88.5% of the dentists who do agree with the ethic are willing to treat these patients in their offices. Out of the total sample, 76% of the dentist would treat an HIV+ patient in their office. I believe this is a substantial number. Why are 24% reluctant to treat HIV+ patients?

I believe the answer lies in the fact that many dentists feel their hands have been tied by government agencies, courts, the Americans with Disabilities Act, and even our own ADA's politically correct positions when dealing with this infectious disease. While there are many studies, cases, and papers which rightfully question the universal safety implied by barrier techniques in viral transmission, the dental profession is told that our level of infection control must be based on the procedure we are performing and not on the infectious status of the patient (ADA resolution 72RC-1996)!

Our members should know that there is a bill in Congress submitted by Representative Tom Coburn, MD, of Oklahoma (HR 1062) that would require that HIV be treated the same as any other infectious disease. The AMA is backing this bill, as should our ADA. If the bill is passed, I would venture a guess that the number of dentists willing to treat HIV+ patients would increase. Contact your ADA delegate and your congressman to restore logic to the treatment of infectious patients in the dental office.

Sincerely,



Robert J. Gherardi, DMD, FACD
ADA Delegate from New Mexico

Dear Sir:

About twenty years ago the federal government perceived a shortage of dentists and further determined that if there were more dentists, competition would tend to drive down prices (fees) and make dental care available to more people at lower cost.

In order to entice the dental schools to cooperate with the expansion plans, the feds offered capitation payments. These payments were funds for each additional student enrolled in the first three years of dental school. A number of schools were lured to increase class sizes. In addition, payments for three years were an inducement to graduate students in three years instead of the customary four.

By the time several classes had graduated and competition was percolating, there came a rather ominous development. Alumni reported that their annual giving was not to be forthcoming. Capitation had run out, and the schools started cutting back. Word got out that dentistry was not such a lucrative endeavor.

By this time, brighter students were choosing other fields which appeared more desirable. Dental schools were enrolling less qualified students due to the shrinking size of the pool of applicants. Although we do not mean to imply that any particular dentist who graduated within that period is less qualified, there have been abnormally high failure rates for licensure exams.

Not surprisingly, this may also have contributed to a possible cause of insurance and Medicaid fraud, as practitioners, marginally employed, sought to enhance income. Contrary to

the assumption of lowered fees, charges were often raised to balance the income loss from seeing fewer patients. For a number of reasons six prominent universities closed their dental schools.

Estimates of at least sixty to seventy percent reduction in cavities and extractions have been documented. The specialty of Pediatric Dentistry (child dental care) has nearly been eliminated because of fluorides and increased use of hygienists.

What's next? Between the years 2010 and 2020 the dental graduates from the bulge of the large classes will be retiring, and again a manpower shortage is projected. More dentists will be retiring than will be coming into the profession. What will big government come up with then?

Can anything be learned from this bit of mischief called government planning? Will this be a lesson studied or are we doomed to repeat it over and over again?

Saul W. Greenwald, DDS, FACD
Homer City, PA

Dear Editor,

The recent issue of the *Journal of the American College of Dentists* which was devoted to ethics prompts me to write. Dental school curriculum committees across the country are constantly struggling with juggling classes and balancing priorities to cram five years of education into a four year stint that is within the limits of the university's resources and the students' indebtedness. They take a long, logical look at everything on the academic table and debate not what has to be added but what has to taken away.

Too often the temptation is to remove an innocuous-sounding course called "professional ethics." Who would miss it? It doesn't give the kids any info on crown and bridge, pharmacology, treatment planning, Ortho, Endo, Perio, etc; or even the optimal powder-weight-to-water-volume ratio for dental plaster. Let them get ethics — after graduation — from the ADA and the American College of Dentists. With so many more "important" courses pressing, who needs it?

Only the patient.

To carry the analogy further, courses on professional ethics should not be on the academic table at all because they are the legs that hold the table up. And there should be one in each of the four years in order to give the rest of the program proper stability. They teach students how to develop the thought processes to deal with ethical dilemmas that they will face daily in clinical practice throughout their careers.

Certainly, these courses cover the basic legal bases; but defining just what is permissible is not passable. The core challenge is to balance beneficence (what is best for the patient) with autonomy (the patient's rights). If students wrestle with some of these scenarios in the classroom first, they will be better able to do what is right when faced with a real dilemma in the clinic. What these courses can't do, however, is turn a sow's ear into a silk purse. They are not going to deter dentists from fraudulently billing insurance companies, selling prescriptions for analgesics, or abusing nitrous oxide or molesting patients. Those with permanent chinks in their moral armor need to be screened out by the admissions process, which should be geared up to investigate dental school candidates' background for basic integrity of character.

Ethics is what defines us as professionals and gives us special status in society. (Have your ever heard a public address announcement for "Plumber Jones, party of two?") It allows patients to trust us. They know we'll always put their interests before our own. Thus any violation of that sacred doctor-patient relationship on the part of the former would be cause for permanent loss of licensure.

So I encourage you to encourage your local dental school to place a high priority on ethics in the curriculum. When you make a donation now — or in your will — earmark all or part for that program which ultimately compels all other disciplines to strive for the highest of standards — professional ethics.

Sincerely,

Victor J. Barry, DDS, FACD
11th District Trustee, ADA
Seattle, WA

Dear Dr. Chambers,

I would like to compliment Dr. Freedland on his great memory in recalling the list of dentists who have played a role in higher education. However, he did make one mistake — Dr. Edmund Ackell was President of Virginia Commonwealth University and not Old Dominion University. Considering all that he did recall correctly, one mistake is really forgivable.

Kindest regards,

Dan Laskin

Daniel M. Laskin, DDS, MS, FACD
Professor and Chairman, Oral and Maxillofacial Surgery
Virginia Commonwealth University

Dear Editor Chambers:

Our compliments to Dr. Jacob B. Freedland for his excellent list of dentists who have moved on to special roles in higher education. It would be proper, however, to list Dr. Edmund W. Ackell as the Past President of Virginia Commonwealth University in Richmond instead of Old Dominion University in Norfolk.

This outstanding dentist and physician previously served as Vice President of the University of Southern California, which last month honored another worthy dentist with its Distinguished Emeriti Award. At age twenty-eight, Dr. Clifton O. Dummette became the youngest dental Dean in the world at Meharry Dental College. This celebrated, eminent dental historian retired as Professor Emeritus and one-time Associate Dean of the University of Southern California Dental School.

Very truly yours,

Francis M. Foster Sr.

Francis M. Foster, Sr., DDS, FACD
Assistant Professor
Virginia Commonwealth University

Dear Dr. Farrell:

Dean MacInnis has referred your communication regarding *Core Values and Aspirational Code of Ethics* to me as Associate Dean for Academic Affairs. This material is of particular interest to us as we are presently collaborating with the Director of the Health Law Institute of Dalhousie University in reviewing the law and ethics components of our curriculum. Thank you for providing us with this material which I will distribute to those involved in curriculum and in teaching ethics.

Sincerely,

H. A. Lyttle, BDS, MSC
Faculty of Dentistry
Dalhousie University

Dear Doctor Farrell,

On behalf of Dean Formicola and the administration of the School of Dental and Oral Surgery I express our sincere appreciation for your generosity in sending us 20 copies each of the *Core Values and Aspirational Code of Ethics* of the College and the December issue of the *Journal of the American College of Dentists*.

The copies have been distributed, as per your suggestion, to the appropriate individuals in our school. I will discuss the possibility of using some of the articles in the Journal in our Ethics course. Your permission to reproduce material form the Journal for that purpose is greatly valued.

Once again, our thanks for your gift, which is but one expression of your continuing interest in important aspects of the education of our future colleagues.

Sincerely,

Letty Moss-Salentijn, DDS, PhD
Associate Dean for Academic Affairs
Columbia University
School of Dental and Oral Surgery

Letters

To Whom it May Concern:

I am writing to you from the Washington State Dental Association. We are interested in receiving more copies of your *Journal of the American College of Dentists*, Winter 1996 — Ethics of Managed Care.

Sincerely,

Jessica Score
Washington State Dental Association

Editor;

As Editor of the *Connecticut State Dental Association Journal*, I wish to thank you for granting me permission to use the section *Core Values & Aspirational Code of Ethics* which appeared in Volume 24, Number 4 of the ACD publication *News & Views*.

Sincerely,

Howard I. Mark, DMD, FACD
Editor, *Connecticut State Dental Association Journal*

Dear Chuck,

Thank you for your gift of 20 copies of the 1996 Winter *Journal of the American College of Dentists* as well as the *Core Values and Aspirational Code of Ethics of the American College of Dentists*. As a member of the American College of Dentists, I am very familiar with these documents and certainly applaud your efforts in promoting these values. I have decided to distribute them to the chairs and deans in anticipation that they will review these documents and consider incorporating some of the issues into our curriculum at the College of Dentistry. There were enough copies to send to the student presidents of each of the four classes as well as the president of the American Student Dental Association.

Sincerely yours,

Frank A. Catalanotto, DMD, FACD
Dean, College of Dentistry
University of Florida

Correction

Due to a printing error, a portion of a paragraph was deleted from the Spring 1997 *Journal of the American College of Dentist*. The missing portion begins at the end of page 13 and continues on page 14. The following is from the article entitled "Consumer Satisfaction with Dental Care: Where Are We Going" by Dr. Gerry Kress and Dr. Jay D. Shulman:

In medicine one might add to the list the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCHCO), non-profit organizations which accredit managed care plans. Thus, patient feedback to providers, which was viewed as a rather novel intervention ten years ago, has by now become not only routine, but an absolute necessity for NCQA and JCAHO accreditation.

The JCAHO (1966) identifies three domains of patient (enrollee) satisfaction, each of which has several sub-domains: provider or service delivery...

A Brief Guide to Using a Lawyer's Mind in Healthcare Business Situations

Randall K. Berning, JD, LLM

Abstract

A lawyer experienced in contract aspects of dental law explores the differences between the ways dentists and lawyers are trained to think about business problems and opportunities. Lawyers are trained to analyze situations to look for alternatives and apply the law to the facts of the case. It is the nature of the law not to have scientifically justified general approaches (what dentists might call parameters or best practice rules). For the lawyer, multiple sources of law, legislative, judicial and regulatory, coupled with the details of a case, provide the framework for decision-making. This can place a premium on finding a lawyer familiar with the field of law in question. Lawyers provide a valuable service in negotiating, mediating, and otherwise finding alternatives to litigation. Communication skills are essential because of the complexity of many legal situations and because the lawyer never decides the correct course of action for a client — the client must do this based on his or her goals and the alternatives presented.

Dentists seeking to prosper in these changing times confront difficult business; tax; employment law; federal and state agency compliance; risk management; and transition, succession, and estate planning questions. Some of these issues produce the gut twisting indecision caused by having too few options or fear of making the "wrong" decision. Such experiences can take much out of life and the enjoyment of dental practice. One resource available to dentists in such situations is the use of competent legal counsel to facilitate effective problem solving. But to use a lawyer's mind in a business situation you need to know what it is trained to do and then how to use it effectively. That is the focus of this article.

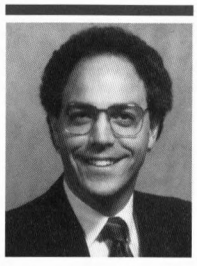
Let's say you are facing a practice business "problem," or option (not a predefined, win or lose situation such as encountered in a malpractice suit). Ask yourself, how do you approach getting what you need to make a good business decision? What process do you use to learn the range of options open to you? How do you determine which options will likely be most effective and which are legal?

The following observations are drawn from eighteen years of providing legal and practice management advice to dentists. I find that many dentists, pressed for time and being surrounded by staff, spouse, or dental colleagues will either make an emotional decision or defer decision making to one of the just mentioned parties. This approach has significant shortcomings. Not only are these the wrong people to make the *dentist's* decision, questions of what is legal need to be addressed early in the decision process. Using a good lawyer's mind can be a significant asset.

How Lawyers are Trained to Think

Most people would agree that a reasoned approach is the best one for determining a course of action dealing with a financial or legal concern. Lawyers are trained to reason. A tortuous education process makes sure budding law students either get the technique grafted into their soul or they are washed out.

To think analytically is both the blessing and curse of legal training. Have you ever had the experience of meeting a lawyer at a social outing and feeling as though you are in a cross examination? All you wanted was to share your experiences on a recent round of golf and the lawyer starts asking questions. Every time you make a statement he or she assumes a serious expression and probes



Randall K. Berning is a healthcare attorney, educator, and consultant who helps dentists make sound decisions about their futures. He is Adjunct Professor of Dental Jurisprudence and Director of Practice Administration at the University of Illinois, College of Dentistry and is also on faculty at UCSF School of Dentistry, and UMD Baltimore College of Dental Surgery. The firm has offices in Chicago, IL, Washington, DC, Naples, FL, and Burlingame, CA and can be reached at (800) 999-8121.

"why" or "how." Some would charge that lawyers analyze everything. They have stopped feeling; they gave up life when they became lawyers. But, using the lawyer's analytical thinking to your own benefit, instead of being repelled by it, can benefit you. After all if the lawyer has already "lost some humanity," no sense in your doing so as well!

In addition to his or her ability to reason, you can use the lawyer's talent to identify workable options. Dentists find great comfort in working with minds that lay out all options, from improbable to solid. Only by "doing the homework" can the full range of choices be determined. In the areas I am most familiar with, practice transition (associateship, partnership, and sale) and annual practice planning for group practices, the possibilities are almost limitless. Is it best to arrange an association for a short term or long term, perhaps with an option to buy-in or to buy-out? Is it an immediate buy-in or a incremental buy-out with a hire back of the founder for a period after the buy-out? What are the valuation, financial, and estate planning constraints? As former ADA President Michael Overby said during a taped interview "as you (dentists) go through practice you never really think about the time when you may want to sell...and there are many, many things a doctor should do prior to that time. And only with good advice and with good professional people do you know exactly what to do..." He went on, encouraging dentists not to delay thinking through alternatives. The long and short of it is that whatever the problem or opportunity you can have, the lawyer — a trained, licensed professional whose malpractice policy helps insure his or her advice — lays out the alternatives and their likely consequences for you.

To think analytically is both the blessing and curse of legal training.

The final decision is always the dentist's; the dentist chooses based on his or her values. Some doctors may ask why doesn't the lawyer just say "do this." Why don't they make the decisions for the client? They can't. Ethically, the lawyer must have the client decide on the ultimate course of action. The authority to make the decision is the client's.

Skills That Can Help You

Getting a handle on the skills that a lawyer in the business aspects of health care can offer is like picking out your next CD player. The higher the capability of the CD system (lawyer) and the better the match of the system to your music (problems), the more likely you'll get the music played (the answers) at the level of quality you want.

An essential skill in a lawyer, after the ability to analyze, would be the ability to counsel a client. In fact, effective, clear communicators of the law as applied to a client's matter command a premium fee. Why? Because the lawyer must explain enough of the law as it applies to the client's particular situation for the client to make the decision.

The law is like a giant swimming pool. Drop in at one end and your ripple will effect something at the other end, the sides, and the middle. In other words, law is not science. Dental training and experience yield high predictability. But in the legal area, there can be innumerable laws, court cases at multiple levels, regulations and administrative rulings, or just plain custom that may impact a client's matter. And on any given day, one of them might change.

All of the foregoing illustrates why experience is compensated at a premium in the legal profession. If a lawyer has lived long enough (not all that easy these days!) he or she will have learned to watch for the ripple. This complexity may present difficulties dealing with some professionals. Dentists and other health professionals understandably have a limited business perspective. The multiple levels of dental practice — service and business — complicate some of the decisions dentists must make.

So now you know you can put to use a lawyer's mind to tap his or her (a) trained reasoning to (b) help you identify sound options and (c) to counsel you with clear communication. I'd call this first cut finding the right legal mind to help you.

The ability to negotiate is the next stratum, at least in terms of being of assistance to dentists. My experience is that most dentists are not quick to want to play the "sue you — sue me" game. I am eternally grateful that is the case. My own experience as an Assistant Illinois Attorney General litigating in the Court of Claims and as a Hearing Officer for the Illinois Secretary of State filled me full of the often weary and expensive process that is litigation. Instead I find dentists want to resolve problems, help make any situation win-win, and get on with their lives. To this day I continue to encourage dentists to resolve problems in a low-key, mediated fashion and avoid turning to litigation unless there is no viable alternative.

