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The Evidence
for Ethics

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excellence, ethics, professionalism,
and leadership in dentistry**

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- 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;
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Cover image Imagine you were on trial, accused of being ethical. Would there be enough evidence to get a conviction?

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From the Editor

A Dead Letter?

Let's consider what to do with this journal. For the first 13 years the college had none. Then for about half a century it was the way the Board of Regents informed the fellowship what they were doing. There were minutes of meetings, announcements, letters, policy positions, committee reports, and some scientific articles. It was what held a national organization together. This was followed by a shift to publishing refereed papers as the newsletter took over the task of sharing timely and personal information. Since 1990 the journal has done theme issues, presenting multiple responsible perspectives on emerging concerns in the profession. It is the only publication in dentistry to be focused on discussions regarding policy issues.

But it may be time to discontinue the journal. This is certainly not because hosting discussions of policy matters has lost its significance. True, it is getting more difficult each year to find the right people willing to write

about topics that seem to be fuzzier and faster moving than in simpler times. But the essential concern is that the ways dentists find information and use it have evolved.

Only a Rip van Winkle would be surprised to learn that the computer has changed the way we communicate. What I have in mind is cost, speed, number of folks who have something they have to say, diversity of opinions, shallowness of messages, absence of expert vetting, and ability on "readers'" part to find anything they want and only that. Twenty-five years ago a troll was a fairy tale creature who lived under bridges in Scandinavia, conflict of interest disclaimers were superfluous, and, as Tom Nichols said in *The Death of Expertise*, knowing what you are talking about was praiseworthy instead of inviting knowing sneers.

It is not so much a question of whether the college should continue to speak usable truth to the profession as whether we should recognize that the game has moved to a new field. Should we not think about moving too? Even if our mission has not changed, it may be time to communicate it differently.

I wrote an editorial about blogs in 2010 based on a conversation I overheard between some senior dentists and a junior member of the profession. The direct question of the millennial was, "Where do you get your information?" The answer was *Dr. Bicuspid*. So I monitored the site for a few months, focusing on dental

ethics. First I learned that the lead material, the few paragraphs of news written by *Dr. Bicuspid* staff, were timely, informative, and balanced. The responses were certainly not. Ethics is not a hot topic. Only a handful of "regulars" seemed to have opinions, but they had opinions about nearly everything. Most tellingly was the chaining of the comments. The first responder addressed "something" in the lead post; that was followed by a reaction to "something" the first commenter had said. By the third or fourth comment, it was impossible to connect the comment to the original story. Remember the game of telephone? The only way to protect your message would be to participate at multiple points in the channel.

The high-value coin in the communication world today is timely pictures and very short messages. And these should be easy to find, flattering, and brief enough to present only the correct perspective. Message selection matters more than message evaluation.

Several months ago I emailed the young dentist I mentioned above and asked whether she ever checked in with blogs such as *Dr. Bicuspid*. The answer was that she "might have done so once long ago." I have a habit of circling back on those who tout reports or articles in meetings. Most cannot remember even having seen

what was once “really great.” The shadow of message awareness increasingly stands in the place of content evaluation.

The point is not to belittle those we want to communicate with. It is to be realistic about who is listening, what they are listening for, and where they are listening. If we do not know this or choose to ignore it, the shame is on us.

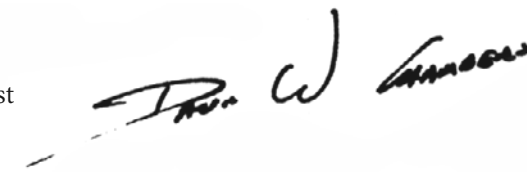
Good communication involves listening as well as talking. The college may well want to invest in systematic and wide listening campaigns to decide who should be part of the conversation and what should be on the agenda. One definition of news is what we get credit for knowing before others do since it will be of little importance tomorrow. The pace of considered change in dentistry is beginning to creep up on the status of news. Certainly yearly or quarterly cycles will be increasingly behind the times. The professionally appropriate ways to practice dentistry are shifting more quickly than big reports can manage. What matters to some does not necessarily matter to all. Or at least not in the same way. The number of channels dentists are listening to is multiple and each often only lasts for a few months. Professors and practitioners of marketing have long known that deep, logical arguments are attractive to those involved in serious matters, but they seldom change opinions. On the other hand, for awareness and forming favorable

first impressions, short, actionable messages from multiple sources work best.

There are only three problems with a serious quarterly journal: (a) it covers only a small segment of the communication market; (b) it is expensive and may burn through the limited resources of the college, and perhaps most worrisome; (c) it nourishes the illusion that we have the most important aspects of communication covered.

Dare we remain the only or one of a very few places dentists can go to find a balanced discussion of emerging issues, knowing that this will be, of necessity, heavy lifting and almost certain to contain a few things some will find indigestible? Do we have the gumption to listen as well as tell others what we think? And do we have the skills and financial resources to undertake this? Would we be welcomed?

I would love to hear what you think.



It is not so much a question of whether the college should continue to speak usable truth to the profession as whether we should recognize that the game has moved to a new field.

Focus Group Results

David W. Chambers, EdM, MBA,
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Abstract

One hundred eighty-two dentists and patients participated in 18 focus groups across the United States in approximately one-hour discussions of the perception of ethical issues facing the dental profession. Additionally, 237 dentists completed an open-ended survey on dental ethics. All data gathering was unguided. Written and oral comments were recorded. Results of this "listening" are reported here, grouped by type of respondent. The findings are reported as frequency of common responses and verbatim remarks. No attempt has been made to interpret these comments or to connect them to positions or opinions regarding approaches to addressing ethical concerns.

Dr. Chambers is editor of the college. This report is part of the empirical study of ethics in the profession requested by the regents of the college and known as the ACD Gies Ethics Project.

Photo by Dr. Herb Borsuk



There is value in listening to what patients and dentists say about ethics in dentistry. If anyone knows how ethics "feels" rather than what it "should" be, they would be the first ones to say. A reasonably large sample should give a true picture, one richer than theory or statistics.

The Sample

Small groups of dentists, leaders in the profession, patients, and those involved in healthcare policy contributed their opinions. Eight focus groups were conducted among 86 patients in the states of California, North Carolina, Ohio, and Oklahoma. Six of the focus groups were organized and conducted by the Citizen Advocacy Center (CAC), a Washington, DC, nonprofit that represents members who serve on state health boards. Two groups were conducted by Dr. David W. Chambers. Patient groups were recruited by professional polling agencies or from church groups in an effort to sample the range of the public. All sessions were recorded, and written summaries were made immediately following the sessions. Dr. Chambers reviewed all tapes and was present at four of the panels.

Thirty-seven dentists in the practitioner cohort participated in four groups, two each in Maryland and North Carolina. By show of hands, approximately two-thirds of those participating identified

themselves as American Dental Association (ADA) members. These sessions were conducted by Dr. Chambers. He also conducted four focus groups with leaders in the profession. These included nine officers of the California Dental Association (CDA), 13 members of the CDA Judicial Council, 20 "young dental leaders" identified by the Ohio Dental Association, and 17 officers in the Oklahoma Dental Association. All of these participants were assumed to be members of the ADA.

The CAC conducted a session for healthcare policy experts in Washington, DC. Those participating on this panel included former staffers of AARP, a representative of a state dental board, and policy analysts and lobbyists. There were nine participants as well as three representatives from the CAC and Dr. Chambers present.

The final such *viva voce* source was an anonymous survey completed by 237 graduates of one dental school as part of the school's annual survey of graduates. Written comments regarding ethical issues in dentistry were provided in response to open-ended questions.

The Stimulus

For all cases, respondents were invited to address questions regarding ethics based on their personal experience. Most groups answered three questions: "What is the greatest current ethical issue regarding the relationship among dentists?" "What is the greatest ethical issue regarding

the relationship between dentists and patients?” and “What is the greatest ethical issue regarding the relationship between dentists and organizations?” Respondents usually answered these questions by writing short phrases on personal but anonymous response forms, followed by public discussion. Both written remarks and group contributions were recorded verbatim and counted in common categories. The discussion sessions were mature and candid, with no steering by the facilitators. Usually no comment was made by the facilitators other than to ask the major questions. Participants did not make frivolous remarks since they were commenting in public in front of their peers.

Summarizing the Data

Conventional standards were followed in analyzing such qualitative data (Charmaz, 2006; Corbin & Strauss, 2008; Denzin & Lincoln, 2003). Recordings and written records were preserved. These were summarized separately for each panel or set of related panels. Naturally occurring clusters of comments were identified in each group independently of what other focus groups reported. The number of mentions of each topic was recorded, and illustrative verbatim comments were recorded [shown below in square brackets]. These numbers may be interpreted as reflecting the extent of concern over various themes. At the third level of

analysis, data was aggregated (but not modified) for each of the types of panels: practitioners, leaders, patients, policy experts, and alumni. The final level of analysis involved highlighting, but not further synthesizing, trends for each of the five respondent groups. This final level was called the “story according to...”

This article reports the summary data at the third level: combined summaries for each of the five data sources.

Results

Practitioner Focus Groups

Fifteen practitioners in two sessions in North Carolina; 22 in two sessions in Maryland. Approximately 66% ADA members. Written notes were completed by participants prior to open discussion.

Dentist-to-Dentist Ethical Issues

[*N* = 18] Differences of opinion among dentists is an ethical issue.

“There’s a dentist in our area who pays people a ‘finder’s fee’ to get referrals. I don’t know what to do about that. There’s no point in going to the board.”

“Afraid of conflict; must go on tip-toes when discussing values in dentistry.”

“Mostly when there is bad dentistry that comes to my attention I try to smooth it over. But if it is serious I suggest that the patient contact the state board—it is ultimately the patient’s problem.”

For all cases, respondents were invited to address questions regarding ethics based on their personal experience.

“When I see something that should not have happened in a patient’s mouth I am angry with my colleague. But I don’t know what to say to him or what to say to the patient.”

“Dentists just don’t talk much with each other about what they have in common, except for common ‘enemies’ such as insurance, understood in the sense of common excuses.”

“ADA Code requirement to report improper behavior is generally ignored.”

“Everybody knows we have problems and challenges, but we are afraid to talk about it. There is no forum for communication and there seems to be a tacit understanding that even talking about differences is an insult to professional integrity.”

“Most differences of opinion among dentists are about very small differences; often just preferred habits.”

“The best way to manage patients’ problems caused by other dentists is to

keep the discussion at the descriptive and technical level. Stick to the facts.”

“Most problems about the poor work colleagues have done is really about money—who is going to pay to make it right. And the insurance companies keep out of these things, saying they have ‘already paid for the treatment.’”

“I just do not know what to say to my colleagues, especially those who have a different idea about dentistry.”

“Problem patients are passed from one dentist to another.”

[N = 13] Each has his or her own standard; dentists mistrust each other; cannot communicate

“There is diversity of opinion regarding standards in the profession.”

“‘Standard of care’ is a term with unclear and often private or expedient meaning.”

“We are a profession of self-appointed experts.”

“Differences in professional opinions are about ego and money.”

“Dentists do not always share information about their patients.”

[N = 10] Competition among dentists
“Criticize others’ work in effort to steal patients.”

“Not commenting on the consistent bad work of colleagues creates an environment where standards other than quality of treatment are acceptable or even come to define the profession.”

“Sense of professionalism seems to be declining. Dentists are withdrawing into their own offices.”

“Dentists competing for insurance contracts drives down the reimbursement rates for everyone.”

“There are too many dentists.”

“Dentistry is becoming a job rather than a profession.”

[N = 9] General practitioners (GPs) and specialists competing for patients

“Fewer referrals. More GPs trying to do all the work to avoid losing the patient.”

“Specialists are now doing general dentistry.”

“Sometimes specialists cherry pick care provided.”

“Turf or scope of practice conflicts in dentistry: specialists want regulations that favor them; generalists want to do traditional specialty treatment.”

“The whole business of the relationship between GPs and specialists is murky; it goes differently in different situations.”

[N = 4] Misleading advertising

“Marketing has gotten out of hand. The claims dentists are making to patients have nothing to do with dentistry. They are about price and convenience and smiles.”

“Some make promises about treatment outcomes that are impossible without seeing the patient.”

“Internet marketing is not about quality of dental care.”

“Voluntary restraint on advertising only penalizes the good dentist.”

[N = 4] Questionable business practices, kickbacks, pay for referrals

“Unethical business practices are becoming the norm: ‘everybody is doing it’ becomes the justification.”