Some would charge that lawyers analyze everything.

Having effective assistance to negotiate or mediate problems can pay off big for dentists. It combines a natural disinclination for confrontation with an objective third party trained to facilitate problem solving. But dentists often waffle because they are too close to their problems, don't know how to find qualified mediators, and are often unaware of

how to structure workable legal solutions. Dentists may be afraid of making the "wrong" decision or may not be aware of their rights and options. And because they often don't know a good mediator or lawyer, they just pay their way out of the problem or simply hope it will go away.

There's more for those who want to use the lawyer's mind to advance their own business, family, or personal interests. This is what I call the icing on the cake. The icing is in how you qualify the lawyer. Too many dentists think one lawyer is as competent as any other (as too many patients think a dentist is like all other dentists). Common sense and experience should tell you differently. For example, it can help a great deal, although it is not essential, for a lawyer to know the dental industry, dental practice, and dentists. Any newly licensed lawyer can be retained to counsel and draft documents to sell a business, draw up an estate plan for a multi-million dollar estate, or undertake a complex law suit against the federal government on behalf of a client. But this seldom happens. The client and lawyer often can't communicate with each other in such situations. The inexperienced lawyer doesn't have the judgment based on experience that allows effective guidance. Lawyers with appropriate experience in oil and gas matters, real estate, or any one of a number of areas of specialization may be of limited help in meeting healthcare regulatory, transactional, or dental practice matters.

The multiple levels of dental practice — service and business — complicate some decisions dentists must make.

In addition to qualifying the lawyer's practice experience, you need to look at the lawyer's essential people skills. In my view these include accuracy, thoroughness in the work done, and routinely meeting deadlines. When you interview a lawyer prior to engaging services, ask about these qualities. The way a lawyer answers will tell you a lot about the experience you'll have with that professional. If a lawyer's mind or character has placed those skills as a priority you'll be on your way to a productive relationship. Bear in mind that the day-to-day practice of law can militate against all of those attributes. Telephone interruptions, difficult research, inscrutable government bureaucrats, and a host of other aspects can interfere with producing a timely, thorough answer or resolution. Nonetheless, appropriate people skills are what any dentist should insist on to get a solid relationship going and to keep one.

Dentists' Approach to Problem Solving

It seems, from my vantage point, that dentists approach problems by either a "tried and true" method or with an emphasis on what is novel. For lawyers, by contrast, different facts, different law, different people with their own agendas can lead to completely different results to what appears to be the same problem.

Influences on Problem Solving

A problem solving approach may also be influenced by education. A dental student's education is grounded in science and clinical technique. Consequently dentists seek to find an answer, usually the "right" answer. Law students' education encourages them to "think like a lawyer." This means use of a specialized vocabulary that structures legal thought and often prevents lay persons from figuring out the nuances of the application of law to particular facts. When a lawyer thinks about a client problem, the goal is to be a neutral, objective problem solver looking at the possibilities through a screen of legal rules. The facts of any case generally allow arguing the application of the law creatively, and it can be the mark of a sophisticated lawyer to "advocate" or be able to view and argue the facts or interpret the law to meet the position desired by a particular client. The right answer is not discovered, it is created.

Feelings vs. Facts

Dentists, once they are outside prescribed rigorous clinical approaches, tend to address problems based on what "feels right." Lawyers look at problems from multiple perspectives. All the particulars are accorded their due weight. This is what allows them to develop multiple options for their clients to consider.

Concluding Notes

My father, a non-lawyer, said to me as a young student, "Lawyers can find the answers to any business question, and they can write and talk about it, too."

Lawyers can find and should suggest options that may provide the answer to any business question the client has.

Now that caught my attention (obviously!), and I found it fundamentally true. In fact if there is a problem impacting not just business, but families, personal liberty, and society at large, lawyers are looking at it for their clients. They

write about what they find and share with their fellow professionals experiential findings.

But today, given my experience, I'd modify his statement. "Lawyers can find and should suggest options that may provide the answer to any business question the client has, assuming several things." The first assumption is that the lawyer's mind has been trained to reason well. Second, he or she is a patient counselor who is a good communicator. Third, he or she knows the industry and the people in it. Fourth, he or she realizes that certain essential people skills are as important as applying the law to the facts.

From this article you should now have a better understanding of how a lawyer's mind works and the ally that mind can be to you in solving business problems as well as evaluating opportunities. As you face various difficult business matters you should now be better prepared to access the resource that the lawyer's mind represents. Here's to your future peace of mind and your prosperity!

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Suits Other Than Malpractice – Loss of License

Charles F. Sumner, III, DDS, JD, FACD

Abstract

Acts and negligence on the part of dentists which result in the revocation or suspension of the license to practice are discussed. The California Business and Professions Code and the California Rules and Regulations are used to present examples from the areas of inspection of books, records, and premises; conviction of a crime; and unprofessional conduct. The acts that provoke civil litigation and state and federal agency action, incompetence, gross and repeated negligence, unprofessional conduct, safety in the work place, sexual harassment, and fraud are also the acts that subject the licensee to discipline from the Board. Investigative and hearing procedures, penalties, appeal, and due process are also discussed.

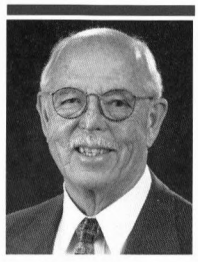
The American College of Dentists publication *News & Views* in Spring of 1997 reports that 3810 dentists passed state board of dentistry examinations in the United States in 1995. They, in turn, were rewarded with the privilege to practice their profession. You may be certain that they all looked forward to many years of practice and a bright financial future. California licensed 538 of those candidates.

In the fiscal year 1995-96 the California Board of Dental Examiners (Board) received 2783 complaints, opened 513 cases, referred 131 to the Attorney General's office and 11 to the District Attorney. There were 53 administrative actions resulting in 12 revocations, 2 voluntary surrenders in lieu of discipline, 13 probation with suspension, 26 probation, and one public reprimand. In the fiscal year 1996-97 the number of administrative actions increased to 78, revocations remained at 12, surrenders increased to 4, probation and suspensions almost doubled to 23. Thirty-four dentists were placed on probation for periods up to seven years for their violation of the laws that govern the practice of dentistry (California Board of Dental Examiners, 1996).

The acts that provoke civil litigation and state and federal agency action, incompetence, gross and repeated negligence, unprofessional conduct, safety in the work place, sexual harassment, and fraud are also the acts that subject the licensee to discipline from the Board (Department of Consumer Affairs, 1994). The consequences of the civil litigation that may result from both employee and patient disputes, the threat of fines, and censure from federal and state agencies all pale against the consequences that may flow from a violation of the laws that govern the profession and make up your state equivalent of the California Dental Practice Act.

This article is about litigation and the loss of the dental license as a consequence of violation of those rules and laws that govern the practice of dentistry. All references to the Board will be to the California State Board of Dental Examiners. The California Board is, as are the dental boards in other states, dedicated to the protection of the consumer through the examination and licensing of dental professionals and by the enforcement of the laws and standards of practice that govern dentistry. These laws are those found in the California Business and Professional Code (B&P) and the California Rules and Regulations (CR& R). A selection of these codes and rules make up the Dental Practice Act. Each state has similar laws governing the practice of dentistry and the rules of conduct for the licentiates.

Revocation, the taking away of an existing license, or denial of the privilege of renewal of that license, is a "death sentence" for the professional life of a dentist. If the evidence of a violation is not so egregious as to demand immediate restraint, a stay of revocation, temporary suspension, or probation may be allowed. When circumstances demand, as



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in drug related cases, a period of suspension from practicing may be included with the sentence of probation. Suspension and probation may last as long as seven years. During the suspension the dentist may not practice or earn income from practice. The conditions of probation, with or without suspension, are restrictive and closely monitored. Collateral consequence, such as the loss of reserve officer commissions and the cancellation of managed care contracts, may follow after conviction and a sentence of suspension or probation.

Investigation begins when a written complaint is received by the Board. Most complaints are received from patients. However, complaints may be made by anyone who believes a licensee has or is engaged in illegal activities related to professional responsibility. Complaints are received from dentists and auxiliaries, though individual licensees are not required by statute to report unprofessional conduct. Insurance companies must report fraud and payments of settlement or arbitration awards for over $10,000. The chief of a medical facility, peer review committees, and the administrator of any health care facility must report when staff privileges are denied, membership terminated, or restrictions imposed for medical disciplinary reasons. Fee and billing disputes, general business practices, and personality conflicts are not within the authority of the Board.

Revocation, the taking away of an existing license, is a "death sentence" for the professional life of a dentist.

Were you to read a list of complaints and study the supporting facts you would question, "Why are these professionals risking so much?" The frauds are petty, the improprieties reckless, and the repeated flagrantly negligent acts are easily avoided (Mosteller, 1997). You may wonder if an insanity defense might be valid. If the dentist does not recognize the value of his or her license, be assured that others do. The threat to suspend a license has proven to be effective. Receiving a report of a violation of the "Deadbeat Dad Law" from the district attorney, the Board sends a notice to the offending dentists informing them that they have a temporary license and 150 days to clear the complaint or the license will be suspended.

A Sample of Violations, With Examples

Inspection of Books, Records and Premises of Dentists (B&P Code Sect. 1611.5). In response to a written complaint to the Board, an inspector may be authorized, without a warrant but with proper identification, to enter the office of any licensee and to inspect the books, records, and the premises. The inspector addresses the issues raised in the complaint and may inspect the premises for any violations of state regulations, including the posters required by other agencies, and for violations of any of the OSHA requirements. A showing of continuing education (CE) records may be requested. If sufficient evidence is found to support the complaint, the allegation of misconduct is referred to the Office of the Attorney General for review. That office may prepare a formal notification of "Accusation/Statement of Issue" which is sent to the licensee who must reply. If no reply is received, the license will be revoked.

Unprofessional Conduct (B&P Code Sect. 1680). "Unprofessional conduct by a person licensed under this chapter is defined as, but is not limited to the following:" (Following that introductory statement are over thirty actions listed as unprofessional conduct under this code. A few will be illustrated.)

1680 (a). "The obtaining of any fee by fraud or misrepresentation."

Doctor AM diagnosed that a ninety-four-year-old resident in a convalescent home needed a denture. He failed to get consent from the conservator, appointed because of the patient's incompetence. An insurance claim was made for the extraction of three teeth on each of three days and for full dentures. The records do not reflect the three visits and dentures were not delivered. The patient who suffered from trigeminal neuralgia died a month after the initial claimed visit.

Charges in administrative hearing devoted to this issue most frequently involve multiple patients and fees. Here is such an example. Visits were submitted for payment under insurance procedure number 303 "bedside visit, one per day regardless of number of patients seen." Doctor AM submitted for 46 visits to one nursing home and 5 to another for the day of April 18,1995. Twelve visits to one convalescent home, 2 to another, 22 to another, and 4 to still another were submitted for April 24, 1995. This billing pattern continued through August 1995.

If the dentist does not recognize the value of his or her license, be assured that others do.

In addition to violation 1680(a) the charge included B&P Code Sect. 810. "False or fraudulent insurance claims."

1680(o). "The permitting of any person to operate dental radiographic equipment who has not met requirements specified under the code."

Doctor LL was charged with allowing his unqualified dental assistant to take dental radiographs. He was also charged with other violations of professional conduct as follows:

1680(e). "The committing of any act or acts of gross immorality substantially related to the practice of dentistry." Evidence was presented that, while treating his dental assistant for TMJ dysfunction, he molested her by placing his hands on her abdomen, thighs, and breast while

she was under hypnotic therapy. Failing to record his TMJ and hypnotherapy on one dental assistant and his bursitis treatment with acupuncture on another dental assistant is unprofessional conduct under B&P Code Section 1683. "Treatment entries in patient records."

1680(s) "Alteration of a patient's record with intent to deceive."

Doctor AK was charged with violation of B&P 1670, "gross negligence" on several patients as a result of his style of endodontic therapy. The alteration of records was the charge most easily proven in the court. Other violations of codes were noted on the premises inspection. 1680(t) "Unsanitary or unsafe office conditions;" 1680(bb) "The failure to use a fail-safe machine with an appropriate exhaust system in the administration of nitrous oxide;" 1680(x) "Any action or conduct which would have warranted the denial of the license."

480 (a)(2) "Any act involving dishonesty, fraud or deceit with an intent to substantially benefit himself."

Doctor MR's license was revoked in May 1997 for violation of the Dental Practice Act. He had requested renewal of his license in March 1996. He signed a form stating, under penalty of perjury, that he had completed fifty hours of continuing education (CE), including mandatory courses for his type of practice. The Board requested that he produce evidence of courses taken from 1993 through October 1995. The respondent failed to produce certificates, failed to reply and, failed to supply proof of completing requirements.

Fraud and quality of care cases require a great deal of investigation.

Conviction of a Crime as Grounds for Discipline (B&P Code Sect. 1670.1). When the Board is informed of the criminal conviction of a licentiate, it must investigate and determine if the conviction is "substantially related to the qualifications, functions, or duties of a dentist or dental auxiliary." Doctor RM's conviction for misdemeanor theft of a $87.00 "mouse" from a computer store was considered "substantially related."

Unprofessional Conduct (B&P Code Sect.1681). It is considered unprofessional conduct, which subjects the certificate to discipline, to use any controlled substance or alcoholic beverages or other intoxicating substances to an extent or in a manner dangerous or injurious to one's self, any person, or the public to the extent that such use impairs ability to conduct with safety the practice authorized by his license. The Board may issue interim orders of suspension (B&P 494) or a temporary restraining order (B&P 125.5,7,8 and Penal Code Sec.23;17535) to suspend or impose a restriction on a licensee if permitting the licensee to continue practicing might endanger the health, safety, or welfare of the public. An Appellate Court decision (*Alexander v. Board of Dental Examiners*, 1991) upheld the constitutionality of Business and Professional Code Section 820 which authorizes healing arts boards to require a licensee to submit to a psychological evaluation upon probable cause.

In 1982, the California Board established a diversion program for alcohol and substance-abusing licensees. The program may be entered by self-referral. The Board has found that placing impaired licensees in treatment programs as quickly as possible is cost efficient. Not only is the individual monitored to prevent further problems, but most of this type of disciplinary cases are resolved with stipulated agreements rather than lengthy hearings

Due Process

Fraud and quality of care cases require a great deal of investigation. The final report is not forwarded to the attorney general until it is determined, with a high degree of certainty, that the subject of the investigation can be successfully prosecuted. As a result, investigations may go on for over two years. As frustrating as this is to those who see an obviously incompetent practitioner still in their midst, we must surely agree that certainty is required before a license is revoked.

A majority of cases are heard before an administrative law judge (ALJ) where the Board is represented by a member of the attorney general's staff and the respondent by a private attorney. After the hearing, a proposed decision is prepared by the ALJ and sent to the Board for review. The Board can elect to adopt or not adopt the ALJ decision. A respondent may appeal the Board's decision. The appeals, when they occur, are on questions of law and interpreting the law rather than the accumulated facts in evidence

Read the rules and regulations...and read them again.

Here is an example of a case that was appealed (*Green v. Board of Dental Examiners*, 1996). The disciplinary action against Dr. Green was premised upon B&P Code Section 726 "The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer which is substantially related to the qualifications, functions, or duties of the occupation for which a license was issued constitutes unprofessional conduct and grounds for disciplinary action..."

The administrative charges against Green were of "improper sexual conduct with two patients through his misuse of craniosacral therapy to treat their temporo-mandibular joint (TMJ) condition." On November 17, 1994, following a disciplinary hearing, the Board revoked Green's license, with revocation stayed, Green was placed on probation for seven years. In his defense, Green asserted that craniosacral therapy is an osteopathic procedure used to correct TMJ prob-

lems. He alleged the treatment involves subtle physical manipulation of the head, neck, shoulders, spine, sacrum, and pelvic areas to eliminate misalignment problems affecting the jaw. He further contended that the sexual acts were consensual and were not substantially related to the dental therapy. He questioned the applicability of B&P 726 to the charges against him. He questioned the Boards interpretation of "substantially related."