“I know a dentist who has for years kept two sets of books.”

[N = 2] Fear of having own work evaluated [not mentioned in the general discussion]

[N = 2] Pseudo credentials and specialties

[N = 2] Quota dentistry displacing quality dentistry in schools and in corporate model

“If parts of the profession are moving to judging success as production, the rest of the profession has an excuse to follow.”

Dentist-to-Patient Ethical Issues

[N = 20] Overtreatment: Profit-driven treatment planning

“In the competition between ethics and business, business usually wins.”

“Treatment options given or preferred may be ones with highest profit margin.”

“Patient selection by ability to pay.”

“Here patients are written up for the most expensive treatment options plausible on the grounds that it is easier to forgive planned treatment than to break the news that more is needed.”

[N = 17] Inadequate informed consent, “steering” patients; breaches of confidentiality

“Who should decide when there are alternative treatment options?”

“Dentists just tell patients enough to get them to go along with what the dentist wants to do.”

[N = 7] Piecemeal treatment, not comprehensive care

[N = 5] Eroded trust; conflicting opinions

“Dentistry is no longer about the dentist and the patient and oral health needs; it is about money and outside interests. The patient is the one who is being used.”

“Patients hear different stories from different dentists and so they lose faith in the profession as a whole.”

“The *Readers’ Digest* story was fully to be expected: each of the alternative treatments could be justified.”

“Patients just go from one dentist to another until they find one they can trust.”

[N = 4] Misleading advertising

“Advertising is creating unrealistic expectations.”

[N = 4] Use of unproven technology, bad science

“New technologies seem to be profit driven and are often untested.”

“EBD [evidence-based dentistry] does not help in this area because techniques are evaluated in isolation and because there is so little actual data.”

[N = 2] Faulty or improper care

[N = 2] Patient self-determination

“Don’t try to stand in the way of patient who wants a second opinion.”

“Patients want to be heard; to know that the dentist has their best interests in mind.”

[N = 2] Not current on CE

Dentist-to-Organization Ethical Issues

[N = 8] Organized dentistry less valuable, declining membership and participation

“Does anybody know why the membership in the ADA is declining?”

“The ADA is ‘toothless.’”

“The way it is now, a smaller and smaller number of dentists is carrying the water for a larger and larger number of those who are getting a free ride. Not sustainable.”

“Organized dentistry’s voice is getting weaker while Kellogg and Macy and others is getting stronger.”

“The ADA does not even seem to be aware of what EBD is or whether it matters.”

[N = 8] Organized dentistry no longer represents the profession, controlled by the few, lost trust

“The ADA gives too much attention to specialties.”

[N = 6] Insurance

“PPOs [preferred provider organizations] and managed care are taking control away from the practitioner.”

“Insurance is intruding on diagnosis, treatment planning, and dentist-patient relationship.”

“Insurance limits treatment options. Patients perceive that insurance undermines patient confidence in the dentist.”

“It is impossible to standardize the correct reimbursement for any procedures because of differences in clinicians’ skills, lab costs, front desk and other practice characteristics.”

“Insurance industry has failed in the role of standardizing and raising level of care: only concerned with its own bottom line.”

“Dentistry needs to involve the employer and government and those who ultimately pay for dental health, not just the insurance companies.”

“Insurance companies are profiling dentists’ claims, ostensibly to detect abusers, but perhaps to lower benefits generally.”

“Capitation doesn’t work for dentists because each office is like a private hospital and we do surgery, not comprehensive and long-range care.”

[N = 6] Lack of transparency

“Corporate hides what is really going on behind nondisclosure.”

“There is no forum for discussing our concerns.”

[N = 5] Organized dentistry is too focused on political action committees and lobbyists, own structure, and survival

“The ADA is too far away and seems to want to relate in terms of money and advertising. Real participation is at the local level.”

“The ADA’s primary objective is to stay in business.”

[N = 4] Corporate entities are taking advantage of student debt to intrude commercial values in place of professional ones

[N = 4] Dentists cheat on insurance

“Waiving copays is common because patients ask for it.”

[N = 4] Live patients on initial licensure exams

“Such tests are out of context and invalid because they do not measure comprehensive care.”

“Would like to see nationally standardized licensure.”

[N = 3] Intrusions into treatment and dentist-patient relationship from various sources

“Beginning practitioners cannot start their own practices so they have to start as associates or employees and pick up the business habits of their profit-oriented bosses.”

“Younger members aren’t joining organized dentistry.” [Fact: They are overrepresented compared to general dentists in their mature years.]

[N = 3] Tech companies, suppliers influencing treatment decisions

“Massive advertising in professional journals, at trade shows, and in ‘throw-aways’ distort true professional values.”

“Gurus hype major productivity; what’s in it for them?”

“The ethics of the emerging graduates is the ethics of the future of the profession.”

“Product endorsements are becoming more common.”

[N = 3] Organizations are “fronts” for self-interest of members.

“Factionalism.”

“Multiple professional organizations are competing for membership, causing a narrowing of focus and appeal to self-interests.”

“Some organizations exist to promote a business model, e.g., sleep dentistry.”

“ASDA [American Society for Dental Ethics] and the ADA need to grow up on this issue of patients on licensure exams.”

“Different organizations are representing particular interests in an effort to draw membership from those seeking personal advantage at the expense of colleagues generally.”

[N = 2] Weak leadership, tolerate unethical members, commercial interests

“State boards have lost control of the profession.”

“Ethics has become ‘enforceable up to the cost of legal defense.’”

“Boards are not taking on the known offenders; afraid of counter-suits, underfunded.”

“Boards are overdoing the idea of recovery or reclaiming previous offenders and letting bad actors back into the profession when they have not changed.”

[N = 2] Government: regulations and low reimbursement rates

“FTC’s [Federal Trade Commission’s] preoccupation with driving down cost is destroying quality of care is an issue that is having unintended consequences.”

“Legislators always respond to appeals for ‘free trade’ and ‘patient safety.’”

[N = 2] Dental school environment fosters competition.

“Dental schools are falling behind in what they are teaching about ethics.”

“The ethics of the emerging graduates is the ethics of the future of the profession.”

“Schools may not be able to do anything about the ethics of young people (already formed in youth), but they should be more selective in admissions.”

“Young people today are going into dentistry for the money.”

[N = 2] Mid-level providers are a question mark.

“The effects of mid-level providers may be positive for patients and negative for dentists.”

[General comment: “There are so many definitions of ethics and so many applications of principles. We need to work on what to do when there are differences.” There appeared to be more concern over dentist-to-dentist ethical issues than over those involving patients.]

Dental Leader Focus Groups

Seventeen leaders in the Oklahoma Dental Association; 9 officers of the California Dental Association (only addressed issues relating to dentists and organizations); 13 CDA Judicial Council members; 20 Ohio “Young dental leaders”

Dentist-to-Dentist Ethical Issues

[N = 40] Practicing in isolation

“We can still afford to live in our own worlds; no need to collaborate.”

“Little real opportunity to communicate or cooperate on treatment standards.”

“Practice is in silos.”

“Patients are confused, and consequently trust in the profession is eroded.”

“Neither patients nor colleagues have a voice in quality or type of care provided.”

“Dentists can collaborate as much or as little as they want to.”

“Lack of clear and consistent standards for what constitutes good dental care.”

“Every dentist can do whatever he wants as long as he can talk enough patients into it.”

“Egos.”

[N = 18] Lack of collegiality: view other dentists as competitors

“Some make unjustifiable negative remarks about others’ work.”

“Overtreatment comes from feeling of competitive need.”

[N = 8] The profession does a poor job of policing itself.

“Justifiable criticism is mistaken for unprofessional poaching, so avoided.”

[N = 5] Unclear relations with specialties and medicine unclear

“Currently care for the patient is divided and allocated to individuals

with specialized training or public perception of best care, including on the basis of patients' perceptions of cost/benefit calculations."

"Fragmentation causes appearance of competition is for market share."

"Generally, evidence is lacking to support often voiced claims of superiority of outcomes for many kinds providers."

"Better interprofessional communication and outcomes-based decision making are needed."

[N = 3] Different practice models and reimbursement systems

"Dentists working for dentists introduces new layers of ethical complexity and responsibility."

Dentist-to-Patient Ethical Issues

[N = 21] Overtreatment

"Overtreatment is driven by competition among dentists."

"Advertising serves greed rather than trying to reach those most in need of dental care."

"The new standards are money, technology, and egotism."

"Patients and insurance companies are putting downward pressure on dentists' ability to maximize treatment offered."

[N = 21] Bad dental practices

Over-diagnosis, Botox, not being honest about own bad work, fraud, cherry-picking treatment, treatment beyond competence, insurance manipulations

[N = 16] Commercialism: business is the new standard.

"Patients as 'customer' rather than individual needing professional care. Dentistry is now something to 'sell'; treating teeth instead of patients."

"Rebranding (anti-aging dentistry), smiles, brand named technologies

disguises what oral health is really about."

"Patients treat dentists as providers of commercial services rather than professionals."

"Loss of trust, bad-mouthing, skipping payment, shopping (both dentists and patients are doing this)."

"Patients demanding specific care based on advertising or recommendations from other dentists."

"Conflicts between treatment priorities and patients' financial resources."

"In the corporate model we are seeing 'diagnosis' at front desk."

"Treating to insurance."

[N = 11] True market demand does not reach what dentists hope for.

"Dentists blame government and insurers for not putting enough money into the system."

"Dental care trends toward services beyond true oral health needs because that is where the money is. This makes dental care appear 'elective.'"

[N = 10] Advertising, misrepresentation, media advertising

"Patients do not hear same story from all dentists."

"Patients are being told that dentistry is a series of one-off transactions rather than a relationship."

"Claims of superior or exclusive skills or services."

"Appeal to uneducated public rather than colleagues to decide who is good dentist."

"Getting too close to commercial organizations, advertisers, web designers, group-ons."

[N = 8] Patients and dentists have different views of good dentistry.

"Dentistry is defining itself in terms of services delivered, especially at very high levels of excellence. But this is not the way patients define dentistry. They seem to define good oral health as not needing to see the dentist."

[N = 7] Failing to present all treatment alternatives, lack of informed consent

"Treatment options are often tailored to maximize profit or the dentist's view of optimal oral health."

"Dentists are trying to take treatment decisions away from patients."

[N = 4] Others than dentists or other dentists are influencing patient expectations; extra-professional values

[N = 4] Increasing specialization and defining practice in terms of techniques rather than comprehensive health outcomes causes fragmentation of both the profession and care.

[N = 4] Patients no longer trust dentists, weak relationship, shift to financial basis of relationship

"Old model of dentist and patient (with dentist having recognized authority) being replaced by multiple forces competing to represent dentists' and patients' interests."

"Patients can no longer afford to stay with a dentist long enough to build relationship because of cost factors."

[N = 2] Conflict between ideal care and what patients can afford

[N = 2] Undertreatment of those without funds

Dentist-to-Organization Ethical Issues

[N = 21] Organized dentistry cannot influence the way dentistry is practiced.

“We are aware of the problem (confusion and miscommunication leading to reduced trust), and we talk about it. But organized dentistry really cannot do anything about the problems.”

“There is no common place to discuss ethics or the alternatives to the way dentistry is trending.”

“Even in the face of strong messaging from organized dentistry and mandatory continuing education, the fact that dentists do not depend on each other collectively for achieving best outcomes, or even financial success, means that public relations campaigns will be superficial and the potential impact of professional communication is diluted by messages from other, often commercial, sources. Organized dentistry may not be using its communication platform effectively, or it may be too focused on legal and financial aspects of dentistry.”

“Enforcement is spotty. State boards no longer involved except in most outrageous cases or cases where dentist does not put up a fight.”

“There are silos; folks are now using private definitions of what is right. There is a growing sense in American culture that ‘everyone has a right to be right by his or her private standards.’”

“It is inappropriate to comment on a colleague’s work. It is even becoming inappropriate to discuss this. We lack the language and opportunities to have discussions (other than attacking others self-righteously).”

“Organized dentistry focuses on legal and regulatory action rather than dealing directly with influential others.”

“The most questionable dentists are probably not members of organized dentistry, so we have no influence over them.”

“The ADA has become a bureaucracy that does not represent individual practitioners.”

“Organized dentistry is prevented by law from interfering in individual dentist’s commercial activities.”

“The [ADA] code of ethics is aspirational and not enforceable.”

“Is it wise to have one organization attempting to speak for all dentists?”

“Oral health no longer a standard.”

“Using political position to advance private practitioner income.”

[N = 20] Benefit of organized dentistry not clear, too many organizations, fragmented participation

“Organized dentistry could overcome the isolation of individual dentists, but it does not seem to be effective at doing so.”

“It is hard for individual dentists to resist the pressures of commercialism, advertising, politics and regulation by themselves.”

“Young practitioners learn how to practice from senior dentists.”

“We want more from organized dentistry.”

[N = 18] Fragmentation in understanding what it means to be a professional

“We are not sure how to reach the cost/value point of practitioners.”

“One can be ‘professional’ without sharing values or activities with one’s colleagues. Traditional dental professionalism competes with many other value sets.”

“Non-membership is a growing issue.”

“Educational debt must be managed.”

“We now expect organized dentistry to promote profession only, not profession and patients.”

“Dentists are getting their values from places other than their colleagues.”

“Money and technical excellence on big cases (‘show-off dentistry’) is becoming an independent standard.”

“HMO [health maintenance organization] practice model is inserting new values.”

“Practice is increasingly being steered by marketing values.”

[N = 13] Benefits companies will not pay for all work dentists want to provide

[N = 6] Turf battles (in court), who gets to provide care, competition among groups, organized dentistry no longer single clear voice

“Many organizations besides organized dentistry are now influencing practice.”

[N = 6] Student debt

“Dental schools cannot change ethical orientation in the face of what is happening in practice.”

“The young want to live the life style of their parents.”

“As a younger dentist, I resent the claims that I must be unethical just because I have a high debt load when no one has shown me any evidence that this is true of me or of my peers in general.”

[N = 4] “Good old boys’ club”: no longer representing all dentists.”

[N = 4] Corporate is a viable alternative

“Corporate and ‘institutes’ are a viable alternative home for dentists drifting toward a business definition of dentistry rather than a professional one.”

[N = 3] Online discussions, social media, unproductive

“I do not trust or participate in online discussions because they are

dominated by commercial interests and people with axes to grind.”

Patient Focus Groups

Eight-six patients in eight focus groups in San Francisco, California; rural and urban North Carolina; Cleveland, Ohio; and Oklahoma City, Oklahoma.

First Thought That Comes to Mind Regarding Dentistry

Cost.....	17
Issues of competence.....	7
Overcharge, overtreat.....	6
Pain, scary	6
Hassle, inconvenience, unavoidable necessity.....	4
Cleaning, health, professionalism, quality.....	5
Communication issues	4

Quality

No specific question was asked about how patients define quality of oral health care. Generally, quality seemed to mean technical outcomes and treatment in the process as expected. “Durable,” “no mistakes,” “preventive,” “effective,” “explained so I understand,” “not being pressured,” “nothing unnecessary.”

Overall, about half have been satisfied with their dentist; those dissatisfied have moved on.

“Good is not having to go back or to hassle the encounter.”

“I think most of the dentists have competence. It really boils down to their personality. Do they make you feel at ease?”

Judging Competence [Criteria valued by patients]

Interpersonal relationship	18
Clear explanations.....	15
Friendly, efficient staff	8

Appearance of office, current equipment.....	7
Care about pain, taking time.....	4
Reputation in community	3
Online references	3

Public Emblems of Quality of Little Value

License on the wall is a given	7
Report card of little value	5
Too much technology	2

“I think when you are a professional you will show that, when you are examining a patient, or whatever; it’ll show. You will know whether they are dedicated to their craft or are just going through the motions. The way they interact with you. You’ll know whether they know what they are doing, or not.”

“I went to a dentist before and he caused the start of my problem. He first said I needed a root canal, so he shaved it all the way down to a point. The next day it broke off at the gum line, so I had no tooth left. When I first started going to him, I just didn’t think he was the right one for me. I shouldn’t have gone back to him. He didn’t even say hello to you. I stopped going to him after that.”

“I don’t think you know it until you actually go to them and see what he’s like.”

“I take ratings kind of with a grain of salt.”

“It [dental license] doesn’t differentiate any of them from each other because they all have it.”

“A professional testing organization would be fine for the technical aspects of what type of equipment they have, what their training is, how good their training was. This is a given. But, once you get into various mouths, everyone in here has different sensitivity.”

Finding a Dentist

References from friends.....	11
Looking for location, convenience	5
Consult lists, shop for price, insurance	4
Avoid appearance of oversell.....	3

“I actually do an internet search and look on the website where they got their degree, when, what they studied. I read all of that.”

“One of the things I look at is do they work in the community for people who are in need. That ranks high. A lot of times they say if they volunteer. When you go online, you find all kinds of stuff.”

“I want to steer away from the people with the new technology and stuff because, I mean, like, you’re going to be doing fillings and root canals and things like that just like everybody else and you’re going to have to charge three times as much for all your new machinery and it doesn’t necessarily make you a better dentist.”

“I refused to get involved in the huge medical school, dental school system. It is so impersonal. I won’t see any healthcare provider in that setting. I want them to remember me from time to time.”

Communication

Could be better	11
Generally good when talking about procedures	8

“The hygienist will come in and explain what she’s doing and what she found. The dentist comes in and agrees with her assessment. Then I go to the front desk.”

“Don’t like the way he comes across as knowing everything but not really telling me anything.”

Paying for Care

Selling, overselling.....	21
Generally, dentistry is too expensive	19
Cost affects when and whether care is sought	11
Postponed work because of cost...	7
Medicaid coverage is inadequate for costs.....	6
Combine dental and medical insurance	6
Treatment offered as “Take it or leave it”	5
Private insurance is good.....	4
Credit, other option “bad deals”	4
Like that insurance covers prevention	4
Fail to distinguish optional from necessary	4

“This ‘full amount up front and then we’ll see what we can squeeze out of the insurance company’ attitude makes me think they are in it for the money.”

“Way too expensive.”

“I’m missing two teeth because I couldn’t pay for what I needed.... I’d still have these teeth if they’d given me a payment arrangement.”

“Under Medicaid we’re usually not covered for crowns or major work or cosmetic work.”

“Cleanings and screenings—I think they should be made available to everybody as often as necessary. Anything that has to be done after that will have to be negotiated.”

“It is a put-off when they start talking about a ‘perfect mouth.’”

“Dentists charge extra if they know you have insurance.”

“Our dentist says, if you want to pay cash, I’ll take some off.”

“Dental insurance makes a lot more sense than medical insurance.”

“(Even with insurance), it’s still too much. From my experience, I feel like a lot of dental offices charge extra because they know it’s covered.”

“They have these vouchers where if I hand them out and get referrals, I get \$100 for every person I get. So, I could get 4 people to go, I could get the \$400 (for a mouth guard).”

“The only other option was to do a credit-type thing where you get a credit card and put money there and there is 37% interest, so you are paying on it beyond the year you die.”

“A good dental visit is when I don’t see the dentist or he doesn’t have much to say.”

“I have insurance, but I’m paying more and more out-of-pocket; it’s like the dentist is trying to get paid twice.”

“Dentistry has become preventive; I don’t expect to need treatment for things I am unaware of.”

“It’s like going to get your oil changed, then the sales guy comes in with a list of things that ‘really’ need to be taken care of even though I didn’t know they were a problem.”

“Is it really true that I need a cone beam every year without the dentist even looking to see if things have changed in my mouth?”

“They do a lot of stuff that is unnecessary.”

“Several charge you interest as high as 18%.”

“I think dentists just charge as much as they think they can get. They get paid by both the insurance company and the patient. They are willing to give me a discount, so I know they are overcharging somewhere.”

“I asked for a payment plan and got no sympathy.”

“Dentists want it both ways. They sell as much as they can, so insurance picks up some and the patient gets stuck with the rest. Those without insurance, are just out of luck.”

“Just like business at the malls.

They jack up the price for any one desperate enough to pay it, and then offer discounts.”

“Now I’ve found a good dentist. Previously I had one I felt was in it for the money. He had a high priced office and needed to make money. He was probably 50% higher than the rest of the dentists in the area.”

“I have doubts about my dentist. He let some stuff go.... I didn’t trust him and went to see someone else.”

“I think he wants to do things just because he can do them.”

Behaviors That Are Not Appreciated

Excessive cost.....	16
Overtreating.....	11
Poor communication	4
Assess for the well-off	3
Self-promotion.....	3

“Cost of procedures.”

“Overcharging.”

“If they can turn it around and have a good practice for years, they become a millionaire they charge such high prices.”

“Dentists go into a lot of debt for schooling. I don’t know if that is tied to what they charge.”

“At least cover part of the cost rather than saying you’re out of luck, man.”

“I think there are a lot of goof-balls out there who are dentists.”

“Somehow he changed after he built that beautiful new office.”

“Make sure everyone has access to care.”

“Make sure they don’t gouge anybody.”

“When you go to the dentist, even if you are going for your six months, every time I go in I get nervous in the chair because first I’m looking to see if they find something and then if they don’t, it always feels like a little bit of a hustle to get more money from

you. ‘Why don’t you think about whitening?’ or, ‘What about that tooth that’s missing?’ There’s always something extra.”

“They have to take continuing education, right? Unfortunately, I can tell you my beautician takes more continuing education than my dentist. How do you know they actually went to those classes?”

“Reduce the amount the dentist takes.”

“Consistency in pricing.”

“Universal healthcare should be a percentage of your gross income.”

“If there were some way to keep the dentist honest. They are in private practice so they charge whatever they want, do whatever they want.”

Response to Bad Encounters

Unaware of reporting options	8
Online and word of mouth	5
Go somewhere else	5
Confront the dentist	5
Fix the problem, complaints are useless	4
Profession and state boards cover it up	4
Report to insurance company or somebody	3
Avoid multidentist offices	3
Preserve dentist’s reputation if possible	3

“The oral hygienist put me in so much pain. I told her and she started crying. The next thing I know, the dentist comes in and I can’t tell you how rude she was. My friends told me that’s how she is.”

“I’d talk about it at work because everyone has the same insurance. It gets around that a certain dentist sucks and people won’t go to him.”

“I wish there were some sort of peer review. Four or five years ago I had a really bad crown put in and I had 4 dentists in 3 different states tell me it was a horrible crown.”

“I’d go back and if I don’t get resolution to my satisfaction, I leave and find somebody else.”

“I am beginning not to trust [some] dentists. But I trust lawyers and the government even less. I hope dentists don’t become like lawyers or big business retailing.”

“I’m more concerned about fixing the problem without putting more money into it.”

“Part of the question for me is the trustworthiness of any agency that monitors the healthcare professions.”

“Is it about teeth or is it about money?”

“I would show up and ask questions.”

“I wouldn’t pay.”

“Address it; fix it; change the practice; not charge you.”

“If they screw something up, they better damned well pay for it.”

“Ethical issues are likely underreported.”

“We should reduce cost by having dentists take home less money.”

“Is there a dentist’s association that a patient could go to?”

Second Opinions

Yes, if did not like options offered	8
Expensive and questionable value	5
Second opinion if suspicious	3
Second opinion if large and irreversible case	3

“The first guy seemed drunk. My sister went to him anyway and they double-charged her, so I decided to get a second opinion.”

Impression of Hygienists

Positive volunteered comments...	13
Favor independent hygiene	5

“To me, the hygienists—they are the face of the practice. They are the ones you’re going to work with.”

Licensure only establishes minimal competency, and is often unevenly enforced. There was little interest in a “report card” or other external monitoring of continuing competence.

“The dentist is playing a smaller and smaller part in the system, just the technical stuff.”

“Keep it simple—go to the hygienist unless you need something more serious.”

“For basic cleaning it would be better to make an appointment directly with the hygienist and have it be cheaper and easier. All the dentist does is go over and look at it for 30 seconds and you have to spend however much money just for that.”

“I go to the hygienist; they have a dentist there too.”

Policy Experts Focus Group

Nine individuals representing various healthcare and patient advocacy groups, such as AARP, who interact with dentistry; one state board representative.

First Thought That Comes to Mind Regarding Dentistry

- High-end procedures
- Patient anxiety
- Expensive
- Total health orientation
- Disconnected from the rest of the healthcare system
- Organizations engage in one-sided conversations

“How can the profession tell the public that oral health is part of total health and then isolate itself from the rest of the healthcare system?”

“Patients are not drawn to dentists; feel they cannot escape.”