The California Court of Appeals ruled that there was sufficient evidence to support a finding that Green misused his treatment to create an emotional environment to foster dependency and an illusion of trust. He used his knowledge of his patient's personal problems and his professional skills to play upon their emotional needs. He incorporated erotic and manipulative touching of intimate parts of their bodies into treatment. He then violated the patients' trust and exceeded the scope of their consent for treatment by seducing them into a sexual relationship. Such conduct is substantially related to the functions and duties of a dentist and supports a finding of disciplinary action pursuant to section 726.

Three of Green's former patients, two who were involved in this appeal, unsuccessfully sued him in 1991 for damages based on claims of sexual impropriety. This court stated that the outcome of the civil action based on financial liability was irrelevant to the current review of an administrative disciplinary proceedings involving the revocation of a license based on the need to protect the public.

Conclusion

Dentistry and law are alike in at least one area. Preventing the problem, be it caries or litigation, is the only resolution likely to please a patient or a client. When treatment is necessary, the resolution is expensive, painful and, too often, disappointing. Each state board publishes the rules and laws that govern the dental profession. My best legal advice is "Read the rules and regulations...and read them again...at least once a year as long as you practice dentistry."

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Malpractice – A Plaintiff's Perspective

Edwin J. Zinman, DDS, JD

Abstract

Evaluation of malpractice litigation considers any breach of the fiduciary responsibility of the dentist, violations of the standard of care, comparative patient negligence, possible defenses such as honest mistake and causation. Issues in determining damages and mitigation are also discussed and a series of questions is offered concerning evidence for various dental procedures. Emerging trends in litigation include disregard of manufacturers' precautionary instructions in using new materials.

Translated from Latin, *primum non nocere* means "above all, first do no harm." This principle is the cornerstone of both dental ethics and tort law principles. A continuing thread, woven through the fabric of dental ethical codes and layers of law, is the fiduciary obligation of the dentist to the patient (*Willard v. Hagemeister*, 1981). As a fiduciary, the dentist's primary obligation is to protect and preserve the patient's best interests irrespective of the dentist's financial interest. This same fiduciary obligation applies to other professionals such as physicians or attorneys.

By contrast, the business community's interest is often dictated by its stockholders' desire to maximize profits. If not balanced with the protection and preservation of the patients' interests, harm to public health results.

The tobacco industry, for example, recently agreed to a $368 billion dollar settlement of forty state attorney generals' class actions. The proposed settlement included payments for a multitude of medical injuries caused by profitable sales of a public-health endangering product (New York Times, 1997). Similarly, managed care organizations run the risk of liability for fiduciary failure if only the fiscal, rather than patients' needs, are fulfilled by discouraging needed referrals (*Shea v. Esenstein*, 1997).

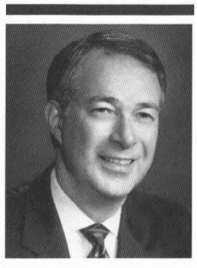
Standard of Care v. Customary Care

The standard of care to which all dentists must adhere is ordinarily established through dental expert testimony. Occasionally the court will intervene and affirm the appropriate standard of care if testifying experts confuse a negligent custom with the legal standard of reasonable care. If an entire industry or profession lags behind what reasonable care is or ought to be, the courts will judicially pronounce the correct standard (*Barton v. Owen,* 1979). For instance, jaywalking, speeding, or not wearing a seat belt is neither legal nor reasonable but instead represents customarily negligent practices. Similarly, absence of full mouth radiographs for a comprehensive dental exam, not probing or recording periodontal pockets, and not diagnosing caries susceptibility exemplify negligent customs rather than reasonable standards of care.

Comparative or Contributory Negligence

Fundamental to protection of a patient's rights is the patient's right to a jury trial which determines the relative responsibilities and obligations of both dentist and patient (see, for example the California Dental Association Patient Bill of Rights). If the dentist breaches the fiduciary obligation to care for the patient's best dental interest, a finding of professional negligence may result. On the other hand, if the patient's negligence contributes to the patient's injury, the patient's recovery may be denied or reduced in proportion to the relative degree of patient fault.

When compared to a patient who does not follow instructions to brush, floss, or maintain recall visits, a dentist who negligently fails to periodontally probe may yet be judged with comparatively less fault, depending on whom the jury decides was a greater cause of the patient's injuries. Thus, the American system of justice contemplates balancing the relative responsibility of dentist and patient. If the patient acts irresponsibly, the civil suit will either be lost or severely compromised, depending upon the comparative degree of any patient irresponsibility. For instance, in most states with comparative fault tort law, if the patient is 40% negligent, but the dentist is 60% negligent, the patient's total damage



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award is reduced 40% rather than eliminated entirely (California book of Approved Jury Instruction, 14.90).

Investigating a Dental Negligence Claim

Since lawyers usually handle dental negligence claims on a contingency fee contract arrangement, the lawyer's fee, if any, is contingent upon achieving a satisfactory out-of-court settlement or jury verdict. Forty percent of a defense verdict is still zero. The plaintiff's lawyer will have invested time and legal costs to no avail if the case is lost. Therefore, the plaintiff's lawyer screens cases to assess the relative risk of trial success versus failure. Assessment factors follow:

Managed care organizations run the risk of liability for fiduciary failure.

Records. As a practical matter, juries generally conclude that good dentists keep good records and poor dentists maintain poor records. Accordingly, the best defense to a dental negligence claim is patient records that document the SOAP (Subjective, Objective, Assessment, and Plan) principles of recording as well as any patient failures in oral hygiene, taking prescribed medications, or keeping appointments.

Lawyers typically review dental records to not only identify potential defendants as well as subsequent treaters, but also to determine evidence of documented diagnostic or treatment errors.

Record Keeping Fraud

Evaluating dental records for assessing the presence of dental negligence analysis requires the evaluating dentist to determine if the records were altered. One hallmark of altered records is that the records appear too good to be true. In this author's experience, added falsified entries in dental records have included (a) additions to an oral surgeon's records advising of post-operative pathological fracture, (b) a general dentist's referral to a periodontist, (c) patient's refusal of recommended radiographs, (d) backdating insurance forms, and (e) post-operative antibiotics following extractions. Altered records expose the dentist to risk of a separate tort termed spoliation (California Book of Approved Jury Instructions, 7.95).

Negligence. Even if a dental procedure is performed in a technically flawless manner, the dentist may still be liable if the treatment was either unnecessary or lacking adequate disclosure to the patient of the informed consent principles of risks, benefits, and reasonable alternatives (California Book of Approved Jury Instructions, 6.11).

Defense attorneys would rather defend poor records than falsified records. In a poorly documented records case, the dentist may have exercised good judgment, but failed to record findings or recommendations, and may still win the case. Thus, the jury must decide if the dentist's negligence was an oversight in recording rather than poor judgment. Dentists who create records for litigation, rather than contemporaneously with treatment, lack credibility that proper judgment was exercised. Instead, dental deceit, if proven, subjects the dentists to Dental Board discipline (California Business & Professions Code 1680(S))and punitive damages. Professional liability insurance defends but does not indemnify for proven fraud since fraud damages are regarded as evidence of intentional misconduct. Professional negligence insurance policies cover careless mistakes but do not indemnify deliberate deception designed to consciously mislead or misrepresent a patient or misrepresent anticipated treatment results (California Insurance Code 553).

The American system of justice contemplates balancing the relative responsibility of dentist and patient.

Defenses. Honest mistakes are defensible as a judgment call in which reasonable dentists may differ. Even if only a dental minority would have done what the defendant dentists did, nonetheless such conduct is not negligent, provided it was a reasonable minority school of thought. However, if the members of the contrary school of thought promote a dangerous or controversial methodology, the contrarian school may be unreasonable and therefore represent an unacceptable substandard practice. For example, paraformaldehyde-containing endodontic sealants, cementing an excessively over-contoured but esthetic crown, or acquiescing to managed care plans which unreasonably delay or deny referrals represent unreasonable minority schools of thought which therefore do not represent a defensible alternative method.

Juries generally conclude that good dentists keep good records.

Causation. Despite the dentist's negligence, if no harm resulted, no liability results. If a non-periodontally probing dentist can demonstrate that no worsening of the patient's periodontal disease resulted despite the absence of recorded pocket measurements, then the failure to probe caused no damage or injury. Conversely, if the radiographs demonstrate progressive bone loss where no pocket measurements were ever done, then the presence of deep pockets implies that earlier in time, the pockets were shallower. Consequently, periodontitis, had it

been treated earlier, would likely have had a better prognosis.

Damages

Prognosis is essential to determine present and future damages. Loss of a single tooth can result in a plethora of damages. If the tooth was unopposed or otherwise non-functional, little damage may have resulted in its loss except for any value as a future abutment should any adjacent teeth be lost. Maxillary incisor tooth loss is significant since arguably the patient's proud smile is lost and the prosthodontist usually can not esthetically match God-given natural enamel.

Defense attorneys would rather defend poor records than falsified records.

Current treatment costs alone may not be the true or a total measure of damages. If a lost tooth is replaced with a bridge, the average longevity of a bridge is approximately ten years. Especially in the maxillary anterior region, due to esthetic matching to adjacent teeth as the patient ages, the esthetic life may be reduced several years less than the ten year average longevity for bridges. Accordingly, juries consider present as well as future replacement costs resulting from teeth lost.

Additional damage to be considered are transportation costs to obtain corrective care, lost wages uncompensated by sick leave, the pain of corrective dental procedures and the mental suffering to have undergone corrective care, and permanent loss of a vital natural part of one's body caused by another's carelessness.

Mitigation

Dentists often mistakenly believe that corrective care should be delayed until examined by others, such as delaying removal of defective restoration so peer review examiners can independently examine.

A patient has a legal obligation to mitigate or lessen damages, if reasonable to do so (California Book of Approved Jury Instructions, 14.67). Accordingly, delaying corrective care potentially damages the patient both dentally and legally. Thus, a crown or bridge patient with open crown margins risks decay, endodontics, and periodontal disease, unless the crown or bridge is promptly replaced.

Evidentiary Proof

Diagnostic quality radiographs, recorded chart entries documenting chief complaints, differential diagnoses, clinical findings, diagnostic testing, informed consent, recommended therapy, and prognosis represent baseline benchmarks for comparison with prior or subsequent care. Some examples of evaluating negligent dentistry follow:

Prosthodontics. Was the crown necessary? Was a radiographic artifact mistaken for decay, which instead required either no treatment or only monitoring and observation (Benn & Meltzer, 1996)? Do radiographs or chart entries of subsequent treating dentists document crowns which have open or short margins, overcontour, closed embrasure spaces, malocclusion, or biologic width invasion?

Endodontics. Was the post adequate in length, type, and direction? If a perforation occurred, is it also observable in any prior treaters' radiographs? Was pulpal testing done to document necessity for root canal therapy? If endodontics failure occurred, was a substantial contributory cause due to failure to use a rubber dam, short root canal fill, or a missed root canal?

Exodontics Was the extraction necessary, or should the tooth have been saved by endodontics? If left alone, was the extraction risk greater than retention, such as in the case of an older patient with an asymptomatic impacted third molar? When performing the extraction, did the dentist have available a complete periapical view, or was the dentist operating blind with either no radiograph or a cut off view? Did a new systemic disease affecting the post-operative course recently manifest, which an outdated medical history failed to detect?

Emerging Litigation

Newer technologies and materials require careful study and strict scrutiny of manufacturer's directions before use. Restorative composite materials are technique sensitive and may predispose to increased need for endodontics if improperly used. When safety margins are narrower, opportunities for operator error increase.

Prognosis is essential to determine present and future damages.

Dentists adhering to the standard of care must also adhere to manufacturer inserts. For instance, certain buildup materials require at least two thirds remaining tooth structure. Thus, failure to follow manufacturers' recommendations exposes the patient to tooth fracture and the dentist to a professional negligence suit, since reasonable dentists usually follow manufacturers' recommendations.

Informed Consent

Representing prognosis for any new material or technique requires the dentist to advise the patient that long-term results are unknown. Even representing the national statistics for a procedure's success may constitute a negligent misrepresentation or even fraud, if the practitioner knows or should know that the dentist's own success rate is poor when compared to the national statistics (*Hales v. Pittman*, 1978). Stated otherwise, informed consent requires the dentist to advise a patient of all material risks. One material risk that a reasonable patient

would want to know is that a greater risk of failure or complications may result with the dentist whose therapeutic track record falls substantially below the national median success rate.

Conclusion

Pursuing only profits rather than patient welfare pushes the liability envelope to the open position. Dentists tempted to increase patient volume by discounting not only fees, but also discounting quality of care, increase the risk of professional negligence litigation if professional quality is also discounted. Patient protection remains the paramount principle which professional negligence suits strive to uphold.

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Malpractice – The Dentist's Perspective

Arthur W. Curley

Abstract

A lawyer with more than twenty years of experience defending dentists in malpractice situations reflects on the attitudes he typically sees in dentist defendants. The "professional" orientation that patients should expect nothing more than that the dentist does his or her best, is often at odds with the patient plaintiff view that they will have their feelings recognized at almost any price. The lawyer's role is often one of education. As the facts and perspectives involved are revealed through disclosure, resolutions begin to emerge. The best approach is for dentists to learn to communicate with patients — from their perspectives.

For the last twenty-three years I have been defending dentists and their staffs from claims of malpractice, known in the law as professional negligence. Most of my dental clients come to me by way of referral from their insurance carrier or another dentist. Regardless of the source of the referral, much of the time I spend with a client throughout the case is devoted to a process of education and reorientation of the doctor's perspective about the law, the legal system, lawyers, patients, and, in many cases, their own staff.

In order to understand the dentist's perspective on malpractice claims, one needs to look at the genesis of a dentist, the realities of modern practice, the public's attitude toward the profession, and the legal system.

Genesis of a Dentist

The reason someone chooses a career in dentistry often forecasts the perspectives they will develop by the beginning of their practice. Many select dentistry as a career because they believe that they can be their own bosses. Some are primarily attracted to the role of care giver and healer or want to follow in the career path of a parent. Still others have admitted that they saw dentistry as a health care profession where they could make the most money with the least amount of hassle: no internship, residency, or hospital issues.

Traditional dental school training does little to dispel the notions of why most dentists choose their career. Students are trained to believe that if they care about their patients and try to provide quality dentistry, their patients should appreciate and understand their efforts even if the results are less than optimal.

Soon after graduating, most doctors are in their own practice, caring for patients, and enjoying a reasonably good income. They are rewarded with letters of gratitude and referrals from patients in addition to fees for services.

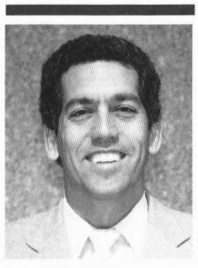
However, dentists receive little training in the "business" of dentistry. During my initial interview, I frequently ask my client questions that involve fee structures, billing, and insurance issues because my experience has been that plaintiff's counsel will often ask those same questions during a deposition or when the doctor is on the witness stand. The most common response to this question is, "I don't know, that's not my area, I leave it up to the staff at the front desk." Indeed, in many cases where the patient had demanded some sort of refund, the doctor's initial reply was to direct the person to the office manager or front desk person, who then dutifully stated that refunds were against office policy.

Modern Practice

The realities of modern practice are that dentistry is now more of a business than a profession. Indemnity insurance dominates the market, often influencing the level of care by way of fee schedules and utilization reviews. Managed care is growing and further limiting the amount and quality of dentistry a patient can afford and a dentist can provide.

Employment laws have changed the relationship of the doctor with the staff. What was once accomplished with a handshake and one's "word," now requires a policy manual; a formal hiring and termination process; and, in many cases, special insurance to cover claims of wrongful termination, discrimination, and sexual harassment.

Lawyers, the legal system, and the insurance industry are seen as the source



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of the changes that are perceived as undermining the doctor's control over the practice, constricting the quality and raising the costs of practice.

Public Attitude

In addition, dentistry and health care in general are seen more and more as a product in the eyes of the consuming public. Advertising, cosmetic treatment, technological advances, and aggressive pricing have created an atmosphere where patients have come to expect pain-free and failure-free care. When they don't get the results they anticipated, the public assumes that the "product" was somehow defective and they often expect the same treatment they get from most well-respected retailers: a replacement, a refund, or additional treatment without cost.