Selecting a New Dentist

- Word of mouth
- Facebook
- Referral from previous dentist
- Major criterion is convenience

How Is the Competency of a Dentist Established?

[The panel expressed some frustration over this question, saying that the true answer is hidden from the public.]

Licensure only establishes minimal competency, and is often unevenly enforced.

There was little interest in a “report card” or other external monitoring of continuing competence.

The best indicator is a strong personal relationship with patients.

Staff confusions and paperwork problems do not reflect well on the dentist; hassle is a bad thing; The standard should be effect on health.

Trust can be gauged by referrals, staff turnover, consistency, willingness to spend time answering questions, instinct.

Informed consent is not really practice.

“Dentists protect each other, so they cannot be trusted to do this job. Government is no good because it cannot get the data.”

“‘Top Doc’ and the like is just advertising.”

“Decision useful information—patient satisfaction, what insurance is accepted, past legal actions, convenience, type of procedures, cost, outcomes, malpractice—is all hard to get because dentists practice in isolation. No transparency.”

“When I asked DC society of dentists, they would not say.”

“Checked online, but that stuff is unbelievable. Everybody can’t be that good.”

“I don’t think the public is listening to what individual dentists or the profession is saying about itself.”

“Dental licenses are like a driver’s license (every dentist has one).”

“Not impressed by technical jargon or talk of their training.”

“I was put off by the dentist taking a doctrinaire attitude that he should save every one of my teeth.”

“The standard should be effect on health.”

“Patients superimpose their own standards on dentists, do not accept dentist’s interpretations *prima facie*. Their concern is outcomes not technique. But many dentists do not seem to understand this.”

Cost

Dentistry works on a different model from the rest of the healthcare system. The other parts are interconnected; dentistry is still largely single provider. This makes the relationship with insurance difficult.

Insurance reimbursement rates have not kept pace with inflation at the same time that dental fees have outstripped inflation.

Cost is becoming a factor in patient decisions regarding care. The well-off are consuming optional care and the poor are postponing or declining it.

Overtreatment is an issue.

Smart patients handle oversell by going to another dentist.

Criteria are being my problem taken care of with minimal hassles and surprises [?]; “All I ask is a sense that the dentist is doing the best by me.”

“Dentists are pricing patients, government safety net schemes, and even insurance companies out of the market.”

“The perception of the public and policy makers is that dentists are refusing to discuss costs and access.”

“I have been successful as a well-educated and well-connected individual in negotiating price adjustment with dentists; as a representative of groups of patients, I cannot get a hearing on this.”

Managing Unfortunate Outcomes

Say nothing, but look for alternative office.

Only the confident and educated can do this.

“Dissatisfied with technical talk about saving my teeth so I delayed payment.”

“There is no platform for discussing changes in dentistry. It is happening without control and in a haphazard fashion.”

“Patients are not agents. They have no voice.”

Treatment by Others Than Dental Practice Owner

Associates are fine as long as they are backed by presence of the head doc.

“I go to the hygienist, not the dentist; hygienists seem to do all the work, reading x-rays, etc.”

TABLE 1. **Greatest ethical problem facing the profession.**

	<i>Established</i>		<i>Young</i>	
	#	%	#	%
Overtreatment, malpractice, fraud	76	40	2	6
Inadequate reimbursement, insurance	40	21	11	35
Corporate, clinics, nondentist owners	39	21	7	23
Not serving the poor	17	9		
Advertising, standards, leadership	9	5		
Debt	7	4	11	35

[General observation: corporations are disruptive technology; need for navigators; there is no platform for discussing changes in dentistry, it is happening without control and haphazard; IC [infection control] is not really practiced; access and outcomes are not part of the discussion; no equilibrium within the field; patient is not an agent, has no voice. (Professional facilitator remarked: "Better patients make better dentists.")]

Practicing Dentist Survey

Administered as part of an annual mailed survey to graduates of a dental school. A total of 237 surveys were returned, 14% of which came from respondents who said they had been in practice for fewer than ten years.

Greatest Ethical Problem Facing the Profession

"Because of the enormous student loans, the low compensation from the dental insurance companies, and the expense of some high-tech equipment, many dentists over-diagnose and over-treat their patients. We dentists are encouraged by clinic owners, CE lecturers, and sales people to 'sell more dentistry.'"

"We place way too much faith in latest and greatest technique or technology."

"We are losing our soul to corporate dentistry and our associations are not addressing the loss of the solo practitioner."

"Dentists are being pressured from multiple directions: insurance companies limiting procedures and lowering or not raising reimbursements. Expenses are increasing for employees, the many insurances required by dentists, taxes, supplies, associations, etc. Patients shop for the lowest prices and use negative online reviews as a threat. Legislative action always increases dentist expenses."

"Dentists are turning into technicians instead of healthcare providers."

"The lack of priority for correct use of dental floss."

"Eliminate the moral code of self-sacrifice and teach the alternative of rational egoism."

"Nowadays, most of our patients of all ages are grossly overweight or clinically obese. These conditions reflect a lifestyle that is hugely deleterious to overall health, and puts most of these patients on a path to having chronic heart disease, diabetes I and II, etc. All dentists and their staffs should advocate for their patients plant-based nutrition with NO EATING of dairy, or red meat."

"Every dentist knows the 'best' way to do things. He thinks that they are

correct & that every other dentist is wrong. Public goes to 3 diff dentists and gets 3 diff answers. Dentists used to be a trusted profession. Dentistry lives in the dark ages."

"Foreign dentists pouring into the workforce and having NO ETHICAL STANDARDS!!! They are graduating and are performing iatrogenic procedures beyond their training, and are cutthroat 'business people' performing unnecessary dentistry to line their pockets."

"The current state of the economy both globally and locally and its negative impact on the ability to deliver optimal dental care in a private practice setting. Inflation, rising cost of supplies and salary, educational debt, etc. require higher fees and more procedures and costs to patients. How do we justify the cost of doing business in private practice?"

"It's a challenge over a practice lifetime of forty years to maintain effective and evolving treatment plans for maturing patients and to treat three generations of patients addressing all of their dental needs and giving excellent dental care. It's unethical to milk a practice for five or ten years and then pass off all the 'problems' to a new owner."

"The correlation of oral health to overall health is not well understood. I have enormous concern over the debt issues graduates face. Additionally, the intrusion of govt, insurance, & corporate into our noble profession is disconcerting. Integrity is being compromised and yet we wonder why. Unbelievable. People from other countries not growing up with basics of unbendable ethics of right from wrong. Get rid of the Democrats."

TABLE 2. What have you done personally in the last six months to make things better on the issue you identified above?

	<i>Established</i>		<i>Young</i>	
	#	%	#	%
Maintain personal standards	36	23	2	6
Nothing	30	19	6	18
Educating colleagues, students, talk about it	23	15	2	6
Persuade patients to my standards	17	11	4	12
Participate in organized dentistry	13	8	2	6
Eschew insurance, fight insurance	11	7		
Personally quit corporate	6	4	2	6
Personally quit organized dentistry	6	4		
More businesslike, raise fees, retire	5	3	7	21
Public service	4	3	4	12
Campaign for conservative politicians	3	2	2	6
Work with insurance	2	2	2	6

TABLE 3. What should organized dentistry be doing to address the issue you identified above?

	<i>Established</i>		<i>Young</i>	
	#	%	#	%
Financial success of dentists, fight insurance	41	23	11	47
ADA, state boards not effective, no discipline	35	20		
Practitioners fine; schools failing ethically	25	14		
Standardize treatment, too much diversity	18	10	3	14
Control tuition, loan forgiveness	13	7	5	21
Curb corporate abuses	12	7	3	13
Educate the public	11	6		
Access and affordable care for all, prevention	6	3	1	4
Continuing education	5	3		
Protect dentists from suits by patients	1		1	4

What Have You Done Personally in the Last Six Months to Make Things Better on the Issue You Identified Above?

“Attempted to facilitate the education of a few hundred folks regarding concepts of individual freedom, anarchy & free market capitalism.”

“Be the best dentist I can.”

“Clear communication with patients regarding the need for the work regardless of insurance reimbursement. Declining to take patients from insurance companies that don’t reimburse adequately.”

“I can’t change other people, so I do my best to serve my patients and community according to my values.”

“I have chosen to continue practicing as a Solo Practitioner instead of joining a larger Group Practice, where there is less control over ethical systems. To save my practice in a highly difficult situation, I chose to let Staff go and to increase my hours. I currently work 14-19 hours/day, Monday through Friday, and I make sure that the important systems are followed. I am exhausted, but proud.”

“I maintain my value and integrity as person, as a health care provider. Although I make less profit, I want to gain patients’ trust. I spend time equally with my patients regardless of what insurance they have or how much the procedure can produce for me. My goal is to have my patients’ dental health improve overtime. My reward is to see their dental health improve and have them as lifelong patients.”

“I retired, didn’t want to deal with the stress anymore.”

“Keep educating my patients of the abuse (of insurance companies).”

“Not much, other than pay my ADA, CDA and local dental society dues. One person can’t do much.”

“Nothing can be done by 1 dentist.”

“Nothing. It has taken me 10 years to reach personal, financial, emotional success.”

“I offer free second opinions to patients and parents who have experienced overtreatment.”

“Paid my dues to the ADA and CDA.”

“Speaking is paying my loans.”

What Should Organized Dentistry Be Doing to Address the Issue You Identified Above?

“Control the insurance companies.”

“Find a way to reconcile insurance coverage with the dental needs of the community and encouraging the public to value their dental health.”

“Social safety nets are important to have... until they begin to swallow up everything else...”

“Making sure the dental field is not in a race to the bottom for affordable dentistry. There will come a point where reimbursements will be so low that it would not make financial sense to do clinically acceptable dentistry. Dentistry will always be practiced, but quality dentistry may fade.”

“They can’t do anything.”

“Work on avenues with the insurance companies for much higher compensation for procedures so dentists can stop doing extra treatment. Dentists that do crappy quality work and over diagnose patients should have their treatment reviewed and license to practice modified. If we as dentists don’t monitor our profession our reputation as a whole will be seriously affected.”

“Don’t admit greedy students, limit corporate influence, get back to basics. Some of the best restorative dentistry was done in the 1960-1980s. It had an

artistic approach, which allowed a bond to the subject matter... the patient.”

“Good luck on that one; organized dentistry is avoiding getting involved.”

“I am too old to worry about this.”

“Many dentists have to sacrifice patients’ care to maintain their profits by spending less time, recommending unnecessary treatment.”

“It is more the responsibility of the dental school to instill a strong ethics concept in the student. Organized dentistry is providing all the ethical education necessary through the ADA CEBJA [Council on Ethics, Bylaws and Jurisprudence] and CDA Judicial Council and local dental society newsletters and ethics committees. It’s time for the dental school to step up to the plate and teach ethics not how to make the most money.”

“More oversight over training for general dentists after dental school. There needs to be some standards put in place to see that a general dentist who takes one weekend course in implant placement is not allowed to start placing implants the next day. Dentist should have minimum educational requirements to perform complex procedures.”

“Poor and elderly people need to have dental insurance in the way they have medical insurance. Patients in rural areas do not have enough dentists willing to live there.”

“Support the efforts of solo practitioners.”

“The ADA and CDA should pressure California to ease regulations. For example, the sick leave law, amalgam separator regulation is significant increase in expenses, while reimbursement fees from insurance companies do not increase. These organizations should focus on helping

“Making sure the dental field is not in a race to the bottom for affordable dentistry. There will come a point where reimbursements will be so low that it would not make financial sense to do clinically acceptable dentistry. Dentistry will always be practiced, but quality dentistry may fade.”

sole practitioners. Is it possible to organize dentists to boycott some of the dental insurance companies with poor reimbursement?”

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The Dental Ethics Teaching Case

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Abstract

Ethics teaching cases, dilemmas, are a staple in dental school curricula and in presentations to practitioners at meetings. They are short, hypothetical situations where various approaches might be appropriate and where the dentist is assumed to be both the independent initiator of the action and the judge of whether it is best. The use of cases for teaching works best in small groups. The goal is to teach habits of reflection-in-practice. They are seldom used to teach principles and more likely to function to explore the edges of the interpretation or application of principles. Published ethics cases in dentistry were compared with those in media, business, and nursing. Dental cases were found to be unique in being more about ambiguous matters rather than clear examples of right and wrong, more hypothetical and open to interpretations, more likely to ask that participants assume that they are the decision maker rather than the explainer of what is appropriate, and that dentists were not answerable to others for their actions.

Discussions that are centered on representative problematic incidents in practice are an important teaching tool in professional ethics. They engage learners and provide a break from didactic approaches that can seem “preachy” when talking about what people should and should not do. In dentistry teaching cases are customarily called dilemmas to emphasize the point that more than one point of view will be justifiable and that a single, completely satisfactory path forward is not expected.

This paper will discuss how teaching cases function as a method for promoting reflective ethical practice and contrast the cases used in four professions: dentistry, journalism, business, and nursing. Perhaps the types of issues taken up in teaching cases can reveal something of interest about how the professions regard the tough choices its members have to make.

Using Teaching Cases to Build Reflective Practice

Teaching cases, whether in ethics, diagnosis, treatment planning, or other aspects of dentistry, are opportunities to reflect on situations where attention is being called to a potential problem. These are not naturally occurring ethical challenges. A group of individuals is brought together for the express purpose of considering a situation that someone with credentials in ethics has identified as a hypothetical situation where one path forward is free of regret. Reflecting on several such cases

is offered as training for the general skill of making better ethical decisions.

How Case Teaching Is Structured

Short descriptions, usually written and ranging from 25 words to three pages, describe the details of a hypothetical situation. Such descriptions allow participants to “fill in” missing detail, and one of the sources of discussion stems from the fact that participants bring something of themselves to cases. Participants are invited to assume the role of a clearly identified individual in the case (“Dr. Soandso just examined Mr. Challenge...”) or to discuss generally a topic from a particular description (“Your benefits carrier just announced a change in documentation requirements for all dentists in the state...”). Learners are invited to discuss the case in small groups, with varying degree of teacher guidance and participation. Cases are chosen so that each of the most plausible actions involves both happy outcomes and disappointing consequences, for both the actor and those he or she interacts with. The goal is to find the course of action or policy that minimizes the moral regret, the ethical dis-ease in a situation that has been crafted to be problematic. Much of the work in analyzing the case is imagining particulars that fill out the brief description, uncovering implications,

and linking preferred alternatives to justifications. Usually there is no attempt to reach a consensus on a course of action or a single justification that all participants will be expected to accept. Varying degrees of participation among participants is accepted.

Cases can also be used to teach by example or as illustrations of the points a presenter is trying to make in a predominantly lecture format. Particulars of situations that went conspicuously wrong are commented on and learners are invited to feel good about not behaving so badly themselves. Usually this kind of case is in the public domain, such as Dr. David Acer, who intentionally infected patients with the HIV virus, or Dr. Douglas Harrington, whose practice drew national media coverage for its awful infection control practices, or cases pulled from records of disciplinary action taken by state boards. All of these are public records and can be found on the Internet. James Rule and Mickey Bebeau's wonderful collection of biographies and analyses of great dentists is perhaps the only collection of exemplary cases (Rule & Bebeau, 2005).

Cases can be studied by individuals alone, but that is rare. The function of a case is not to learn that someone had a problem or that an expert commented on it in a certain fashion. Cases are usually discussed in small groups in order to maximize the likelihood that differences of interpretation and different value profiles will emerge.

How Cases Teach Reflection-in-Practice

Donald Schön's research on how professionals learn to solve problems is relevant here (Schön, 1987). When faced with the need to take an action where the previously learned and habitual responses look as though they will not be satisfactory, the professional begins to reframe the problem using intellectual and actual tools particular to one's profession. The patient complains of pain in a tooth that shows no obvious signs of trauma. Problem solving is needed and will include considering several alternatives such as referred pain. Physical tests will be performed. Based on the results, new hypotheses will emerge. The process of reframing continues until it is unlikely that any further adjustments in framing seem justified...then action is taken. When processes such as this are repeated in a particular domain, the professional learns reflective skills. Case work in ethics is based on this model and is intended to teach reflection-in-practice.

In the academic setting, most cases are "given." Learners do not sense or discover that an ethical problem exists as part of their natural lives. They are told explicitly that some imagined person has a problem and it is strongly implied that reframing is expected or at least that the next few minutes will

be devoted to those who wish to engage in this process. The artificiality of case learning is magnified by confining case work to previously announced times, locations, and attendance, and by instructors establishing context, even to the extent of giving a brief introduction to the topic heading, say nonmaleficence, before inviting discussion.

The size of the group working on a case is critical. When multiple participants share their perspectives, it is more likely that alternative interpretations of the situation, insight into how actions will affect others, and

Overtreatment is wrong, so is fraud, and no ethics course should place that on the table for debate.

ways of justifying a chosen action will emerge. That is useful input for constructive reframing. The optimal size for case discussion is about four to six. A highly skilled facilitator may be able to add one or two more to the group. But beyond that number there is a danger that some will assume the role of “performed in front of their peers” and others will become “the passive audience.”

Above half a dozen individuals discussing a hypothetical case, the definition of the task shifts from individuals trying out various constructions on the problem in the context of their friends to an artificial and academic task. When the group is too large for equal, open exchange of ideas, some simply become spectators. They reflect on what others are saying, not on how they would structure the matter. When the facilitator can no longer maintain active participation and begins inserting content, the process becomes academic and only a few students participate in the “guess what word the instructor wants us to say” game (Doyle & Straus, 1976).

There are two goals in a clinical case consultation involving a dental

student, a faculty member, and one or more specialists: (a) what should be done for the patient’s good; and (b) what can be learned by the student about how to reflect on such situations. In ethics cases, only the latter is at stake. The cases are hypothetical, or if real, they concern past events. They are also simulations or incomplete descriptions of situations. Anyone who has observed case discussions will quickly be struck by how easily participants can come to different interpretations based on plausible fabrication of missing details. Such suppositions occur in real life, but actual context is more concrete, and the assumptions can more easily be verified.

It would not be exactly right to say that cases are useful for teaching ethical principles. Overtreatment is wrong, so is fraud, and no ethics course should place that on the table for debate. Beneficence is always good, and no dental school ethics course has ever tried to prove or disprove that point. What cases are useful for is helping students recognize which are examples of principles held by the profession and which are not and how to navigate the nuances of interpretation in particular instances. The “Ethical Moment” column in the *Journal of the American Dental Association* that has been published almost monthly since 2004 has never changed the five guiding ethical touchstones or considered that there may be others. It is always about whether specific behavior fits each principle.

This is known in classical moral philosophy as the ethical syllogism (MacIntyre, 1988). Ethical principles are givens, or at least are not to be questioned in the current context. This is the major premise of the syllogism. The minor premise introduces the particulars and the

circumstances. The conclusion connects the particular action with the moral character of the principle. Lying to a patient is unethical (major premise); failing to tell a patient about all the effective treatments available is a form of lying (minor premise). Therefore failure to inform the patient is unethical (conclusion). The American Dental Association (ADA) Code contains three levels. The five principles in the *Principles of Ethics* are the major premises. The 28 Standards of Professional Conduct and the 27 Advisory Opinions are examples of minor premises. Teaching ethics by means of cases is excellent practice for students in learning to transition between general ethical norms and particular classes of application. It should be constantly held in mind, however, that norms are not created or challenged in case discussion; only their application is, and that is an open-ended and continual process. It is also the case that minor premises can never be an exhaustive list. A dentist can conform with every Standard of Professional Conduct in the ADA Code and still be unethical. Although billing differentials are mentioned in relationship to coverage plans, there is no prohibition in the ADA Code against overbilling generally. Nor is collusion among dentists or corporations to corner a geographic market to drive up prices mentioned.

For some, there is an alternative secondary goal in using the case method with discussion in addition to building the capacity to think about complex hypothetical ethical situations that have been pointed out. Group discussion affords an opportunity for students to learn and use language that justifies their ethical intentions. Overtreatment is wrong.

Ethics might not mean the same thing across the professions. The differences flow from the relative power and independence of the actors in various professions.

There is no particular reason to know which ethical principle is relevant in this case. Knowing the name of the principle cannot be counted on to change the behavior of those who overtreat. It is handy, however, to have some facility with ethics language to discuss this and to be able in public settings to connect good and bad types of behavior with commonly used terminology.

Is “Naming That Principle” Enough?

When the justifying business overshadows doing the right thing the case method begins to wander from its original goal. Too often case discussions become an opportunity for faculty members or outside “experts” to demonstrate their insight. It is also not uncommon for a few students who are skilled verbally and politically to practice their polemic skills. When there are two or more such students in a group, others drop out, but the conversation goes on until each has sufficiently demonstrated fluency in talking about the hypothetical. Then it is agreed that “there are legitimate professional differences.”

Sometimes cases are exercises in identifying particular circumstances that excuse professionals from their obligation to follow the spirit of general norms. When one hears students and faculty talk about ethical issues in the locker room or around the edges of committee meetings, the conversations are usually of a different nature. Discussion of actual ethical incidents tends to be brief, indirect, and tentative. Sometimes a principle is mentioned, but that most often is a single-word sentence.

A nursing study on teaching with the case method illustrates this point (Hofling et al, 1966). A case was discussed in class where student

nurses were asked what they would do: The doctor ordered a 20 mg dose of a drug for a patient in a psychiatric ward. As described in the case, when the nurse went to the dispensary, she read the directions that 5 mg was the recommended dose, but 10 was the maximum that should be administered. Eighty percent of the nursing students said, after discussion, that they would refuse to administer the ordered dose. At the same time, in the hospital where these students did their rotations, the exact experiment was being conducted (with a placebo drug). Five percent actually refused the order.

Joshua Greene reviews the evidence that moral decisions are usually made within milliseconds of recognizing a problematic situation. It is unusual to engage in conscious reflection, and that most often happens when it is really apparent that the old ways may come up short or when we are forced into an artificial role-playing format (Greene, 2013; Haidt, 2012). In some cases, we engage in an extended rational reflection on cases that are complex or interesting, including some that we have never actually encountered or which make no practical difference to anyone we know. Preparing an ethics lecture would be such a situation. Reflection is a separate activity from behaving in natural settings.

Ethics teaching with cases assumes the two conditions of reflection and choice of action are built into the task. In teaching situations we normally encounter reflection without action. In practice, we usually find the opposite. There is the potential in ethics teaching that reflective practice will help form our more autonomous moral habits. But the amount of

ethical reflection required to shape reliable, serviceable moral habits is probably more than a few cases. There is no evidence that working through ethics cases makes a professional more ethical, other than by other measures of simulated (classroom) outcomes (Bebeau, 2006).

Are All Professionals Ethical in the Same Way?

As part of the American College of Dentists Gies Ethics Project, surveys were sent to deans of 62 dental schools in 2015 asking them to identify the individual responsible for teaching ethics in their schools. Ten were not able to identify such a person. Fifty-seven individuals who identified as being responsible for the ethics program in dental schools completed a survey, and phone interviews were also conducted with 14 of these. The overall results are reported separately in this issue (Survey of Dental Ethics Education). The basic findings relative to use of case teaching are as follows: Courses in ethics have an average number of 22.8 hours, 39% of which are conducted in small groups. Thus most of ethics instruction is in the one-to-many format. The small group format may mean that a one-to-many interaction is repeated in blocks. There may also be a variety of small-group activities such as skits or group projects. Respondents reported discussing an average of 24.6 cases, one-quarter of the cases involving activities in the dental school, and that 75% of cases covered activities in practice after graduation with which students have no direct

experience. Cases could have been discussed in small groups or used in a lecture format to illustrate the presenter's points.

Sources of Professional Ethics Cases Studied

Many faculty members who teach ethics have developed their own set of cases. The most widely used collections of ethics cases are those contained in *Dental Ethics at Chairside* by David Ozar and David Sokol (with a third edition just released and available online through the American College of Dentists); *Ethical Questions in Dentistry* by Jim Rule and Robert Veatch; and the material available from the American College of Dentists at dentaethics.org. There are books on dental law and ethics by Lambden; Graskemper; Weinstein; Frey and Nichols; and Brennan, Oliver, Harvey, and Jones. There are also four texts containing cases for dental hygienists.