Indeed, most merchants have a system in place to handle customer complaints and a manager with full authority to do whatever is necessary to "make it right." The success of retailers today is often measured in large part by the efficiency of their dispute resolution system. "If you are not completely satisfied, you can always bring it back for a full refund, no questions asked."

Additionally, the marketplace is such that, in most communities, there is a over-supply of doctors and the patient can frequently find another office that will offer to replace unsatisfactory dental work at a lower cost or give a refund.

On the other hand, the perception of most doctors is that patients see a complaint about dental care, or the filing of a malpractice claim, as a way to get free dentistry or in some cases a way for them and their attorney to make money they don't deserve.

Psychologists have opined that many times when a patient files a claim or suit, it is a last resort and more as a way of forcing some form of acknowledgment from the practitioner that the treatment or result they obtained was not successful or what they were led to believe they could anticipate. The origin of the problem frequently stems from unreasonable patient expectations created by inadequate communication, particularly where the dental marketing overshadows discussions of the risks and alternatives to a chosen treatment plan. Balancing marketing efforts with appropriate informed consent discussions is a skill few dentists learn in school or during their early years of practice when they are struggling to establish themselves in a particular community.

The imbalance between the doctor's perception and the patient's expectations leave a disappointed and frequently frustrated patient who then seeks advise from another dentist, a family member, or friend. All too often, when the patient seeks the second opinion of the other dentist, that doctor's marketing efforts do nothing to modulate the patient's perception. Rather, by offering comments such as: "That restoration is inadequate and we can fix it with something that you will be very happy with for a cost of..." they merely confirm the patient's suspicions that they got a defective product. When they convey these discussions to family and friends they are often advised to seek legal advice or peer review.

Dentists are trained to believe that if they care about their patients and try to provide quality dentistry, their patients should appreciate and understand their efforts even if the results are less than optimal.

The Legal System

Many doctors have little knowledge of the legal system and how lawyers most often operate. They perceive lawyers as the cause of the problem because they are somehow manipulating patients and distorting the system. Indeed, some have expressed the impression that lawyers, particularly those who specialize in dental law, are the reason most patients decide to bring a claim or suit and that most ethical lawyers wouldn't take the case.

Yet at the same time, those doctors frequently state that if they could just tell the judge "their side of the story," or if they were allowed to show a judge or jury that several other doctors in their community would have provided the same treatment, the court would dismiss the complaint.

In addition, most doctors, like most Americans, have a distorted perception of how the legal system really operates. Television and movies lead them to believe that the process is swift and trials take a few hours, a couple of days at most, allowing time for commercials. Hollywood has given them the notion that during trial, some witness will suddenly blurt out the "truth" during cross-examination and the court will dismiss the case or the jury will find for the "right" person.

My first hours of meeting with a new and unseasoned client, generally includes a discussion on the realities of the legal system and how it, judges, and juries, work. In many cases, the doctor then shifts to a new perception, that the system is stacked against the health care provider and there is no hope, and that all the lawyers will get a lot of money. As the case progresses, the doctor generally comes to understand the "business" of dentistry and the reality that the legal system is not so much about trying to find the absolute truth as it is a civilized attempt to resolve differences between the doctor and the patient caused by communication failures, unreasonable expectations, inadequate office systems, and in some cases, sub-standard care.

Defense Perspective

During the early investigation of a claim or suit, I frequently search for what I call the "trigger point." This is the area or moment where the previously appre-

ciative patient became the adversarial plaintiff. That point may be when the patient was seen for the "fifth try-in" and began to express frustration, or when the patient was told that there was nothing wrong, the doctor's work was the best in the community, and the patient would "just have to get used to it."

The law provides a civilized attempt to resolve differences between the doctor and the patient.

At that point I begin the re-education process of the doctor and, in many cases, the staff as well. First, despite what many doctors believe about attorneys, they don't cause malpractice suits. Unlike driving a car, working on a construction site, or buying a home, the business of dentistry is not conducted out in public view. Rather, due to issues of confidentiality and infection control, health care is a private matter. While one cannot easily dismiss the notion of attorneys flocking to the scene of a train wreck or following an ambulance to the hospital, such images do not include lawyers sitting outside of dental offices seeking victims. Indeed, the first contact is generated by the angry or frustrated patient seeking legal advice from a family member or business attorney. Often that attorney, not being familiar with the malpractice process, refers the patient to a office with a reputation in the legal community for handling dental malpractice cases.

Next, after hearing the patient's side of the story, the attorney attempts to gather some evidence to verify the claims. Generally that effort includes obtaining copies of the would be defendant's records and then the records of the other doctors who saw the patient. Contrary to the perception of most doctors, these attorneys seldom take cases with the idea that they can make some quick money merely by filing a lawsuit, regardless of the merit of the case, or lack thereof. Like the cost of the practice of dentistry, the cost of the practice of law has risen greatly. Today, in many communities, the cost of hiring a first-year attorney is less than the pay of an experienced legal secretary. In a contingency fee case, where the doctor must consent to any settlement, the attorney is all too aware that 30% of nothing is nothing.

In most cases that are filed, the attorneys find the trigger, something they feel they could take to a jury if they had to prove their client was wronged. Typically the triggers are inadequate, inconsistent, or altered records; failure to recognize a problem requiring different treatment or a referral to a specialist; lack of informed consent; absence of adequate pre-treatment imaging; or a failure to appreciate that a patient was medically compromised.

The attorney for the patient is not hired to find the truth, rather they are advocates, attempting to support the patient's position and allegations.

The case then begins with the filing of the lawsuit. The perspective of most doctors is that the suit will specifically state all the claims being made and the plaintiff is limited to the statements in the suit. In fact, most complaints filed with the court are drafted from forms taken from past complaints in a similar case. They are typically broad, sometimes vague, and often not specific as to the facts of the case. The law does not require specificity, only that the plaintiff allege substandard dental treatment that caused injuries while under the defendant's care.

The court then commands a process called discovery. It is the design of that process that most suits would be resolved without going to trial, if each side is forced to disclose all the evidence in the case. Indeed that is the case. Fewer than 5% of all suits against dentists ever go to trial. To put that in perspective, only 10% of all suits filed in the United States involve claims of personal injury, and of those, only 10% involve claims of malpractice. Fewer than 10% of those suits involve dentists or a ratio of 1:1,000.

During the discovery process both sides learn the strengths and weaknesses of the case. It is the goal of the defense to expose to the patient, and particularly the patient's attorney, evidence, and issues that weaken or destroy the case. Some cases are abandoned by recommendation of the plaintiff's attorney as a result of the evidence revealed in the discovery process. Yet most continue until just before trial, pressed by the patients' need for some recognition that they were wronged and the doctor's insistence that everything was done correctly.

The judge or court does not resolve questions or issues of fact. In most states, that role is left to the exclusive province of the jury. Therefore, the court will seldom dismiss a case merely because it seems weak, has only a small chance of success, or involves limited injuries and damages.

At some point, one or both sides begin to see that litigation is also a business, a time-consuming and expensive process that is focused on trying to give everyone the opportunity to explore many issues and present various pieces of evidence.

Dentists often begin their careers with the perception that merely delivering quality dental care to patients in a caring manner and at a fair price will keep them out of a legal system.

At the conclusion of the discovery process, most seasoned attorneys can reasonably predict how a case will fair if presented to a jury. Many courts require

the parties to undergo non-binding arbitration to give them an early sense of how a case might turn out.

The doctor, who at first sees the litigation as an opportunity to tell his or her side of the story and to be vindicated, begins to recognize the tolling effect of the disruption of the practice and the emotional strain of litigation. Typically a defendant will lose from five to ten days out of the office if a case goes to trial. Resolving the matter without further disruption then becomes the goal. The patient, while still looking for some recognition, however small, also begins to want closure.

If the resolution of a case achieves its purpose, both sides conclude the process with the sense that they gave up something, didn't get all that they wanted, but feel that the matter was concluded to the point where they can get on with their lives.

Conclusion

Dentists often begin their careers with the perception that merely delivering quality dental care to patients in a caring manner and at a fair price will keep them out of a legal system they see controlled by lawyers who somehow talk patients into becoming plaintiffs.

The dentist often comes out of the litigation process with the new understanding that dentistry is indeed a business and, that if handled as one and not just as a profession, the legal system can, more often than not, be avoided even where there is a poor outcome or a dissatisfied patient.

They also learn that litigation is an inefficient way of resolving disputes. It is hoped, if the education process works, the doctor will also learn that resolving disputes internally and early on is the best way to stay out of the litigation system. That goal can be best achieved by maintaining a dialogue with the patient, practicing quality record keeping with risk management, being open to a refund or early referral to another colleague whom they trust.

Over the years I have consulted for a number of clients, performed office audits, and advised on techniques for risk management and early dispute resolution. I have seen through experience that these principles work and that when the doctor views the practice of dentistry as a business and the legal system with a new perspective, that they achieve the ultimate goal — they never have to hire me again.

Expert Witness or "Hired Gun?"

Mert N. Aksu, DDS, JD

Abstract

The good intentions of dentists are not a protection against malpractice suits. The role of the expert witness in malpractice cases is to explain to judges and juries what the standard of care is and whether it has been followed. The historical practice of looking to local standards has given way to a national standard and the requirement that an expert be qualified and will assist the judge and jury in determining relevant facts. The motives of expert witnesses for both the plaintiff and the defense are open to scrutiny. Tort reform has begun to codify some of the properties of expert witness activities. Parameters of care may become interpreted as legally defining the standard of care. Expert witnesses testifying in criminal cases as forensic dentists must meet the standards of providing scientifically verifiable evidence passing the test of peer review.

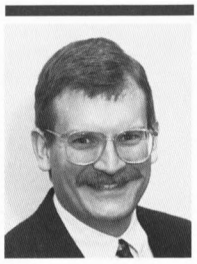
There are numerous reasons the legal profession is so often viewed with suspicion from the perspective of a dental professional. Repeatedly, over the past decade, dental graduates have been told that statistics show each graduate will be named as a defendant in a malpractice claim at least once over the course of a career in general dental practice. This fact, combined with the dental professional's perception of the adversarial process, makes the legal profession's role in dispute resolution of dental claims often unwelcome.

To those unfamiliar with litigation, the judicial processes are often reminiscent of a theatrical production. The parties to the claim include the defendant, the individual answering the allegations, and the claimant or plaintiff, the individual bringing forth legal allegations. Each of the parties will without doubt have legal counsel. In claims of dental malpractice, other than the parties, witnesses will often include other dental professionals. Often the subsequent treating dental professional is called to offer testimony, as well as professionals called by each of the parties to present testimony as expert witnesses. It is the historical perspective of the role and present status of dental expert witnesses that this paper will focus upon.

Members of the dental profession, trained in the scientific method, are often dismayed when an accusation of malpractice arises. This dismay comes from the general outlook of the dental professional which differs from the outlook of the legal profession. The dental profession operates with the basic presumption that licensed practitioners deliver and provide preventative and therapeutic care with the general intent of improving the practitioner's patients' quality of oral health. Dental practitioners understand the demands of patient care, are taught to respect their colleagues, and often view litigation as an undesirable alternative for dispute resolution. In contrast, litigation for the legal profession is an avenue where a dental practitioner's patient is compensated for that practitioner's failure to fulfill a professional duty. The general perspective of the legal profession is that certain percentages of services rendered by the dental profession might in fact fall below a certain "minimum standard of care" as defined by an expert witness who is a dental professional.

The Expert Witness

As the term "expert witness" is used in the legal profession, it is a term of art. There are primarily two areas where an expert witness from the dental profession will be involved with litigation. Dental professionals most often serve as expert witnesses in claims of dental malpractice. In these cases, expert witnesses are called to establish the minimum standard of care for given procedures and provide testimony on how the defendant dentist acted in conformity, surpassed, or failed to meet that minimum standard. Dental expert witnesses are also used to present forensic dental evidence in criminal cases. While evidentiary procedural guidelines for the civil malpractice claims will be primarily guided by individual states' rules of evidence and tort reform statutes, criminal cases with forensic dental evidence have been guided somewhat



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by federal court decisions and the Federal Rules of Evidence.

Looking at these causes of action, there are fundamental differences in the historical development of the role of the expert witness. Dental experts providing testimony in criminal cases are called to provide a basis for the admission of scientific evidence in the form of dental forensic data. The Federal Rules of Evidence allow the dental professional to testify according to the following rule:

"...if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, expertise, training or education, may testify thereto in the form of opinion or otherwise" (Federal Rules of Evidence 702).

Until 1993, dental expert witnesses were allowed to provide relevant testimony on dental forensic data designed to assist the trier of fact, either judge or jury, so long as methods of analysis and rationale for assertions had reached a level of "general acceptance" in the dental profession (*Frey v. United States*, 1923). However, in 1993, the Supreme Court held that dental experts providing forensic testimony must base their testimony on verifiable scientific methodology with a basis in peer review and publication (*Daubert v. Merril Dow Pharmaceuticles*, 1993). The change from a standard of "general acceptance" to verifiable scientific methodology with peer review could in effect limit admissibility of expert witness testimony on certain types of forensic data. The dental professional providing expert testimony on a forensic matter in most cases is facilitating the admissibility of bite mark data. Such data, while controversial, have been instrumental in securing sustainable convictions.

Litigation is an avenue where a patient is compensated for that practitioner's failure to fulfill a professional duty.

The Expert Witness in Malpractice — The "Locality Rule"

In contrast to the dental expert witness assisting with forensic evidence, dental professionals testifying as expert witnesses in claims of dental malpractice have limitations which have evolved from quite a different areas of case law. Within the past three decades, courts and tort reform statutes have changed the criteria used in defining whether a particular practitioner would be a legally competent medical/dental expert witness in claims of malpractice. This change reflects primarily the opinions of numerous court decisions establishing national standards for patient care within the medical/dental profession. Cases adjudicating claims of malpractice previous to this period defined expert witnesses as practitioners from the same locality practicing under the same or similar conditions. This locality rule for expert witnesses posed several problems that ultimately led courts to define experts on the basis of a national standard of care.

In deciding to abolish the locality rule, court decisions have focused on several notable issues. In reviewing the locality rule, courts have often written opinions suggesting that practitioners from the same locality practicing under same or similar conditions were often reluctant to serve as expert witnesses in claims of malpractice against their peers. As an example, with the locality rule, claims of malpractice required an expert witness often from the same locality familiar with the conditions of the defending practitioner to establish the minimum standard of care for that locality under same or similar conditions. Potential expert witnesses from outside the same local region were often excluded, as courts found it difficult to measure requirements for "same or similar" conditions and that these professionals were unaware of the local standards of care. Many courts, through written opinions and writers of legal treatises, often wrote that the locality rule created a conspiracy of silence among the local medical practitioners, and that with national standards for medical training and improved access to information, a national standard of care is appropriate for claims of medical/dental malpractice. The implication of these decisions on dental practitioners is that practicing dental professionals faced with claims of malpractice could expect to find that courts will permit a colleague practicing anywhere in the United States to define the minimum standard of care and render an opinion as to whether that professional in question practiced in conformity with that minimum standard.

Accepting a national standard of practice, the courts have emphasized that the standard of care still depends on the resources reasonably available to the practicing professional. The opinion of the expert witness must reflect the circumstances of the case and information reasonably available to the practitioner accused with malpractice. An isolated rural practitioner providing an emergency procedure without the means to take a panoramic radiograph could defend against claims of malpractice brought by a plaintiff's expert witness insisting that the standard of care required a panoramic film.

Courts will permit a colleague practicing anywhere in the United States to define the minimum standard of care.

With these decisions, the courts have widened prospective plaintiff's choices of potential expert witnesses. However, plaintiffs must demonstrate to the judge that their prospective expert witness is qualified to serve as an expert, the expert

witness's testimony will assist the trier of fact, and that the expert witness's testimony is based on facts which will substantiate the expert's opinions (Furrow, et al, 1991). With regard to qualifying an expert, courts in some jurisdictions have permitted specialists to testify against generalists provided that the subject of testimony was knowledge common to both the specialist and generalist. Practitioners not certified by boards have served as expert witnesses in cases against board certified practitioners. Psychiatrists have been allowed to serve as experts on areas of post-operative prophylactic antibiotic coverage on breast implant patients. In contrast to these jurisdictions, an increasing number of jurisdictions, either through case law or tort reform legislation, require that a potential expert witness must practice in the same field as the defendant practitioner.