The standard format for such texts is to cover principles and theories of bioethics and follow with cases and expert analysis of the cases. The exception is the cases developed for use by the American College of Dentists. These are available in both text and video format and feature normative feedback from both practicing dentists and patients rather than expert analysis. A set of cases was developed by Dr. Tom Hasegawa in the 1970s that appeared in the *Texas Dental Journal*. These cases focused on which treatment might be most appropriate clinically and featured the innovation of publishing the case in one issue of the journal, followed by selected reader responses in subsequent issues. These are available

at the American College of Dentists' website. Since 2004, the American Dental Association Council of Ethics, Bylaws and Judicial Affairs has published a regular "Ethical Moment" column in the *Journal of the American Dental Association* using a format of a fictitious case that is analyzed in terms of the ADA Code. Other dental journals, most notably the *Journal of the American College of Dentists* and the *Academy of General Dentistry Impact*, publish cases on an occasional basis.

Beginning with the assumption that the experts who write the books on professional ethics have an educated opinion about the nature of the problems professionals face, it would make sense to study case material to learn about the challenges thought to face the profession. It may be the case that dentists are engaged in a different set of ethical challenges than are other professionals, or at least that the problems that confront them are managed in a different context. This hypothesis was suggested by the chance review of ethics case text in several cognate disciplines.

This hypothesis was tested by analyzing the nature of ethics cases in nursing, business, and journalism, as well as in dentistry. The following sources were compared:

- Rule, J. T., & Veatch, R. M. (2004). *Ethical questions in dentistry* (2nd ed). Chicago, IL: Quintessence. [88 cases]
- Ozar, D. T., & Sokol, D. J. (1994). *Dental ethics at chairside: Professional principles and practical applications* (2nd ed). Washington, DC: Georgetown University Press. [15 cases]
- Patterson, P., & Wilkens, L. (2014). *Media ethics: Issues and cases* (8th ed). New York, NY: McGraw Hill. [61 cases]

- Lewis, P. V. (2014). *Ethics in the world of business*. Dubuque, IA: Kendall Hunt. [47 cases]
- Fry, S. T., Veatch, R. M., & Taylor, C. (2011). *Cases studies in nursing ethics*. (4th ed). Sudbury, MA: Jones & Bartlett Learning. [148 cases]

All 358 cases were read and notes were taken. In the various texts studied, cases were grouped into sections based on topic. For example, dental cases were organized by type of challenge (such as compromised patients and dentistry as a business, including honesty and third-party financing). The issues addressed in media included conflicting alliances and mass media in a democratic society. This was similar to the type of organization in business case texts, which looked at corporate social responsibility and leadership, for example. Nursing was organized around the seven principles in its code, but other topics included abortion, control of human behavior, death and dying, and the ethics of human research. No attempt was made here to classify the cases by topic since the domains covered across these professions differed so greatly.

Instead, four code categories were developed that reflected the context of the cases and the role the professional was supposed to take. The four coding categories are:

- **Type:** 1 = legitimate conflict (more than one position could be ethically defended), 2 = clearly negative example intended as a warning, 3 = clearly positive example intended as an encouragement
- **Source:** 1 = hypothetical, but with considerable level of imagined detail, 2 = real, description of a situation that has actually taken place

TABLE 1. Characteristics of ethics teaching cases in four professions.

	Type=unclear	Source=hypoth	Role=actor	Authority=self
Dentistry	0.833 (0.400) ^b	0.889 (0.312) ^a	0.794 (0.406) ^a	0.529 (0.502) ^a
Journalism	0.885 (0.321) ^b	0.475 (0.504) ^b	0.393 (0.493) ^c	0.328 (0.473) ^c
Business	0.383 (0.491) ^c	0.127 (0.337) ^c	0.617 (0.491) ^b	0.255 (0.441) ^c
Nursing	0.987 (0.116) ^a	0.919 (0.274) ^a	0.351 (0.479) ^d	0.399 (0.491) ^b

- **Role:** 1 = case reader is expected to take the part of one person described in the case and to choose an action, 2 = discussion, how does one feel about these issues in general
- **Authority:** 1 = reader assumes they have freedom of action and that others will be the beneficiary, or victim, of their actions, 2 = interactions with others of equal power and ethical status, 3 = participate as part of a group process

Results

Cases were coded three times over a two-month period. The Cronbach alphas for the four scales were Type = 0.967, Source = 0.927, Role = 0.957, and Authority = 0.935. Where differences occurred, the code most frequently given was used in subsequent analysis.

Contingency tables were prepared for each of the scales, crossing profession with scale categories. This reveals that there were few cases coded as positive or negative examples. Apparently the focus of ethical teaching cases is on problematic situations rather than exposing students to behavior to be emulated or avoided. Similarly there were relatively few examples of peer and group authority, so these two categories were

combined. Finally the pattern of the two dental case sets was similar, so these were combined into a single professional category.

Table 1 shows that there were large differences across professions in the context of ethical issues featured in texts on this subject. In this table, “type” refers to whether the case was a challenge or an example, with high values representing ambiguous situations or situations where several alternatives are defensible. “Source” means whether the situation was real or made up for the sake of discussion. High values are hypothetical; low values are descriptions of situations that actually occurred. “Role” refers to whether the student was supposed to take the role of one who is expected to be the ethical actor (high value) or just to comment from an objective perspective on the case (low values). “Authority” is the degree to which the actor can count on being the final authority for the ethical resolution. A high value means that the actor is answerable only to his or her conscience; a low value means that the values of others, either on the professional team, outside authorities, or the public, must be reconciled with those of the actor.

The proportion of cases having the characteristic identified in the column heading is shown here, with standard deviations in parentheses. The cases considered by the professions differed

significantly on all four characteristics. One-way ANOVA tests found p-values less than .001 in all cases. The superscripted letters beside the scores reflect *post hoc* tests using the Scheffé and Duncan multiple-range tests at $p = 0.05$. Professions with the same superscripted letters belong to the same groups. For example, most dental cases (53%) described situations where dentists were free to act on their own. That was so in 40% of the nursing cases, a statistically significantly smaller proportion (hence the different superscripted letter). A third group included journalism and business cases where individuals were expected to act as part of an organization or where the organization was judged to be the moral agent. These groups share a common superscript, reflecting the fact that they cannot be distinguished from each other in this respect.

Cases felt to be representative of the issues facing dentists were challenges (rather than examples of desirable or undesirable behavior) that were hypothetical and required the dentist to engage in behavior that the dentist had full authority to initiate. The

summaries of the two cases below illustrate this type of case. Thirty-seven percent of the cases fit this pattern exactly.

- *Should Dr. X adjust the case presentation to Ms. Y to make it more likely that she will select the treatment the dentist feels is best for her?*
- *Should Dr. X treat patients differently if they seem to disregard their own oral health and show indications that they may not follow through on care or payment?*

By announcing in advance that ethics cases in dentistry are dilemmas, it is being suggested that dentists can be ethical despite following diverse actions. Certainly the fact that dentists practice in contexts where neither peer nor superior nor the public in general look over their shoulders is consistent with the type of cases used in ethics education.

Journalism cases were also challenges needing to be worked through, but they were more apt to be realistic examples rather than hypothetical, constructed cases, and they more often invited general discussion rather than independent action. Those in the media can readily become part of the public debate about how Americans choose to live. Thirty-three percent of the cases exactly matched this model format.

- *Is it right for for-profit organizations to sponsor charity events in order to get free press coverage?*
- *What does the reader think of an organization that seeks to suppress publicly available information that is not favorable to it or its sponsors?*

The business cases were particular and exemplary of what might be considered good or bad practice. Future business people were invited to consider the issues from the perspective of an active participant, but they were made aware that they could seldom act independently. Only 17% of the cases fit this typical pattern, however, and there was considerable variation in the types of cases offered.

- *A named firm engaged in selling a defective product to consumers and readers were asked to reflect on how they might have acted differently had they been part of that firm.*
- *How would the reader fit into a company that enjoys a reputation for having a culture that grows people?*

The nursing cases had yet a fourth distinctive fingerprint. The cases were clearly selected to represent hypothetical issues that combined both positive and negative aspects with unclear paths. But unlike the cases faced by dentists, nurses seldom

found themselves in positions where they could act on their own authority and were usually invited to reflect on the issues generally. This was a dominant template, with 42% of cases fitting this model.

- *What does the reader think when observing patients being treated in a fashion they are uncertain is right?*
- *The hospital is considering making staffing changes that might affect the quality of care to patients in order to save money. What do you think of that?*

Reflections

Ethics might not mean the same thing across the professions. Said differently, those asked to think about what it means to be an ethical professional are being asked to use different lenses. The differences flow from the relative power and independence of the actors in various professions. Business cases have a long tradition of being concrete and of teaching students to work through a complex set of facts. Business people work in teams, their actions affect multiple groups simultaneously, and they cannot count on being the sole or dominant judge of what is right or wrong in individual cases. Often business teaching cases contain many pages of detail about a specific firm where we know what eventually happened, and groups of students work on the cases for a term and present their critique as a group report.

Journalism is similar, although many of the outcomes involve open questions about political or philosophical standards over which the public and the industry continue to wrestle. Journalism students are invited to think about how their work affects the values of society rather than the conditions of one person at a time.

The health professions were distinct in this dataset in that readers

were urged to consider situations that they had the power to make “right” or “wrong,” or at least to argue for their point. Dentists and nurses function in relatively closed systems and information about what they do is protected by confidentiality standards, the inability of the public to understand what is being done, and other barriers to scrutiny. The difference between dentists and nurses was largely a matter of power within the organization. Nurses were confronted in these cases with a background issue of “distancing” or managing moral distress where, as a condition for their continued employment, they were required to engage in behavior they considered questionable. They often can have well-developed ethical views but not be free to act on them. The same would be true for staff and associate or employee dentists.

The health professions cases were also the ones dominated by hypotheticals. The cases were rich in detail but still open to personal interpretation. Because the dental cases were overwhelming theoretical, readers had the opportunity to insert personal interpretations that supported self-justified action. Only dentistry describes its ethics teaching cases as “dilemmas.” A lemma is a previously worked-out small proof that can be applied in various situations. “People must have freedom of action to be responsible,” “People should not be allowed to make choices that are not in their interests,” and “People should be responsible for their own health” are lemmas. Often ethical arguments are shortened by invoking a lemma that justifies the chosen position of the speaker and makes the recounting of particulars unnecessary.

When there is more than one lemma in a situation, it is a dilemma and there is a *prima facie* justification for any action taken (Beauchamp & Childress, 2009; Gert, 1998). By announcing in advance that ethics cases in dentistry are dilemmas, it is being suggested that dentists can be ethical despite following diverse actions. Certainly the fact that dentists practice in contexts where neither peer nor superior nor the public in general look over their shoulders is consistent with the type of cases used in ethics education.

In these respects, dentistry may play the ethics game by slightly different rules than do other professions. ■

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Dentists' Knowledge of ADA Code

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Abstract

Codes of ethics inform members of organizations about the expectations their colleagues have of their behavior, serve as justification for disciplinary actions, and create a positive image of the organization and its members in the public's perception. The three-part form of the *American Dental Association Principles of Ethics and Code of Professional Conduct*, with advisory opinions, is discussed. Knowledge of the ADA Code was tested with a multiple-choice test and an open-ended survey. It was found that knowledge of the code among ADA members was less than 50% and somewhat higher for students who had not yet been given instruction on it. This does not mean that ADA members are unethical. The research does raise some questions about the strength of the relationship between the existence of a code, knowledge of the code, and ethical behavior of organization members. Research on codes and organizations generally confirms this weak association.

Ethics codes are developed by organizations to serve, at least, these three purposes: (a) inform members of the kinds of behavior expected of them; (b) state reasons members may be dismissed or disciplined by the organization; and (c) communicate a positive image of the organization and its members to the public at large. To a lesser extent, a code can serve as the focal point for discussion among the inner circle of an organization regarding its identity.

The first two of these functions depend heavily on the code's being understood by the members of the organization. This report presents some data bearing on how familiar dentists are with American Dental Association (ADA) Code.

Nature of the ADA Code

The official name is the *American Dental Association Principles of Ethics and Code of Professional Conduct*.

As stated in its introduction, the term "ADA Code" is used as a shorthand expression for the longer designation. There is no ADA Code of Ethics. Quoting from the introduction, "The ADA Code has three main components: The Principles of Ethics, the Code of Professional Conduct, and the Advisory Opinions."