The reputation of our litigious society has deepened the concerns many medical and dental professionals have in regards to litigation.

In retrospect, abolition of the local standard was often opposed by local communities of medical and dental practitioners who sought protection from out-of-town experts typified as "charlatans willing to provide an opinion for a fee" (*Hall v. Hillbun*, 1985). While one look at the classified advertisements of most legal journals may substantiate this concern, it is the trier of fact, either judge or jury, who will ultimately weigh the credibility of the expert witnesses' testimony and decide whether a particular practitioner failed to meet the minimum standard of care, therefore holding that practitioner liable for malpractice. The reputation of our litigious society has deepened the concerns many medical and dental professionals have in regard to litigation. The legal profession and legislatures are sensitive to the concerns stemming from an ever-increasing number of million dollar settlements in claims of medical/dental malpractice. As a result, state legislatures throughout the United States have passed into law numerous bills targeting these issues. These "tort reform" bills have addressed areas from limits on non-economic losses for emotional distress and pain and suffering to legislating criteria for expert witness qualifications.

Expert Witness and Tort Reform

These legislated tort reforms have provided the courts in several jurisdictions with guides for qualifying an expert in particular tort cases. Tort reform and some court decisions have emphasized that, for the most part, dentists serving as expert witnesses must practice or teach the areas covering the subject matter of the malpractice action about which the expert will be rendering an opinion. In jurisdictions without statutory guidelines, dentists serving as expert witnesses must meet minimum legal requirements reasonable for that jurisdiction and must have credentials sufficient to gain the respect of juries and judges who will be deciding these claims. The role of the expert witness in the legal process has been expanded with some tort reform statutes as well. In some jurisdictions, claims of dental malpractice (defined as tort claims) require the plaintiff's attorney to submit to the court in the jurisdiction where the claim will be brought either an affidavit of merit or the posting of a bond prior to filing the claim. The affidavit of merit is based on a report reviewing the professional care rendered by the prospective defendant dentist prepared by a dental practitioner who will then serve as the expert witness for the case. The plaintiff's attorney in this case will submit to the proposed expert all of the potential plaintiff's dental records, notes from the client interview, as well as a brief outline of the potential case from the attorney's perspective. Based on the findings of the plaintiff attorney's expert, the attorney will either file a claim, refer the case, or advise the client of the expert's no cause findings and advise the client of the statute of limitations and provide the client with a potential referral should the client still wish to pursue the potential claim.

The findings of the expert are significant. The judgment to move forward with cases is often based on expert's reviews of cases, and with the expense of litigation and ethical and legal obligations of attorneys, this decision cannot be assumed to be taken lightly. Litigation is quite expensive and attorneys are ethically obligated to inform clients that the costs of litigation, including the experts' fees, are the responsibility of the client, even in the event the patient's attorney should fail to prevail with the claim of malpractice.

Regardless of all these details, it is common knowledge that the outcome of many malpractice claims are won or lost based on not only the content of the expert witnesses' testimony, but also sometimes won or lost based on the personal stature of a particular expert witness.

Techniques of witness selection are taught in trial advocacy classes in law schools throughout the United States. An experienced malpractice attorney will look for witnesses to teach the juries; these witnesses will rely on common experiences of laymen and develop images based on these experiences. "An expert witness is another opportunity to seize the high ground of credibility — to provide a trustworthy guide" (McElhaney, 1997, 82). In addition, the counsel for the

Tort reforms have provided the courts with guides for qualifying an expert in particular tort cases.

plaintiff will learn the strengths and weaknesses of the case from the expert witness.

An added factor that often becomes a subject of the legal process is the motives of the expert witnesses. Experts have numerous motives for providing testimony, some of which are subject to attack on cross examination. Monetary remuneration of plaintiffs' experts is an area subject to routine questioning during cross examination. The idea is to undermine an expert's credibility by having the jury's attention shifted to the fact that any particular expert may be paid upwards of $300 to $500 per hour of trial testimony in addition to all travel expenses.

Defendants may also rely on experts during litigation. While defendant dental practitioners will undoubtedly testify on their own behalf, the defendant dentist's attorney might also rely on expert witnesses to counter claims from the plaintiff that care was either below the minimum standard of care or that the breach in the standard of care was the proximal cause of the alleged damages. The defendant dentist may rely on subsequent treating dentist's opinions or the opinions of specialists from the defendant dentist's local community. The motives of these individuals are also subject to attack on cross-examination; however, these experts have motives that might be different from the plaintiff's expert. In addition to monetary remuneration, experts who are subsequent treating dentists or are specialists from the community depend on the interprofessional relationships of the community. A specialist from the community testifying on behalf of a dentist defendant who also refers patients to that specialist for care is faced with several possible challenges. In addition to professional, collegial, benevolent, or monetary motives, the motive of the specialist could be challenged on the basis that the specialist feels obligated to serve as an expert in support of the defendant dentist because the specialist's referral base is dependent on the local community. A specialist who offers expert testimony in opposition to the locally practicing general dentist may soon find a decline in the numbers of referrals.

Practice Parameters

This all could become a moot point should the dental profession continue to develop and publish practice parameters as guidelines for the diagnosis and treatment of oral disease. In 1996, the American Dental Association House of Delegates adopted practice parameters for the diagnosis and treatment of twelve oral conditions (American Dental Association, 1996). While at the time of publication these parameters were intended as voluntary guidelines for use by practicing dentists, an expert may not be needed to establish a standard of care in a case against a dentist accused of malpractice in an area covered by one of the practice parameters. The implications of adopting practice parameters, even as voluntary guidelines, should not be underestimated. Once an organization such as the American Dental Association proposes and publishes particular parameters, court decisions could make these parameters legally binding standards of care even though the professional organization merely considered these parameters to be voluntary guidelines. With practice parameters, the expert witness is not needed to define standard of care and the decision of whether a particular defending dentist acted in conformity with a particular parameter would be a question that the judge or jury could answer by comparing the defending dentist's care with the care guidelines of the practice parameters

Once an organization proposes and publishes particular parameters, court decisions could make these parameters legally binding standards of care.

Most significantly, while expert witnesses render opinions based on the facts of the case, it is the judge or juries that ultimately look at the parties, their expert witnesses, and their testimony to make a decision. It is the function of the judge to remind juries of the roles that various experts offering testimony have in the judicial process. It is the ethical responsibility of the parties and their attorneys to only bring meritorious claims. The expert witness is a powerful player in malpractice litigation. While there may be some professional disagreement over professionals serving as experts, as long as the judicial process is involved in claims of dental malpractice, we should work to educate ourselves about this process so that we may better understand the process itself and the roles of individuals in this process.

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Ethical Codes for Attorneys: A Brief Introduction

Pamela Zarkowski, MPH, JD

Abstract

Ethical standards for lawyers are contained in the Model Rules of Professional Conduct (which lays out both "shall/shall not" rules and "may" suggestions in nine broad areas) and the Model Code of Professional Responsibility (which covers essentially the same topic areas but offers more detailed commentary). Topics included in the Rules are the client-lawyer relationship, the attorney's role as an advocate and counselor, law firms and associations, public service, transactions with individuals other than clients and information about legal services including advertising, firm names, and letterhead. The American Dental Association's Principles of Ethics and Code of Professional Conduct is organized around the five ethical principles of patient autonomy, nonmaleficence, beneficence, justice, and veracity. There are substantial similarities in intent between the ethical standards of dentists and lawyers; there are also differences.

A dentist seeking the services of an attorney views the attorney as an expert or advocate in situations dealing with the purchase or selling of a practice or negotiating an associate contract or partnership agreement. A dentist involved in an alleged malpractice lawsuit views the patient's legal counsel, the opposing attorney, in a significantly more negative light. In all legal matters, an attorney adheres to a code of ethics that is lengthy and carefully drafted to address legal practice and business relationships. Dental professionals and attorneys, as a result of their professional status, will interact with each other. This article will offer insight into the codes of professional responsibility that serve to influence attorneys in their various roles and assist dental professionals in interacting and using the skills of an attorney. A brief comparison of the code of ethics guiding attorneys compared to the American Dental Association's recently revised code of ethics will also be reviewed.

As a professional, an attorney is guided by a code of ethics. Within the legal arena, attorneys may be influenced by two sets of standards, the Model Rules of Professional Conduct and the Model Code of Professional Responsibility. A brief review of these codes will allow the dental professional an opportunity to reflect on the principles that impact on the practice of law. This article will highlight primarily the Model Rules to assist the dental professional in gaining an understanding of the themes and principles that guide the legal professional.

The American Bar Association's (ABA) first effort to codify ethical rules was the adoption of the Canons of Professional Ethics in 1908. These remained in effect for sixty-two years. In the 1970s, the ABA replaced the Canons with the Model Code of Professional Responsibility. Within a few years, every state had adopted the new code in some form, with California making the most significant modifications. In 1977, the Kutak Commission drafted the Model Rules of Professional Conduct which were approved by the ABA House of Delegates in 1983. As of Fall 1993, thirty-eight states and the District of Columbia have adopted all or significant portions of the Model Rules. Attorneys are therefore guided by a set of Model Rules of Professional Conduct (Model Rules) and a Model Code of Professional Responsibility (Model Code). The ABA has not amended the Model Code since the adoption of the Model Rules and does not intend to amend the Code in the future (Gillers & Simon, 1994).

The Model Code consists of canons, ethical considerations, and disciplinary rules. The Code discusses, in general terms, the professional conduct expected of lawyers in their relationship with the public, the legal system, and within the legal profession. Both the Code and Model Rules review similar basic tenets. Attorneys, for the most part, rely both on the Code and Model Rules for an ethical framework. There may be state by

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state variations to specific portions of the Model Rules to which an attorney licensed within the state must follow.

It is useful to review the features of the Model Rules that impact the lawyer/dental professional relationship and compare similarities in principles with the ADA's recently revised Code of Ethics.

Model Rules of Professional Conduct

The Model Rules of Professional Conduct are rules of reason. Some rules use the imperative "shall or shall not," and if violated, the violation may result in professional disciplinary action. Others use the term "may," implying professional discretion. These rules are viewed as part obligatory and part disciplinary. Attorneys are cautioned that the Rules must also be considered in light of the legally mandated obligations that influence practice including court rules, statutes relating to licensure, and state and federal laws defining specific obligations. The Rules cover a wide range of topics including the client-lawyer relationship, the attorney's role as an advocate and counselor, law firms and associations, public service, transactions with individuals other than clients, and information about legal services including advertising, firm names and letterhead (Morgan & Rotunda, 1997).

The Rules must also be considered in light of court rules, statutes relating to licensure, and state and federal laws defining specific obligations.

Texts reviewing the Rules address the language of the Rule, parallel information and citations for the Model Code, comments, legislative history, cross reference to other rules and in some, state by state variations. Each rule is followed by subcategories that further define the general heading.

In Model Rule 1, the *Client-Lawyer Relationship* is discussed. The rule is divided into seventeen subsections focusing on specific aspects of the client/lawyer relationship. The first subrule (MR 1.1) addresses the lawyer's obligation to provide competent services including legal knowledge, skill, thoroughness, and preparation reasonably necessary for representation. This speaks to the attorney's general training and experience in the area of concern. This particular rule must also be considered in light of the sixth Amendment of the United States Constitution that guarantees defendants the "assistance of counsel" for their defense in cases of life and liberty. This phrase has been consistently interpreted to guarantee effective assistance of counsel. At the same time, a lawyer cannot provide counsel (MR 1.2 (d)) to a client to engage in conduct that the lawyer knows is criminal or fraudulent. The subrules also address diligence and competence.

Of interest to dental professionals are the guidelines for fees. Language suggesting a reasonable fee, based on time and labor, customarily charged in the locality is used. A fee may be contingent on the outcome of a matter, for example one third of a settlement for a malpractice action, unless prohibited by the rules or law. For example, a lawyer cannot charge or collect a fee contingent upon securing a divorce, or based on the amount of alimony or support. However, it should be noted that if there is a contingent fee arrangement, the plaintiff patient may is responsible for payment of specific fees such as filing fees and expert witness costs. In the contingent fee arrangement, the attorney only collects if the plaintiff prevails. There are also guidelines for dividing a fee between lawyers of different firms based on the proportion of services.

Model Rule 1.6 addresses confidentiality of information and advises that the lawyer must hold "inviolate" confidential information. This requirement of confidentiality is influenced by the attorney-client privilege and professional ethics. Confidentiality is a strict requirement which contributes to the unique relationship between an attorney and client. Confidentiality is subject to interpretation depending on the circumstances. For example, dentists employed by a major incorporated dental practice which is being sued by a patient will often find themselves facing legal counsel with apparently divided allegiance. When the corporation hires an attorney, however, the attorney's client is the corporation. Thus, if the attorney, during the course of representing the corporation discovers information about a dentist employee, which would subject that employee to liability, the attorney can share that information with the corporation to assist in the defense of the corporation. Conflict of interest specifically relates to the representation of one client that would be directly adverse to another client or the attorney's own personal interests. This is based on the belief that loyalty to the client is essential in the lawyer's relationship with the client and may apply to situations related to former client relationships as well.

Respect for the client-lawyer relationship is a hallmark of the legal profession. As another example, an attorney retained by a malpractice insurance company for approximately ten years to represent insured dentists, after leaving the employment of the insurance company to begin a practice, may arguably represent patients in suits against other insured dentists. The question then is raised, is there an ethical issue of concern? In reality, although the insurance company employed the attorney, the attorney's clients

Respect for the client-lawyer relationship is a hallmark of the legal profession.

were the dentists that were insured by the company, and the duty was to the dentists, not the insurance company. Thus, the attorney may not have an ethical conflict in the action.

Model Rule 2 addresses the attorneys' role as *counselor* and suggests that the lawyer shall exercise independent professional judgment and render candid advice. The lawyer may give the advice orally or in writing and is obligated to inform clients about their legal rights and obligations as well as practical implications resulting from them. A lawyer is not expected to give advice unless asked.

The lawyer shall exercise independent professional judgment and render candid advice.

Model Rule 3 speaks to the role of the lawyer as *advocate*, that is, one who presents evidence and argument before a tribunal on behalf of the client. The comments following the rule suggest that the lawyer has a duty to use legal procedures to gain maximum benefit for the client's cause. However, the attorney must not abuse the legal procedure on behalf of the client. As part of the obligations to serve as an advocate, the lawyer must make reasonable efforts to expedite litigation (MR 3.2) and show appropriate decorum to the tribunal (MR 3.5). Specific language addresses a need to show candor toward the tribunal, advising the lawyer not to make false statements or offer false evidence. The lawyer is expected to show fairness to the opposing party and counsel and not obstruct the other party's access to evidence nor conceal material having potential evidentiary value. An additional key aspect is guidance about publicity so as not to prejudice a hearing. These rules also suggests professional conduct guidelines for a lawyer representing a client in a non-adjudicative hearing, such as an administrative agency.

Model Rule 4 addresses *transactions with persons other than clients*, such as individuals lacking representation from an attorney.

Model Rule 5 highlights *law firms and associations*. Most attorneys practice law in a firm setting and the rule addresses the requirements of partners to hold attorney colleagues to the standard suggested by the Code of Ethics. Relationships with non-attorney staff, such as secretarial, paralegal, and student interns also suggest a need for all members of a law firm to conduct themselves in a professional manner.

Model Rule 6 captures the ABA's and the profession's strong desire to encourage *public service*. The rule targets the number of hours an attorney should dedicate to *pro bono* work, legal work without a fee (approximately fifty hours per year), and emphasizes that the majority of *pro bono* work should be for the poor. The emphasis by the profession of a requirement on *pro bono* services for the disadvantaged began in 1908 and continues to be a strong theme. Comments about the need for legal representation for the poor and the obligation of the profession to meet the need are repeated throughout the commentary.

Model Rule 7 discusses *information about legal services* and suggests truthful advertising without the use of false or misleading statements. Any advertisement used by an attorney must be kept for two years after its last dissemination with a record of where it was used. A lawyer may not solicit, in person or by live telephone, employment for financial gain. This addresses the incorrect image of the attorney as "ambulance chaser."

Model Rule 8 addresses the *integrity of the profession* and reviews professional misconduct as well as disciplinary matters.

Model Code of Professional Responsibility

For the most part, the Code highlights similar themes to the Model Rules and uses the preface Canon for categorizing major principles. Within each canon are lengthy discussions about the ethical considerations which cites ABA advisory opinions, law review articles, and legal citations to support the message. For example, Canon 2 discusses at length the need for making legal counsel available to all citizens and suggests within Ethical Consideration 2-27 that "one of the highest services the lawyer can render to society is to appear in court on behalf of clients whose causes are in disfavor with the general public." Recent high profile trials reflect the adherence of attorneys to this ethical consideration. Canon 7 speaks to the attorney "zealously" representing a client within the bounds of law and reviews the obligation to the client and the legal system. Canon 8 reminds the attorney to assist in improving the legal system because of the changes in "human affairs and human systems." The Code consists of nine canons and offers insightful commentary to guide the attorney. It supplements the Model Rules in offering a framework for the attorney to practice.

ADA Principles of Ethics and Code of Professional Conduct

The ADA recently revised the Code of Ethics for the profession (Council on Ethics, Bylaws and Judicial Affairs, 1997).

The lawyer has a duty to use legal procedures to gain maximum benefit for the client's cause.

The introduction to the code suggests that the ADA Code is an "expression of the obligations arising from the implied contract between the dental professional and society."

Thus, a legal concept or contract, is significantly related to a Code of Ethics guiding dentists. The revised Code is divided into five sections guided by five ethical principles. The principles include patient autonomy, nonmaleficience, beneficence, justice, and veracity which are

the aspirational goals of the profession. Within each section are topics identified as a Code of Professional Conduct that express specific behaviors that are required or prohibited. For example, within the section discussing autonomy, confidentiality of patient records is listed and discussed as a requirement. When appropriate, advisory opinions are also included within each section to offer the profession guidance on a particular matter.

The dental and legal professions' codes of ethical conduct share similar themes. An attorney puts a client's best interests first; similarly, the dentist is required to consider the patient's needs and desires as an important factor in informed consent and treatment planning. Confidentiality, a critical aspect of the operator/patient relationship, is held sacred, similar to the client/attorney relationship. Within Section 3, under beneficence, the ADA Code suggests community service on the part of the dentist. However, unlike the legal codes, the concept on *pro bono* is not evident. Fair representation in a competent manner is a common theme in the Model Rules and Model Code. This is embodied in the ADA principle of justice which addresses the principles in the area of discrimination. Dentists are reminded they may provide expert testimony as part of their ethical obligation to support the legal profession in its efforts for justice (4.D) It is clearly emphasized in the ADA code that it is unethical for a dentist to agree to a fee contingent upon favorable outcome of litigation in exchange for testifying as an expert. The fee structure for attorneys, in certain situations, rewards attorneys for specific successes in the courtroom. Veracity, as applied to professional conduct, is emphasized in the legal and dental codes with a strong emphasis on representation of care and fees applicable to dental professionals (5.B). Throughout the Model Code and Rules, truthfulness and honesty are emphasized. The ADA code and state dental practice acts also address advertising, although the legal codes offer a lengthy discussion on the specific actions that are allowed or prohibited. The nature of the two professions allows for the dental code of ethics to review more clinically related issues within all five principles, with little parallel to the ABA's Model Rules and Code. However, both codes emphasize the requirement to use the special skills and education for the best interests of the client.

The dental and legal professions' codes of ethical conduct share similar themes.

A violation of the ADA Code of Ethics may have the consequence of a letter from a peer review committee or other monitoring entity. An ethical violation on the part of a dentist may not result in a dental license revocation or suspension unless it is also a violation of a state board regulation or civil or criminal allegations. However, a violation on the part of a lawyer of an ethical obligation may result in an attorney losing a license to practice law. Disciplinary action for violation of the Rules or Code, based on state regulations, can be severe. Thus, the legal profession's awareness and knowledge of the guidelines offered in the Model Rules and Code is a necessary professional obligation.

Both lawyers and dentists have their own professional associations. Membership in the state bar association is required for licensure, membership in a dental association is voluntary. The impact and weight of the Model Rules and Model Code for lawyers is closely related to membership in the state bar and licensure. Lawyers take seriously the mandates suggested in the Code and Rules. Dentists, as part of their professional responsibility, also rely on a Code of Ethics to influence decision making in the patient care setting.

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American Dental Association Division of Legal Affairs

The Division of Legal Affairs, which includes the Council on Ethics, Bylaws and Judicial Affairs, is the primary source of legal advice and services for all areas of the association. The division protects the legal rights, interests, and assets of the association while helping to achieve its objectives and serves as the association's legal advocate.

The division provides legal advice and services with respect to corporate affairs of the association and its nine subsidiaries, including drafting and reviewing hundreds of contracts and other legal documents each year. As necessary, the division engages and supervises outside counsel in specialized matters such as patents and copyrights, employment litigation, and real estate tax assessments. The division also provides legal advice and services with respect to dental issues, including education, science, licensure, dental practice, ethics and peer review, dental benefit programs, community health, members' insurance and other benefit programs, and communications. In this context, the division serves the House of Delegates, the Board of Trustees and its standing committees, the eleven councils, three commissions, and numerous special committees of the ADA. For ongoing agencies and projects, the division makes certain they are built on a firm legal foundation, their legal needs are anticipated and served, and legal counsel is available with strategies and insights to facilitate achieving their goals. With new agencies and programs, the division analyzes the issues and undertakes careful planning to avoid legal problems before a project begins.

In its advocacy role, the division has ongoing legal projects including the Federal Trade Commission's threatened enforcement action against the ADA stemming from the 1982 consent decree regarding announcements to the public; managed care and other third-party issues; antitrust issues; OSHA matters; legal issues pertaining to HIV and other infectious diseases in the dental office; the Americans with Disabilities Act; and dental office waste.

The primary source of legal advice and services for all areas of the association ...

Resources available from the Division of Legal Affairs include:

1. *Legal information* to dental societies on issues affecting associations generally (including JADA articles by the general counsel and periodic memoranda on legal trends and issues of interest). Consistent with the association's long-standing practice of helping its members, the division also provides information to assist members in finding answers to their individual legal questions. However, for legal, ethical, and practical reasons, the division cannot serve as the lawyer for individual members.

2. *ADA Legal Adviser* is a monthly guide to the law for dentists which is prepared by the Division of Legal Affairs and available by subscription from the ADA Publishing Co., Inc.

3. *Contract Analysis Service* is offered to members through their constituent and component dental societies. Dental societies that are aware of a particular contract offered to their members can send a copy of it to the ADA for analysis, then make the results available to its members. In 1996, the Service received 344 dental provider contracts to analyze for the profession. In addition, constituent and component societies can request a contract analysis seminar and a free publication entitled "What Every Dentist Should Know Before Signing a Dental Provider Contract." Periodically, the service also writes newsletter clips for constituent and component societies to publish about provider contracting issues.

4. *ADA Principles of Ethics and Code of Professional Conduct* is available upon request and in quantity.

5. *Guidelines for Disciplinary Hearings* and a synopsis of all decisions of the Council on Ethics, Bylaws and Judicial Affairs.

6. *Sample Component Society Bylaws* updated as needed, to help keep component bylaws in harmony with the ADA *Bylaws* and also to respond to inquiries from constituent societies regarding bylaw issues.

7. *The Antitrust Laws in Dentistry* is a clear and practical guide for members and dental societies on how to comply with federal antitrust laws.

8. *Other publications* are available on a wide variety of topics, including OSHA, the National Practitioner Data Bank, the Americans with Disabilities Act, federal law on the nondeductibility of the portion of dues attributable to lobbying, employment tax issues for associateships,

terminating the dentist-patient relationship, and more.

9. *Special project assistance* includes filing friend of the court briefs in cases having national significance for the profession; for example, preserving dental freedom of choice in the ERISA context; Americans with Disabilities Act cases in an effort to obtain a clear definition of "disability;" and fluoridation cases.

10. *Special assistance in litigation of national significance.* There are times when a constituent or component society, a related dental organization, or an individual dentist seeks assistance with a case having national significance for the profession. Very often what is requested is financial assistance to help defray the expenses of such a case. To assist in evaluating these requests, the Board of Trustees has established the following eight criteria: (a) The matter must be of national significance to the dental profession and must be supportive of the programs, policies, and mission of the ADA. (b) The request must be timely with respect to the course of action chosen; the course of action for which support is requested must be the best method of accomplishing the desired result for the profession; and there must be a reasonable chance for success on the merits in the matter. (c) The ADA must have authority to participate in and direct the project for which the funds are requested, to the extent it considers appropriate and necessary, e.g., selection of outside counsel in legal matters; participation in the development of strategies; and participation in decision making on issues that may affect the outcome of the matter. (d) The requesting party must demonstrate a significant commitment to the matter, in almost all cases of a financial nature, and must make a commitment that the funds will be used only for the specific purpose stated in the request. (e) The ADA may request additional supporting documentation on a case-by-case basis to substantiate the request, including but not limited to a projected budget, copies of correspondence, court documents, and related materials. (f) Before a grant is approved by the ADA Board of Trustees, the Division of Legal Affairs reserves the right to investigate the facts of the matter to determine if awarding a grant will create any possible legal liability for the association. (g) The requesting party must agree to provide ADA with periodic reports, upon request, and documentation about how the funding has been used, including permission to allow ADA to examine financial books and records regarding the matter. (h) The requesting party must submit the request through the appropriate ADA trustee. In the instance of an individual ADA member, the request must be submitted first to the constituent dental society. These are guidelines only and all final decisions regarding assistance rest with the ADA Board of Trustees.

The Division of Legal Affairs can be reached at the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611 or by phoning (312) 440-2500, extension 2886.

A Class of Their Own

Marci Brown

Acknowledgment

In the Winter of 1997, Dr. Jacob B. Freedland wrote the Editor pointing out that a number of dentists have become top administrators in colleges and universities. He provided a list of twenty-three whom he knew of personally. Because of the interest generated by this letter, the *Journal of the American College of Dentists* obtained permission to reprint this article, "A Class of Their Own" which originally appeared in *Contact Point*, the quarterly publication of the School of Dentistry, University of the Pacific in San Francisco in Spring 1992. The article was written by Marci Brown, at the time a freelance writer and now Managing Editor of that publication. Please note that some of these individuals have gone on to other positions.

In the university world, there are two types of administrators: those who are dentists, and those who are not.

The former group comprises a relatively small number (20-25 administrators) who are reaching the upper echelons of university administration. How does one make the transition from fillings and root canals to managing multi-million dollar budgets and hundreds of faculty and staff members? How did their dental education prepare them for their eventual careers in administration? How do they view their jobs? What makes them successful?

Dental Education a Key to Success

Dr. James Mulvihill, vice president and provost for health affairs and executive director of the Health Center at the University of Connecticut, notes that he, like some of his colleagues, is over-educated for what he is not doing, and under-educated for what he is doing. But he and other university administrators who are dentists agree that dental education was a building block that provided a solid foundation for their careers. For example, some say the fine attention to detail, a skill honed in dental school, is a helpful trait.

Compulsivity can be negative, but it can be of value when applied to a commitment to excellence and quality," explains Dr. John DiBiaggio, president of Michigan State University. "Dentists are trained to be problem solvers. They are good at managing time and want to get the job done," says Dr. Wallace Mann, provost and vice president for academic affairs at the University of Louisville, Kentucky.

Dr. J. Howard Oaks, vice president for health sciences, State University of New York, Stony Brook, attributes dental education with preparing him to analyze questions, deal with people, accept an imperfect world, develop respect for individuals, and learn to avoid jumping to conclusions. Many educational backgrounds, he explains, do not offer such preparation.

Dr. Charles A. McCallum, president of the University of Alabama at Birmingham, says his dental training reinforced his ability to interface with people

Dr. James Mulvihill, vice president and provost for health affairs, and executive director of the Health Center, University of Connecticut, Hartford: Dr. Mulvihill graduated from the dental school at Harvard. Shortly following his graduation, a new dean, with whom Dr. Mulvihill had been conducting research, asked Dr. Mulvihill to become the assistant dean for student affairs at the dental school. He was then asked to take the position of dean for the clinical campus at Stony Brook, which included two hospitals, and the educational facilities for the school of medicine, dentistry, social work, allied health, and nursing that was just then being built. Dr. Mulvihill then became vice president for the medical center. Then he was offered his current position with the University of Connecticut. He was ready to return to his native state and has been there ever since.

Dr. John DiBiaggio, president, Michigan State University: Following graduation from dental school, Dr. DiBaggio was a general practitioner for seven years. He also was a part-time faculty member at the University of Detroit and was asked to join the university faculty full-time while completing an additional degree. In 1967, he was appointed assistant dean at the University of Kentucky. In 1970, he was named the dean of the dental school at the Medical College of Virginia, Virginia Commonwealth University. In 1976, he became vice president of health affairs at the University of Connecticut, where he also served as president from 1979 to 1985. He was then named the president of Michigan State University in 1985.

because of the dentists' familiarity with the concerns and apprehensions of the patient. "A personal approach is helpful, because university administrators serve at the discretion of those they serve," he says. "Medical and dental training also provides a wonderful opportunity to learn and develop leadership and management skills."

Dr. DiBiaggio adds that dentists are highly organized people and must operate their practices with structure and discipline. "This skill is equally applied to a larger environment," he notes.

Yet, Dr. DiBiaggio points out that the university environment is a complex one in which considerable flexibility and tolerance are required. "Universities tend to be more deliberative than dental practices. The problems dealt with are not as simple as making a diagnosis and carrying out a treatment plan. The issues are more abstract; one has to have a tolerance for ambiguity."

Dr. J. Howard Oaks, vice president for health sciences, State University of New York at Stony Brook: Dr. Oaks graduated from the Harvard School of Dental Medicine in 1956 and was offered a full-time position in the operative dentistry department at the school. He remained in the position for two years, and then left to go into private practice. In 1961, he was then asked to return to the dental school as assistant dean for student affairs. In 1968, he then left Harvard to join the staff at the State University of New York at Stony Brook. There, he acted as dean of the dental school until he became vice president of the Health Sciences Center.

No one knows this better than Dr. James B. Edwards, president of the Medical University of South Carolina, who, having served as a governor and cabinet member for a United States president, can honestly liken his job to that of a politician. "It is the most political job I've ever held. The art of politics is having vision and getting others to help you reach your goals," he says.

Elements of Success

The year was 1954 or 1955. The day was Friday. The dean of the dental school had just received notice that the Marquette University's application for a federal grant proposal worth nearly a million dollars (no small amount a that time!) had been denied. Dr. Thomas Zwemer, then a young assistant professor, was asked by the dean to rewrite the proposal by the next deadline, just four days away. Working at home over the weekend on a portable typewriter, Dr. Zwemer was able to restructure the proposal. By the end of the weekend, all that was needed was final editing. The proposal was in the mail by Monday afternoon. Within months, the university was notified that the grant was awarded. Within eighteen months, Dr. Zwemer was named chair of the Department of Oral Rehabilitation and acting chair of the Department of Periodontics.

Dr. Wallace Mann, provost and vice president of academic affairs, University of Louisville, Kentucky: Dr. Mann followed his graduation from the Tufts school of dentistry in Massachusetts with five years in the Navy. He then spent ten years at the University of Alabama and trained to be a periodontist. He then served as associate dean at the University of Connecticut. Following this, he was chosen to be dean of the school of dentistry at Mississippi, where he remained from 1974 to 1986. He then was selected to be the dean of the dental school of Louisville. While in that position, he was asked to serve as acting provost while a national search was conducted to permanently fill the position. Dr. Mann was then asked to be a candidate to permanently fill the position and was subsequently offered the assignment.

This was Dr. Zwemer's first taste of what it takes to be a success in a university environment. "I saw rewriting the proposal as an opportunity. I did it because it was exciting and was the proper thing to do. I had been at the university for four years by then and I guess the dean thought I had the ability and the willingness to do the work," Dr. Zwemer recalls. He recently retired from his position as vice president for academic affairs for the Medical College of Georgia.