There are five ethical principles: patient autonomy, nonmaleficence, beneficence, justice, and veracity. These were introduced in the 1990s and borrowed as a superstructure for

the 80-year-old Code of Professional Conduct. The first four of these principles are the common set, referred to as the "Georgetown manta," developed in the then-emerging field of bioethics (Beauchamp & Childress, 2009). Robert Veatch, of Georgetown, served as a consultant to the group at the ADA that developed this exoskeleton. As a third of the items in the code of conduct—particularly detailed matters pertaining to fees, advertising, names of practices, announcement of specialty care, and so forth—could not easily be classified under the traditional ethical principles, an additional category, veracity, was added. The bioethics principle of autonomy or respect for persons was redefined to exclude dentists, staff, and individuals in need of oral health care who are not patients of record and is now known as "patient autonomy."

The Code of Professional Conduct enumerates 28 "specific types of conduct that are either required or prohibited" for members of the association. Such listings of expected behavior have a long history in the professions, where they were formerly known as "Codes of Professional Etiquette." They have been developed to create a common set of expectations regarding what behavior individuals in a particular profession should expect from each other. For example, the original ADA code of 1867 required that dentists consult with each other to fix common prices within

communities. When the Principles of Ethics was added to the ADA Code, the Code of Professional Conduct remained essentially as it had been at the time.

The ADA Code also contains 27 Advisory Opinions. These offer guidance as to how the elements in the Code of Professional Conduct might be interpreted in specific situations. For example, the Code of Professional Conduct item on justifiable criticism expresses three obligations: (a) reporting cases of gross or continual faulty treatment to an appropriate authority; (b) informing patients of their present condition; and (c) refraining from making disparaging remarks about prior services. The Advisory Opinion is a 200-word explanation of the meaning of the term “justifiable,” including the possible action of contacting the prior treating dentist to discover the conditions under which care was provided.

The numbering of elements in the ADA Code makes it easy to follow this three-part structure. Principles are indicated by a single number: 1 for patient autonomy, 2 for nonmaleficence, etc. Items in the Code of Professional Conduct are designated by an uppercase letter following the number. So justifiable criticism is the third item under the principle of justice, or 4.C. Advisory Opinions are indicated with an additional number. Recommending or

It is difficult to maintain the ADA’s position that the five principles it has chosen to emphasize constitute “the principles of the profession” in distinction to being the principles of the American Dental Association.

performing unnecessary services being unethical is not part of the Code of Professional Conduct; it is the sixth interpretive guidance under representation of fees under the principle of veracity, or 5.B.6.

The Principles of Ethics are aspirational in the sense that the ADA suggests that these are the ethical standards for the entire profession. By distinction, the Code of Professional Conduct is enforceable. “The Code of Professional Conduct is binding on members of the ADA, and violation may result in disciplinary action.” Advisory Opinions are guidance for how the ADA Council on Ethics, Bylaws and Judicial Affairs might interpret the Code of Professional Conduct in a disciplinary proceeding.

Something like this structure is repeated at the state level, although the content, wording, and interpretation may differ. Other organizations in the profession, such as ethnic, specialty, or honorary groups, also tend to have their own aspirational and enforceable ethical guidelines. It is difficult to maintain the ADA’s position that the five principles it has chosen to emphasize constitute “the principles

of the profession” in distinction to being the principles of the American Dental Association. Society in general has many such codes as well, including universities, the government and military services, community organizations, and commercial firms. There is potential for conflict among codes and always a trade-off between specificity of rules and their generalizability. As stated in the American Dental Association Principles of Ethics and Code of Professional Conduct, “principles can overlap each other as well as compete with each other for priority... and the ADA Code is an evolving document and by its very nature cannot be a complete articulation of all ethical obligations.”

How Well Is the Code Understood?

The very existence of a code is of value to an organization. Being able to say to those the organization serves that there is a code guiding behavior of members has public relations value. This is especially true for enforceable codes, as this signals a willingness to self-police. There is also a sense of pride members feel in belonging to a group that publicly announces its commitment to ethical principles. The logic runs something like this: Group X stands for ethics; I am a member of X; therefore, I am ethical.

Undoubtedly, this is true in fact in many cases, but it is awful logic. The better argument would be: My behavior is consistent with the ethical standards of Group X; X is seeking members who exemplify their standards; therefore, I should be invited to membership in Group X. Some organizations, such as the American College of Dentists, follow this logic. Individuals make the organization ethical. One cannot become ethical just by joining an organization.

A full understanding of how ethical codes in organizations affect the behavior of members in those organizations is still years away. One element in this understanding is almost certainly the extent to which members know the codes. The straightforward argument is that members learn codes and that knowledge affects their behavior. This

is certainly a simplified view, and there are numerous contextual factors that mediate between what we know and how we behave. However, if it can be shown that members have a poor understanding of the codes, the argument that members of groups with codes are ethical by virtue of their membership is shaky.

The research reported here is intended to provide a first glimpse into how well dentists understand the ADA Code.

The Study

A 16-question test on the ADA Code was developed and pilot tested on faculty and residents in a dental school. The test and the passages supporting the keyed answers in the ADA Code are displayed in the appendix to this paper. The test was administered three times. Fifty-four students at the Oregon Health Science University took the test as part of their course on ethics, but prior to coverage of this topic. One hundred thirty-nine fellows and candidates for fellowship in the American College of Dentists completed the test as part of a workshop presentation on ethics. Twenty-three dentists of various backgrounds completed the test in a continuing education program sponsored by the University of the Pacific. An additional 16 individuals who were either Canadian dentists or American dental hygienists completed the test. All four groups were scored as part of one set and separately.

Questions were scored right or wrong based on the key described in the appendix. Unanswered questions were handled two ways. Where an item was left blank between previously answered items and following questions that were attempted, the item was marked wrong. Where a succession of questions at the end of

the exam was left unanswered, it was assumed that the respondent ran out of time. The unanswered items were not scored and the respondent was given a score proportioned only to those items attempted to that point.

The Cronbach alpha, which reflects internal consistency of the test, was 0.582. This is satisfactory for such a short test. The overall score for 232 respondents was 46.5%. This is less than half of the questions answered correctly. As there was one correct response and three distractors for each question, the purely random score would have been 25%. A one-way ANOVA test across the four types of respondents was significant at $F = 15.100, p < .001$. The highest scoring group was the dental students who had not yet been exposed to the code.

In Their Own Words

Multiple-choice tests with low scores are easy to criticize. By comparing the keyed responses with the exact language in the ADA Code in Table 1, it should be possible to gauge whether there were trick questions. An alternative explanation is that the test did not “ask the right questions.” An open-ended evaluation would have inquired about what respondents did in fact know about the ADA Code.

In order to test this possibility, one of the sessions—the one at the American College of Dentists convocation—included an open-ended question. The following instruction was given in writing: “List one element in the ADA Code of Professional Conduct that really stands out to you.” Respondents were given about five minutes to complete this exercise. Table 1 displays the responses.

TABLE 1. Elements in the ADA Code of Professional Conduct that stood out most to dentists.

Number Item

Elements in the Code of Professional Conduct

- 5 Inform patients of procedures and reasonable alternatives [1.A]
- 4 Keep knowledge and skills current [2.A]
- 3 Justifiable criticism [4.C] (plus an additional comment "Do not pass judgment")
- 2 Unnecessary treatment [5.B.6]
- 2 Charts and records [?]
- 1 Obligated to treat everyone
- 1 Announcement of services [?]
- 1 Provide emergency services [4.B]
- 1 Must refer if possible [?]
- 1 Announcements should bring esteem to profession [3.A]

Other Parts of the ADA Code

- 3 Put the patient's interest first
- 2 Honesty, veracity, fidelity
- 2 Beneficence
- 1 Autonomy
- 1 First do no harm
- 1 Contract between the profession and the public

The first and last items above are in the preamble of the code. The others are principles. Respondents were instructed in writing: "Remember, patient autonomy, nonmaleficence, beneficence, justice, and veracity are principles. Do not list any of these. Only list items in the Code of Professional Conduct."

Other comments

- 2 Dentists are encouraged to be ethical
- 1 Professionalism
- 1 Ethics and law are different
- 1 Evidence-based dentistry
- 1 Judgment
- 1 Communication
- 1 "I have never read it"
- 1 "I depend on my conscience"

About half of the volunteered standout points in the ADA Code of Professional Conduct were not actually elements in the Code of Professional Conduct. Perhaps of greater concern is the fact that three-quarters of those given an opportunity to mention anything that mattered to them in the code offered nothing. To protect against the possibility that respondents may have come late or otherwise not have been in a position to respond to this item, only those forms were considered where respondents had answered the questions previous to and the questions following this item. This very large nonresponse to an open-ended question about the code is consistent with a low or nearly random response on the multiple-choice questions.

Discussion

It is essential to recognize that this research does not support any conclusions about whether the respondents or dentists in general behave ethically. If anything, there is a bias that this sample is skewed toward the high end of ethical practitioners, as shady actors tend to avoid gatherings where ethics is likely to be a topic of conversation. What the data do challenge is the relationship between knowledge of a certain set of rules and one's reputation for professionalism. Because the American College of Dentists requires membership in the ADA, the majority of the respondents in this research were certainly bound by the ADA Code.

The ADA cannot be criticized for paying insufficient attention to getting out the word about the code. Since 2004, the association has published a feature in the *Journal of the American Dental Association* called the “Ethical Moment.” This usually appears ten times per year and is usually a two-page discussion of a practice dilemma. The incidents appear to be selected because they are related to the ADA Code; or at least it is a common format for the articles to step through most or all of the sections of the code, noting the relevance of each to the case.

A long-serving member of a state dental board explained that exposure to information alone is insufficient. We learn and retain information best when there is a need to know it. He said that the kind of individual who knew every detail of the state dental practice act was the one who was defending against an action against his or her license. Dentists who are ethical or who believe they are have little incentive to memorize the details of a code, especially one filled with so many terms such as “obligation” or “duty.”

Although we are not able to use the data from this study to make a strong case for knowledge of the ADA Code being linked with ethical performance, it may still be the case that the Code of Professional Conduct part of this document functions as a foundation for the association’s enforcing positive ethical standards, at least among the two-thirds of dentists who belong to the ADA.

In the spring 2018 issue of the *Journal of the American College of*

The very existence of a code is of value to an organization. Being able to say to those the organization serves that there is a code guiding behavior of members has public relations value.

Dentists (Chambers, 2018) it was reported that the rate of disciplined licenses among nonmembers of the ADA is about the same as that for members. Further, there are virtually no complaints against dentists filed by their peers. This would be unexpected in light of 4.C in the ADA Code of Professional Conduct that obligates dentists to do so.

As stated in the code, Advisory Opinions are provided as interpretations of how the Council on Ethics, Bylaws and Judicial Affairs might apply the Code of Professional Conduct when disciplinary actions are taken. It has not been reported that any ADA member has been disciplined for failing to report incidents of gross or continual faulty treatment by a colleague. Although national and state judicial councils have the responsibility to propose, interpret, publicize, and apply sanctions on members who violate the codes, such sanctions are limited to privileges within the organization and do not extend to the ability to practice dentistry. Judicial bodies in organized dentistry typically apply codes after a matter has been handled by other

agencies of the state, such as drug enforcement. Often dentists who have been sanctioned by the state withdraw of their own volition from organized dentistry. They occasionally will bring legal action seeking relief from the characterization of their practices as “unethical” by a group that lacks status to set standards for nonmembers.

The evidence is mixed on whether other organizations that have codes of ethics are less likely to have legal actions brought against them for violating social conventions (Bried et al, 1996; Kaptein & Schwartz, 2008). It certainly did not help in the case of Enron, which had a very strong code that can be seen online. ■

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Appendix: ADA Principles of Ethics and Code of Professional Conduct

[Test on the ADA Code: items, response, and documentation of the keyed response. Keyed response in italics.]