Dr. Zwemer's experience is illustrative of the leadership qualities that many university officials who are dentists believe is a key to their success. "Regardless of one's profession or career, and probably long before one goes to undergraduate school, there is a leadership role one takes on at an early age that in some way prepares one for the future," says Dr. Robert Biddington, vice president for health sciences at West Virginia University.

Dr. Biddington explains that part of this leadership role includes being a person who sees him or herself as being an agent for change - and enjoying it. "One

Dr. Charles A. McCallum, president, University of Alabama, Birmingham: Dr. McCallum is unique in that he has remained with the same university since his administrative career began. Following his graduation from dental school in 1951, he went to the new dental school in Birmingham to do his residency in the oral surgery program. He also went to medical school and obtained his medical degree. He became the chair of the oral and maxillofacial surgery department and spent fifteen years as the dean of the dental school. He subsequently served for ten years as vice president for health affairs and director of the medical center at the University of Alabama at Birmingham. Five years ago, he was named president of the university.

Dr. James B. Edwards, president, Medical University of South Carolina: Dr. Edwards graduated from the University of Louisville Dental School and joined the Navy for two years. He did his oral surgery residency and returned to his home town of Charleston, South Carolina, to begin practice. In the early 1960s, he became involved with politics, and in 1970 ran, and was defeated for a congressional seat. Meanwhile, he maintained his practice in Charleston. In 1974, he successfully ran for governor, and had to stop practicing dentistry. After serving for four years, he returned to his practice and then was called upon by then President Reagan to serve as secretary of energy. Following two years in the Reagan administration, Dr. Edwards returned to Charleston to take his current position.

must appreciate that change is ongoing and constant," he notes.

Building a Cabinet

Dr. Biddington adds that an ability to surround oneself with a high quality administrative team is extremely important to success. "One must recognize the strengths and weaknesses of those with whom you work. In establishing the administrative core, it is important to recruit a group of deans, directors, and other administrators and faculty who have quality attributes, and are dedicated to the institution's mission, goals, and objectives," he says.

High-level university officials also must deal with a broad range of constituents (from students to legislators) who must be confident in the abilities of an administrator. This, says Dr. Biddington, makes interpersonal skills of utmost importance.

Dr. Mann concurs. "One develops a great sensitivity and insight for people. It's more than managing people and resources. It is setting goals and getting people to work together. Leadership and caring are inseparable."

Most of all, as Dr. Biddington says, it is important to enjoy one's job. This makes an administrator a more enjoyable person with whom to work, and that is reflected through the people with whom he or she works.

Dr. Thomas J. Zwemer, formerly vice president for academic affairs, Medical College of Georgia: Dr. Zwemer graduated from the University of Illinois dental school. He went on to teach at Marquette University School of Dentistry and then went to Northwestern University Graduate School to earn his degree in orthodontics. He returned to Marquette to chair the department of oral rehabilitation. Later, he joined the School of Dentistry at Loma Linda University as chair of the orthodontics department. In 1966, Dr. Zwemer went to Augusta, Georgia as assistant dean for clinical affairs to establish a new dental school. He was responsible for federal grant applications, facility design, construction supervision, and for curriculum development. In 1984, he became the vice president for academic affairs. He retired in January, 1991.

A Problem-Solving Democracy

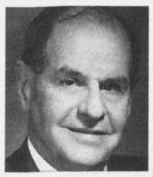
Dr. Mann notes that the worst thing an administrator can do is let a problem slide and expect that it will disappear. "An administrator needs to listen and gather data and make a decision by involving as many people as necessary. A university environment includes a great deal of participatory democracy," he explains.

Dr. McCallum explains that universities, once looked upon as perhaps self-sufficient entities, are now big business. Needless to say, the administration of such institutions has changed as well. "The issues with which one must deal, such as disabled students and harassment, are much different. These things weren't given appropriate attention ten or fifteen years ago, and now need a lot of attention."

Many of these issues are long-term and will not be resolved overnight. "I don't mind ambiguity," says Dr. Oaks, adding that sometimes a long-term problem will require a long-term resolution rather than a knee-jerk reaction. "I can get a great deal of personal satisfaction out of seeing things evolve and succeed over a long time," he explains.

Dr. Robert Shira, assistant to the president at Tufts University in Boston, attributes his success to his background with the armed forces. "I use the same philosophy I used to become the chief of Army dental corps," he says, adding that that job involved overseeing three thousand dentists. "The problems are the same. They involve programs, finances and personnel. It is best to seek the consultation of several people to de-

Dr. W. Robert Biddington, vice president, health sciences, West Virginia University: Dr. Biddington graduated from the Baltimore College of Dental Surgery Dental School, University of Maryland, in 1948. He served as a member of the Navy Reserve from 1943 to 1946 and as a Navy dental officer during 1948-1949. He joined the full-time faculty at BCDS, University of Maryland in August of 1949. He remained at the school as a faculty member for ten years, during which time he also served in the Navy for a year. In 1959, he was named chair of the endodontics department at the University of West Virginia. In 1965, he became assistant dean of the dental school, and three years later, dean of the dental school. He remained as dean until June, 1991. During 1979-1980, he served as interim provost and vice president for academic affairs at West Virginia University and in 1981-1982 served as interim vice president for health sciences.



Dr. Robert Shira, assistant to the president, Tufts University, Boston: Dr. Shira graduated from the University of Missouri's dental school in 1932. Following six years in private practice in Oklahoma, Dr. Shira entered the United States Army. His armed forces career culminated with appointments as chief of the Army's Dental Corps and Assistant to the U.S. Army Surgeon General with the rank of major general. During this time, Dr. Shira, an oral surgeon, spent sixteen years at the Walter Reed Hospital in Washington, D.C., where he served some of the country's highest government officials. In fact, he was once called upon to extract one of President Eisenhower's teeth. Dr. Shira retired from the Army in 1971, and became dean of the dental school for Tufts University. In 1978, he was appointed provost and senior vice president of the university. In 1982, he became a special assistant to the president of Tufts.

termine the alternatives, and select the one you feel best addresses the problem."

They may make success sound easy, but to these administrators, what may have begun as a career has now become a lifestyle.

Weighing Responsibility and Reward

The responsibilities of high-level university officials seem mind boggling to say the least. It is a myth that there is a daily routine. For example, on a "regular" day in November, Dr. DiBiaggio's calendar had the following entries:

A meeting with the provost/vice president for administration;

A meeting with a leader in the Michigan biotechnology industry;

A meeting with faculty;

An appointment with university legal counsel;

A phone interview with a magazine writer;

A meeting with government officials;

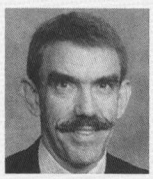
A conference with the president of the community college to discuss how the two schools might expand their relationship;

A citizen's advisory committee meeting on minority affairs; and

A university dinner.

In between these events, Dr. DiBaggio took phone calls and reviewed and answered correspondence. The day was not out of the ordinary in its diversity.

Dr. Garland Hershey notes that his job has three dimensions: he is vice chancellor of health affairs and vice president of the University of North Carolina. "I have a central role in the administration of the campus in general, in addition to my work in health affairs," he notes, adding that this role makes his job somewhat similar to that of a president.



Dr. H. Garland Hershey, vice chancellor for health affairs and vice provost, North Carolina University, Chapel Hill: Having attended the University of Iowa in Iowa City, Dr. Hershey joined the faculty of that school before joining the administration. He was named assistant dean of the dental school in 1975, and then became vice chancellor at North Carolina in 1983. His position allows him to continue to see patients, both privately and with residents.

Dr. Mulvihill, in his position of vice president and provost, describes the scope of his job as follows: he is the chief executive officer of the health center, including supervision of the school of medicine, the school of dental medicine, two university hospitals, and an outpatient program. He oversees a budget of $350 million per year, only 15% of which comes from the state. He oversees 3,850 full-time employees.

Dr. Mann sums up the responsibilities of his position: "I am constantly amazed at the types and diversity of problems that come to my office."

"Most of us in the academic life at this level are probably working longer hours and have more demands than we might have in private practice. As a reward, we are probably making a salary that is one-fourth to one-half of what we would make in private practice," jokes Dr. Mulvihill.

Dr. Mulvihill may or may not be exaggerating. While the salaries of university administrators are probably nothing to turn one's nose up at, all agree that the salary is not what keeps them in the job. The rewards, and there are many, come from other areas.

"For me, the perks are the opportunities to deal with and become friends with people of substance and those from diverse cultures and careers," says Dr. Zwemer.

Dr. McCallum agrees that such opportunities are unique to the university environment. "The enrichment gained from the university because of the people met are incomparable. The opportunity to relate to people in philosophy, history, and people from other countries is great."

For Dr. Mulvihill, job satisfaction comes from the seemingly simple things that actually have great impact on many lives, such as giving out diplomas at commencement. "Or, when I sit with the leaders in the business community and plan to deal with problems such as AIDS or getting more children into the health care system, when we get a big federal research grant, or when we get an endowed chair."

Advertising Dentistry

Eric K. Curtis, DDS, FACD

In 1983, the American Dental Association was preparing for a bold move. The profession, many of whose practitioners reported "busyness" problems, seemed to need a public boost. In response, a national advertising campaign was formulated for approval by the association's 1984 House of Delegates. A "Smile, America" theme was developed, a spokesman designated, and sample video spots produced.

The package was readied, but the matter was far from decided. After a stormy debate, House members voted 215 to 202 in favor of a resolution to unleash the public relations package. The narrow majority fell short of the two-thirds vote needed to send it into the world, and the resolution died. What happened? The theme wasn't appealing, said dissenting voters, and they complained that designated spokesman James Whitmore—the academy award-nominated actor who portrayed Harry Truman, Theodore Roosevelt, and Will Rogers—had unattractive teeth. And, more than a few admitted, they just didn't feel comfortable advertising dentistry.

Advertising wasn't always an uneasy subject. In the 18th century, dental advertising was important for patient education. The fledgling profession needed to spread the word of its existence and possibilities. Dentistry in those days was the pursuit of individuals who lacked the influence or shared values of underlying institutions such as schools and associations. Dentists were on their own, and they published books and pamphlets and advertised their services in newspapers. In a famous 1768 classified ad from the Boston Gazette, goldsmith Paul Revere carefully described his offer to fashion dental prosthetics. Indeed, no less a critic than Thomas Jefferson declared, "Advertisements contain the only truths to be relied on in a newspaper."

Later, dentistry exploited advertising to distance itself from quackery. "Dr. R. has had a thorough professional education, being a graduate of the Philadelphia Dental College, receiving a *diploma*, with the degree of D.D.S.," read the copy on an 1868 presentation card. "Beware of traveling quacks, and other incompetent persons calling themselves 'Dentists.' Their operations are frequently worse than worthless."

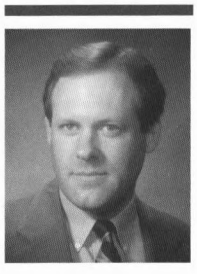
In the 18th century, dental advertising was important for patient education.

As dentistry matured as a profession, however, advertising was increasingly frowned on. Dentistry now needed to present a dignified, united front to the world to be properly understood and taken seriously by the public. A lone practitioner arguing his superiority would be counterproductive to the coherent, elevated image the profession struggled to project. In 1871, a Dr. L.P. Meredith warned of dentists who "detract from the dignity of the profession by resorting to cheap advertisements and unprofessional trickery." In 1888, the ADA determined that it was unprofessional to list anything on cards or signs except name, title, and address.

Early advertising efforts were typically personal, promoting a specific dentist and often specific treatments. What the ADA proposed to do in 1983, however, and what various state dental associations have since accomplished on their own, is not personal advertising, but institutional or awareness advertising. Institutional advertising promotes an entire industry rather than a single vendor, while awareness advertising is meant to heighten recognition rather than influence specific purchasing behavior.

The Irish physician and writer Oliver St. John Gogarty once described the presentation of a consultant who had given a paper called *Advertising in Medicine*: "It was like listening to a loudspeaker blaring out 'Mum's the word.'" In the world at large, however, the word was "publicity." While personal advertising by dentists was discouraged within the profession, on the outside consumer dental advertising was about to explode. As it plugged its products, the dental manufacturing industry—particularly makers of toothpaste and toothbrushes—also promoted, indirectly but powerfully, dentistry and oral hygiene.

Trade advertisements have provided de facto institutional advertising for den-



Dr. Curtis is in private practice in Safford, AZ. He is Past President of the American Academy of the History of Dentistry and Editor of the Journal of the Arizona State Dental Association.

tistry for almost a century. The germ theory of disease led to the identification of dental microbes in the 1890s, which in turn led to a toothpaste company-inspired "rush to brush" that permanently welded dentistry to prevention. Colgate and the Florence Manufacturing Company, maker of the Prophylactic, the first widely advertised toothbrush, taught America to brush. Colgate Ribbon Dental Cream, introduced about 1905, molded toothpaste so it "comes out a ribbon, lies flat on the brush." In the process, dentistry's importance was tacitly reinforced.

Advertising evolved in response to the developing sophistication of not only products but society itself. Until 1900, the object of advertising was simply to keep the advertiser's name in front of the public. Then cottages became corporations. Customers became consumers who bought mass produced goods, which became branded. Advertising became more than information; it became persuasion, and was essential to the success of capitalism. (In the 1960s, economist John Maynard Keynes estimated that if Madison Avenue's television commercials disappeared, the gross national product of the United States would drop by more than 50%.)

The bloodiest marketing war of the 1950s was between Crest and Colgate toothpastes. Colgate hired hard-hitting adman Rosser Reeves, who created *Gardol*, an "invisible protective shield" that convinced millions of Americans that Colgate was better. In the Colgate commercials, sports announcer Ed Herlihy threw a baseball towards the camera. As it approached, the ball looked as if it would shatter the television screen. Suddenly the baseball slammed against a clear plastic wall. Herlihy walked over, confidently rapped his knuckles on the hard surface, and began describing Colgate's similar "invisible protection." Front runner Crest protested that the ad was misleading, but a lenient Federal Trade Commission allowed it to stay on the air.

By the 1980s, the pitches were story-focused. "The consumer isn't a moron; she is your wife," the advertising legend David Ogilvy said. Or your husband. One Colgate commercial in the Reagan years begins with a small girl in pajamas brushing her teeth before bed. Since her mother is working late at the office, she asks daddy to tell her a bedtime story. In the middle of the story, the child dozes off. The sensitive dad gives his daughter a peck on the forehead, pulls up the covers, and turns off the light. An announcer explains, "Colgate doesn't fall asleep when she does. It stays wide awake fighting cavities." The commercial resonates as a perceptive slice of American life, showing consumers as liberated and sophisticated, as well as thinking, caring people.

Institutional advertising promotes an entire industry rather than a single vendor

"Commercials are almost never about anything trivial," point out Neil Postman and Steve Powers in *How To Watch TV News*. "Mouthwash commercials are not about bad breath. They are about the need for social acceptance...There are, in fact, some critics who say that commercials are a new albeit degraded means of religious expression in that most of them take the form of parables, teaching people what the good life consists of."

Advertising aims to reflect social attitudes even as it tries to shape them. Products are not just commodities anymore, but cultural symbols charged with social significance. You are what you wear, eat, do...and what you brush with. "We have on the radio every Sunday a stroke of culture," the journalist Lincoln Steffens once wrote, "—a symphony concert from New York or somewhere with a [commercial for] toothwash."

"That's the culture part," Steffens added. "The toothwash."

The persuasive, pervasive nature of advertising cuts in all directions. One strategy of pharmaceutical companies is to market prescription drugs directly to the public in order to pressure doctors to prescribe. The Food and Drug Administration this spring cleared for marketing a laser system for treating tooth decay. Although the laser system is expensive and not well known to many dentists, an ADA spokesman told the Chicago Tribune that it will become "very commonplace" in two to four years. "The public's demand will be the thing that drives dentists to get the laser," he said. Presumably, the demand will come from advertising.

In 1997, the ADA House will again vote on a proposal to launch an ad campaign. Some dentists worry that such a public relations initiative would be self-serving and unprofessional. Others are anxious to influence the directions of dentistry's public image.

But whatever dentists' attitudes towards publicity, it would be unrealistic to resist institutional advertising just because it is advertising. Indeed, the ADA itself has been associated with advertising for over sixty years. Its Seal of Acceptance, granted to consumer dental products that have undergone independent tests of safety and effectiveness, has long been promoted to the public by manufacturers.

Dentists became a readily recognizible, highly visible part of contemporary culture in the first place partly because of dentistry's historical roles in advertising. Whether or not American dentistry ever sponsors its own advertisements, it is already a permanent landmark on Madison Avenue.

Competition

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

Abstract

Our ambivalence toward competition can be traced to an unspoken preference for certain types of competition which give us an advantage over the types we value less. Four types are defined (a) pure (same rules, same objectives), (b) collaborative (same rules, shared objective), (c) market share (different rules, same objectives), and (d) market growth (different rules, value added orientation). The defining characteristics of the four types of competition are respectively: needing a referee, arguing over the spoils, differentiation and substitutability, and customer focus. Dentistry has features of all four types of competition, thus making it difficult to have a meaningful discussion or frame a coherent policy on this topic.

As a nation, we are uncertain where we stand on competition. We extol its benefits and decry its abuses, all without taking a firm position on the activity itself. It promotes cheating, waste, and greed, while eroding the fabric of commerce. Look, for example, at some of the best known college athletic programs. It also builds character, brings out our best efforts, and raises the overall standard of performance, all while strengthening the fabric of commerce. Look, for example, at some of the best known college athletic programs.

In dentistry, competition leads to advertising, a broader range of services for patients, discount pricing, a service orientation towards customers, third-party interference, and a massive infusion of additional dental dollars into the market from these sources. The profession quickly jumps to its feet to defend unregulated free-market enterprise; and is equally quick on its feet to promote restrictions on third-party interests.

Competition is any activity which satisfies the following three criteria: (a) the benefits to A depend on the actions of both A and B, (b) what is true of A in this regard is equally true of B, and (c) there are not enough benefits available so that both A and B can satisfy their wants by pursuing their primary strategies. Framed in these terms, competition is everywhere. There is even competition within the individual in his or her roles as practitioner, parent, spouse, and leader within the profession. Not one day and probably not one hour goes by without a competitive clash between what one would prefer to do in each of these roles.

The grand experiment to create an economic system free from competitive pressure through coordinated planning was the late Soviet Union. Since competition has both desirable and undesirable consequences and is impossible to avoid, it might be useful to look at several types of competition. It is quite likely we will discover that those who complain about competition or "unfair competition" are really expressing a preference for one form of competition (which they, presumably, judge to give them a competitive advantage) over other types.

Competition in a game of chess and for the attention of the most attractive girl in high school are very different. In the first case, the rules, the available moves, and the desired outcome are all fixed and are exactly the same for both competitors. Competing for the attention of the Homecoming Queen can be done through athletic prowess, a fancy car, one's personality and existing network of friends, etc. The motives might similarly vary from one competitor to another. It is possible, then, to distinguish between competitive situations where the rules, moves, and objectives are symmetrical and those which are not.

Another useful distinction regarding competition is between zero-sum and other types of contest. Poker is the archetypal example of a zero-sum game. There is only so much money available at the table, and somebody else, individually or collectively, must lose in order for one to win. Regardless of the amount of the stakes and the length or outcome of the play, the sum of all individuals' winnings equals zero. There are also positive-sum games, such as Monopoly, where the longer the game progresses the larger the overall stake. Capitalism is based on the belief that commerce generates wealth generally — a positive-sum assumption. There are also negative-sum games such as divorces and many other legal actions.

Based on combinations of these two dimensions, it is possible to identify four types of competition, which I will label (a) pure, (b) collaborative, (c) market-share, and (d) market-growth competition.

Pure Competition

Board games, athletics, the American education system, and much of our business are set up to be pure competition. The rules and the prize are fixed in advance and are the same for all competitors; the scarcity of the reward and the symmetry of the rules mean that one player's advantage must come at others' expense in a zero-sum setting.

The dental profession is often assumed to follow this model of competition. Solo practitioners are expected to operate their practices independently and to all abide by a standard code of professional conduct. Fluctuations in business practices are frowned upon as being excessively "competitive." It is also assumed that the market for oral health care is fixed and that increases in the number of dentists or "excessively competitive" strategies on the part of other dentists will decrease the earnings of those who uphold the standards.

This last assumption is based on a misreading of the laws of supply and demand in professional contexts and is certainly false. For example, research in medicine shows the following pattern. In a town where the number of specialists doubles, income levels remain constant because physicians halve the number of hours they work and double their fees. There is also the story of a small town where the only lawyer languished in near poverty until two others moved into town. All three are doing very well now.

The defining characteristic of pure competition is enforcement of the rules. We need referees, or even lawyers. We protest questionable practices while simultaneously exploring the fringes of what is possible on our own right. This preoccupation with fair application of the rules leads to standardization of both procedures and results and an aversion to innovation. Markets characterized by pure competition tend to be regressive.

Collaborative Competition

A staple in management training is to set up an apparent competition with a payoff matrix such as the following. A will get either a large reward or a tiny reward for acting independently depending on the independent action of B or, if A and B cooperate, both will receive a reward somewhat above the expected average of the independent actions. This exercise is designed to show that situations which appear to be purely competitive can be converted to include a collaborative element. (Obviously there is no advantage in collaborating if the collaborative payoff is less than the average of the independent actions, as is true in a great many realistic settings.) The rules and the rewards are symmetrical in this situation but it is not a zero-sum game; both parties can be winners at the same time. Because, however, each party must forego its preferred strategy and the reward is dependent upon the action of both parties, this is still a competitive situation despite its elements of local collaboration.

We protest questionable practices while simultaneously exploring the fringes of what is possible on our own right.

It is not that easy to find examples of collaborative competition. Some business partnerships, unions and fraternal organizations, and point shaving schemes in professional athletics come to mind. The social dynamics in such arrangements are inherently unstable and the kind of payoff matrix required is anything but universal. Finally, there is the barrier that such arrangements may be regarded as illegal. The Federal Trade Commission enforces specific laws intended to protect against restraint of trade specifically structured around arrangements such as collaborative competition.

The rationale for regulation of this type of competition is derived from an analysis of competitive situations. If A and B are taking more resources out of the system by collaborating than they could have by competing, then somebody must be putting more resources in. In the business context, these somebodies are suppliers and customers, and from their point of view this is a zero-sum game between them collectively and the collaborators collectively. American social policy is suspicious of cartels.

The salient characteristic of collaborative competition is secondary disputes. If more resources are available to the collaborating team then the aggregate of the independent rewards, how is that surplus to be divided? It is not obvious that the surplus should be divided into equal shares in every situation. And for a price, one can retain a lawyer who will define "equal" appropriately, while further reducing the surplus. Partnerships that struggle through the hard times frequently fail under conditions of success over disputes about relative contribution to that success. Collaborative competition also creates the conditions for social loafing (expending less effort on the community project than on the personal one), free riding (withholding effort while still expecting to receive group benefits), and other opportunistic behavior.

Market Share Competition

One of the most common forms of competition assumes a fixed purse or package of benefits but allows a wide range of competitive strategies. Consider entertainment. A family with a fixed entertainment budget could spend this on eating out, a boat at the lake, theater or the symphony, travel, or many other alternatives and their combinations. In market share competition, the benefit structure is zero-sum (a dollar on the movies is a dollar that cannot be spent eating out) but there is very little symmetry among the rules and expectations of the competitors.

The distinguishing characteristics of market share competition are differentiation and substitutability. In pure competition, there is only one way to win; in market competition there are several. This means that competitors must distinguish themselves from each other as viable alternatives which appeal to significant market segments. A dentists might compete, then, on being friendly, conve-

nient, appearing high-tech, being an established and trustworthy member of the community, price, or any other differentiated characteristic which is supported by a large enough segment of the market to make business sense. The fastest growing competitor in the dental market is the group practice, including those group practices managed by investors trading equity over the counter. The prospect is frightening since the market efficiencies of such investor-operated systems will surely focus on the most profitable segments of the market, leaving less lucrative opportunities for traditional professionals. In some ways, however, this is just a further spin on fee-for-service dentistry which has competed for the most lucrative segment of the market up to this point, leaving significant pockets of under served individuals.

The other defining characteristic of market segment competition is less obvious. Substitutability is a market term used to define the set of any good or service that satisfies consumers' wants. In relative terms, there is hardly any competition among traditional dentists. There is relatively more competition between the established profession and alternatives such as capitation and large clinics. But the real competition is between a dollar spent on oral health and the same dollar spent on anything else, say entertainment. Dentists compete with electronics salesmen, travel agents, restaurateurs, and even ministers. To a large extent, dental expenses are discretionary. The bad news on this view of competition is that it cannot be regulated by enforcing standards within the profession. The good news is that dentists have been extremely successful in this type of competition. For the past several years, expenses on oral health have risen at just over two times the rate of increases in the consumer price index. This reflects a preference on the part of the public for selecting oral health over other expenditures. The bad news is that in a free market economy, excess profits invite competition. The competitive success of dentistry is a major driving force in the rise of managed care.

Market Growth Competition

The final form of competition to be considered combines differentiation and substitution from asymmetrical competition with the "win-win" goal of non-zero-sum games. Rather than working to increase the size of one's piece of the competitive pie, market growth competition aims to increase the size of the overall pie.

Many American companies are in the market growth business, especially those in the rapidly expanding markets of information and service. They do not define themselves in terms of having the best product, rather in terms of meeting more of the customers' needs. Orthodontics would be a good example in dentistry with its burgeoning market in adult orthodontic care.

Dentists compete with electronics salesmen, travel agents, restaurateurs, and even ministers.

It is even possible to consider market growth competition in strictly individual terms. This would be competition against one's own personal best.

The leading idea in market growth competition is value added. Customers are now asking "for every dollar I spend, am I receiving 90 cents, the same dollar, $1.10, or $1.50 of value?" Competition favors those who return the best value added. In the dentistry of previous generations, frank breakdowns in the dentition called for immediate repair, usually of an obvious type without choice of alternatives. Under those conditions, value added was in the technical quality of the repair. Today, patients are seeking elective services, and advances in research and education have opened up alternatives. Today value added is in the overall management of the patient's oral health. For many, including some large dollar care purchasers, the best value added to their dental dollar is in prevention, diagnosis, and patient management rather than procedure-code dentistry.

There is an ironic and even non-competitive side to market growth competition. It is a turning away from head-to-head confrontation and a searching for the gaps that established competition has left unserved. It is a constant redefining of the market to better serve customer needs. An example would be the banking industry and other financial institutions. Rather than a few giants slugging it out, the past ten years have seen differentiation, substitution, and value added at a dizzying pace. Big banks are in supermarkets and on the Internet. Medium sized banks are refocusing to service the needs of specific industries. Community banks which offer customized and personal service are flourishing. Brokerage houses are going out to meet their customers. Mutual fund checking accounts have shifted billions of dollars in savings from banks to the stock exchange. All of this has had a notable effect on the value of the U.S. dollar, employment, and the stock market, including the share prices of banks themselves. Perhaps oral health care will undergo a similar redefinition of what it means to be competitive and a similar explosion of value added.

The four types of competition could be summarized as follows. (a) "A will beat B at his or her own game (pure competition), (b) "A and B will collaborate to get as much as they can from C" (collaborative competition), (c) "A will beat B by shifting the playing field" (market share competition), and (d) "it doesn't much matter about B as long as A serves the needs of C better then anyone else" (market growth competition). Competition is still competition, and the three defining characteristics mentioned above still prevail. Resources will continue to be limited in most cases. What makes market growth competition so attractive among the alternatives is that, while other resources may be limited, customer needs and wants will continue to remain unlimited.

Recommended Reading

Axelrod, R. (1990). The evolution of cooperation. *New York, NY: Basic Books.*

Comprehensive study of the "prisoner's dilemma" — structured competition where the payoff to A or B depends on the joint strategies of both. In repeated "games," a natural strategy of "cooperation" evolves through a process of tit-for-tat, punishing one's opponent for deviations from the strategy which yields the best group payoff.

Hamel, G, and Prahalad, C.K. (1994). Competing for the future. *Boston, MA: Harvard Business School Press.*

Competition in the future is the competition for opportunity. Firms profit ratio is the value added to customers divided by the cost of adding that value. Historically, we have focused on cost cutting and efficiency (the denominator). In the future we must look to growing the numerator. We will compete for the chance to give the customer what he or she wants.

** Kohn, A. (1992).* No contest: The case against competition. *Boston, MA: Houghton Mifflin. ISBN 0-395-63125-4; 325 pages; about $12.*

A very popular book among those who have a philosophical antipathy to competition. A vast amount of literature is reviewed on claims that competition is inevitable, productive, enjoyable, and builds character. In every case, Kohn says competition is wanting. Kohn's arguments are framed as win-lose alternatives between the proponents of competition and his own view, and he aggressively attacks his opponent, demonstrating in his own writings exactly what he would have us set aside. There is little offered by way of alternatives to competition.

** Levinson, J.C. (1993).* Guerrilla marketing: Secrets for making big profits from your small business. *Boston, MA: Houghton Mifflin. ISBN 0-395-64496-8; 327 pages; about $13.*

A "how to" manual for advertising small businesses. With background in advertising in both large and small firms, Levinson shows how the techniques that work for the giants don't work (and are not necessary) for firms that have local markets. The heart of the book is nineteen chapters, each describing the advantages and disadvantages of different media such as personal letters, brochures, direct mailing, seminars, trade shows, and even t-shirts and the yellow pages.

** Porter, M.E. (1980).* Competitive strategy: Techniques for analyzing industries and competitors. *New York, NY: The Free Press. ISBN 0-02-925360-8; 395 pages; about $35.*

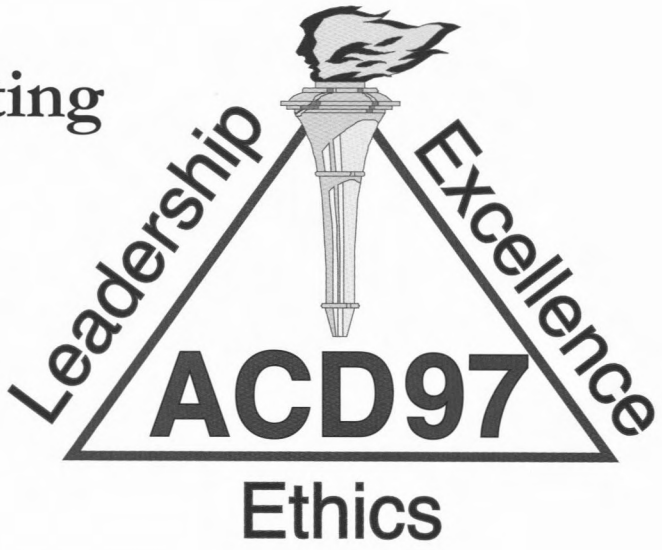
A true classic. Many MBA students are familiar with the seminal concepts of generic competitive strategies, industry life-cycles, buyer selection, and strategic groups without realizing that one man introduced them together in a single book. This is a combination of economics, marketing, and business strategy. It explains how firms work. The book is packed with a wealth of material and the examples tend to be brief, so a basic familiarity with business is helpful.

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each is about five pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Office in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on competition; a donation of $50 would bring you summaries of all the 1997 leadership topics.

ACD 97 Annual Meeting

October 16-17, 1997
Sheraton Washington Hotel
Washington, DC



Preliminary Schedule

Thursday, October 16th

9:15 a.m. - 11:15 a.m. 1:00 p.m. - 3:00 p.m.	LeaderSkills Workshops
3:15 p.m.	Fellows Forum

Friday, October 17th

7:30 a.m. - 8:30 a.m.	Breakfast
8:30 a.m. - 9:15 a.m.	Business Meeting
9:15 a.m. - 11:15 a.m.	Keynote Presentation
11:30 a.m. - 1:30 p.m.	Luncheon and performance by The Capitol Steps
3:00 p.m.	Convocation and address by Knight Kiplinger
7:00 p.m. - 8:00 p.m.	Reception
8:00 p.m.	Dinner Dance

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