1. The ADA Code is a written expression of

- 1 % a. The aspirations of select members of the profession.
- 68 b. *The obligations arising from an implied contract between the dental profession and society.*
- 21 c. The standards required for membership in the American Dental Association.
- 5 d. The aspirational values of the American public for oral health.
- 6 [Blank]

"The ADA Code is, in effect, a written expression of the obligations arising from the implied contract between the dental profession and society." [Introduction]

2. Because the ADA Code represents "the profession's firm guideposts," its principles are

- 27 % a. A comprehensive and consistent listing of the conduct of ethical dentists.
- 59 b. A consistent, but not entirely comprehensive, listing of the conduct of ethical dentists.
- 6 c. *Incomplete and sometimes conflicting suggestions for ethical conduct.*
- 15 d. The same as the principles in medicine, nursing, dental hygiene, and other health fields.
- 3 [Blank]

"By its very nature [it] cannot be complete." "Principles can overlap each other as well as compete with each other." [Introduction]

3. The ADA Code of Professional Conduct is

- 26 % a. The same as (alternative name for) the Principles of Ethics.
- 35 b. Developed and subject to modification by the Council on Ethics, Bylaws and Judicial Affairs.
- 14 c. *Managed by the ADA House of Delegates and binding on all ADA members.*
- 17 d. The part of the ADA Code that is suggestive and open to the professional conscience of practitioners.
- 9 [Blank]

"All elements of the Code of Professional Conduct result from resolutions that are adopted by the ADA's House of Delegates. The Code of Professional Conduct is binding on members of the ADA." [Introduction]

4. The principle of autonomy (self-governance) applies to

- 35 % a. Dentists, both in their relationship to the public and to their peers.
- 4 b. *Patients only.*
- 7 c. All individuals in need of oral health care.
- 51 d. Everyone.
- 6 [Blank]

"The dentist has a duty to respect the patient's right to self-determination." [Principle 1: Patient Autonomy]

5. Under the ADA Code (advisory opinion), it is NOT ethical to

- 2 % a. Charge patients for copies of their records.
- 0 b. Release records to patients (they can only be released to licensed dentists).
- 16 c. Release records to other dentists directly (they must be requested in writing by patients).
- 7 d. *Withhold records of patients with significant past due balances (bad debt).*
- 6 [Blank]

"A dentist has the ethical obligation on request of either the patient or the patient's new dentist [to furnish copies of records]. This obligation exists whether or not the patient's account is paid in full." [Advisory Opinion 1.8.1]

6. Nonmaleficence is

- 39% a. A technical term for a reference to the Hippocratic Oath, specifically calling out not practicing below the standard of care.
- 1 b. A flower with large red and orange blossoms native to Central America.
- 0 c. A skin condition.
- 56 d. *Expressed as conduct that avoids inadequate training and failure to refer when appropriate, proper delegation of auxiliary personnel, not practicing while impaired, patient abandonment, and interpersonal relationships with patients that may impair judgment.*
- 4 [Blank]

Nonmaleficence code items: education, consultation, referral, use of auxiliaries, impaired practice, personal relations with patients, patient abandonment. [Principle 2: Nonmaleficence]

7. The principle of beneficence specifically FORBIDS

- 6% a. Entering into contractual relationships for providing care under capitated and some other contractual relationships.
- 72 b. *Adjusting the level of care to patients' ability to pay or mechanism of payment.*
- 2 c. Serving as an expert witness, if that involves testifying against a colleague.
- 4 d. Being compensated for endorsing products or procedures.
- 7 [Blank]

"The same ethical considerations apply whether the dentist engages in fee-for-service, managed care, or some other practice arrangement." [Principle 3: Beneficence]

8. Under beneficence, the ADA Code specifically expects dentists to perform all of these duties EXCEPT

- 8% a. Make the results of their research and practice experience available to all members of the profession.
- 19 b. Participate in organized dentistry.
- 61 c. *Avoid seeking public office because of inherent conflicts with the perception of esteem for the profession.*
- 4 d. Learn about and report suspected cases of patient abuse and neglect.
- 8 [Blank]

"Dentists have an obligation to use their skills and experience for the improvement of the dental health of the public and are encouraged to be leaders in their communities." [3.A]

9. Under the principle of justice, the ADA Code admonishes practitioners to

- 17% a. *Actively promote access to care.*
- 20 b. Enter into arrangements to share revenues with others to the extent that this promotes more patient care.
- 45 c. Accept all potential patients, regardless of race, sex, national origin, or nature of oral condition.
- 14 d. Make provisions for emergency care only for patients of record.
- 4 [Blank]

"Actively seek allies throughout society on specific activities that help improve access to care for all. (Dentists may not, should not, accept all patients regardless of their oral condition.)" [Principle 4: Justice]

10. When dentists become aware of instances of gross or continual faulty treatment by other dentists, they are obliged to

- 61% a. *Inform the patient of their condition and notify the appropriate local component or constituent society.*
- 25 b. Refrain from commenting disparagingly to anyone because the conditions of treatment may not be known.

- 5 c. Avoid contacting the previous dentist because of potential legal complications.
- 4 d. Offer to "make it right" for the patient, without questioning the previous dentists' intentions or skill, so the patient will have a good dentist.
- 4 [Blank]

"Dentists shall be obliged to report to the appropriate reviewing agency...instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services." [4.C]

11. The ADA Code advisory opinion on amalgams states that it is unethical to remove intact amalgam restorations from patients

- 34% a. *When the procedure is recommended solely by the dentist who will perform the work.*
- 7 b. When the procedure is requested by the patient and agreed as indicated by the dentist.
- 6 c. Only when it can be established that the patient is allergic to amalgam.
- 46 d. There is not mention of this specific matter in the ADA Code.
- 7 [Blank]

"When [removal of amalgam from non-allergic patients] is performed solely at the recommendation or suggestion of the dentist, [it] is improper and unethical." [5.A.1]

12. Waiving copayment (accepting a reduced fee as payment in full for an insured procedure)

- 48% a. Is unethical under all circumstances.
- 7 b. Is appropriate at the discretion of the practitioner.
- 1 c. May be appropriate if it promotes patients seeking better care and dentists providing more services.
- 43 d. *May be appropriate on an individual basis, provided that the insurance carrier is notified in advance and authorizes the specific case.*
- 1 [Blank]

"A dentist who accepts a third party payment under a copayment plan as payment in full without disclosing to the third party that the patient's payment portion will not be collected, is engaged in overbilling." [5.B.1]

13. A dentist who *recommends unnecessary services* is unethical

- 92% a. *PERIOD.*
- 0 b. If the patient waives informed consent.
- 0 c. If fees exceed usual, customary, and reasonable.
- 4 d. Only if the services are actually performed.
- 0 [Blank]

"A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct." [5.B.6]

14. Dentists are obliged by the ADA Code to report serious adverse patient reactions to drugs or devices to the Food and Drug Administration

- 9% a. If the drug or device is investigatory or experimental.
- 5 b. If the drug or device is used "off label"—for purposes other than approved by the FDA.
- 54 c. *In all cases.*
- 29 d. In no cases, there is no mention of this issue in the ADA Code.
- 3 [Blank]

"A dentist who suspects the occurrence of an adverse reaction to a drug or dental device has an obligation to communicate that information to the broader medical and dental community, including...the Food and Drug Administration." [5.D.1]

15. The title "doctor" or the initials "DDS" or "DMD" are appropriate in communications with patients, but it is discouraged as misleading to the public to include any of the following EXCEPT

- 14 % a. Honorary distinctions by abbreviation such as FACD or MAGD (for Fellow of the American College of Dentists or Master, Academy of General Dentistry).
- 36 b. *Earned advanced degrees from accredited institutions, such as masters or PhD in a health field.*
- 7 c. Membership in professional organizations, such as "Member of the ADA."
- 38 d. Recognitions from institutes, academies, or continuing education programs that are not accredited by a body recognized by the U.S. Department of Education.
- 5 [Blank]

"A dentist may use the title Doctor or Dentist, DDS, DMD, or any additional earned, advanced academic degrees in health service areas in an announcement to the public." [5.F.3]

16. For a dentist to ethically announce to the public credentials in a discipline not recognized as a specialty by the ADA, a general dentist must satisfy three of the following requirements. Which one is NOT required?

- 20 % a. Completion of a formal, full-time program of at least 12 months' duration, plus testing.
- 52 b. *Fees charged for involved services do not generally exceed those charged by general dentists in the area.*
- 10 c. It is disclosed that the dentist is a "general dentist."
- 15 d. It is disclosed that the ADA does not recognize this discipline as a specialty.
- 3 [Blank]

Specialist announcement of credentials in nonspecialty interest areas required "completion of formal, full-time advanced educational program, (graduate or postgraduate level) of at least 12 months' duration...and testing; announcement [that practice] is not recognized as a specialty area by the American Dental Association [5.H.2]; and general dentists who wish to announce the services available in their practices are permitted to announce the availability of those services...[and] state that the services are being provided by a general dentist." [5.I]

Ethical Touchstones

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Abstract

Where do dentists turn for guidance on ethical challenges? A survey was conducted using six ethical problems and five potential sources for advice on how best to proceed. Dentists overwhelmingly consult their own conscience, followed by their expectations regarding what their colleagues would approve. This is especially the case when the challenge involves the dentist's own welfare in matters such as income. Codes are much less apt to be consulted and dentists shy away from experts, such as lawyers and ethicists. This may be a function of how likely the outside advice is to be in one's interests and how easy it would be to set the advice aside if it is not welcome. Dentists do engage others who are involved in the issue to some extent.

A touchstone is what one holds tightly when making a decision. It is the place where we store our necessary supply of "because." One dentist says, "I do not waive copays because that would be insurance fraud, and the law is clear that this is a criminal offence." Another says, "It is not such an uncommon practice, on occasion, and some of my friends do it pretty regularly." The third says, "It is fundamentally a matter of what I believe to be right in each individual case." The touchstones here are the law, one's colleagues, and oneself. Where one looks for ethical reassurance matters for one's ethical behavior. Touchstones are the keepers of our conscience. When dentists diverge on the preferred course of action given a common problem, it is often because they are using different touchstones.

We check multiple sources for approval, some regularly and frequently, others not so often or only on special occasions. But the hierarchical profile of touchstones differs from person to person. It would be helpful to know if there are similarities from dentist to dentist in which sources of ethical guidance have priority.

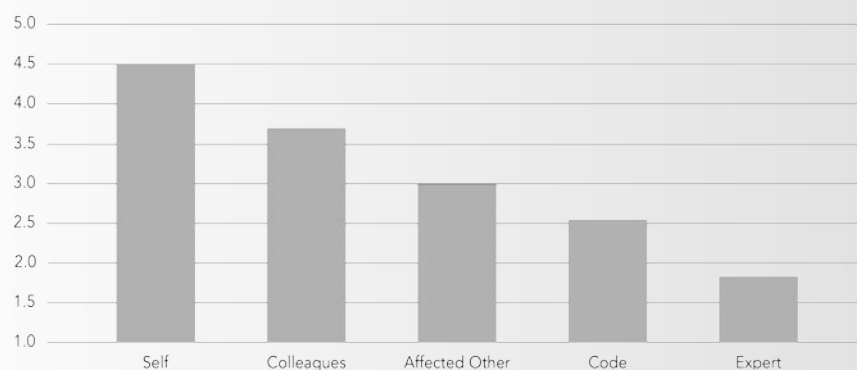
If there are patterns among dentists in the touchstones they follow, this would be helpful in understanding ethics in the profession. We want to place the ethical landmarks that guide the profession in plain sight where dentists are looking for them. Do dentists pay attention to ethics experts? If the answer is "perhaps,"

then perhaps we need to activate additional touchstones. Before we design programs to guide dentists toward better ethical choices, we should first listen to who they are listening to. This is a report of a research study intended to provide some preliminary answers.

Materials and Methods

Two hundred sixty-five dentists in several samples in various continuing education settings from across the country completed a short survey that asked about where they would turn for help in making ethical decisions. The survey is shown in the Appendix at the end of this article. Six hypothetical scenarios were presented: (a) detected faulty treatment by a colleague; (b) use of an insurance reimbursement loophole; (c) sale of one's practice to a dentist with a shaky reputation; (d) dealing with a patient trying to avoid payment; (e) taking on very large and complex cases using untested procedures; and (f) treating Medicaid patients. Each of these situations has an ethical component and might be responded to differently depending on where one looks for relevant standards. Dentists were not asked, "What is the right thing to do?" in the various cases. Instead they were asked how important it would be to be square with five alternative sources of ethical guidance commonly referenced. Each touchstone was rated based on how likely the touchstone was to be

FIGURE 1. Where do dentists look for help in making ethical decisions?



consulted on a scale from 5 (“Almost in every case”) to 1 (“Very rarely”).

Results

A consistent ordering of touchstones was found. One source of ethical guidance (personal convictions) was three times as likely to be consulted in cases where ethical choice was involved as was the least common touchstone (legal experts and ethicists). Personal feelings were given about twice as much weight as were codes of ethics. A statistical test (one-way ANOVA with *post hoc* contrasts) was performed that confirmed that each of the five touchstones was different from those adjacent to it at $p < 0.05$. So, for example, dentists were significantly more likely to consult their own conscience than their colleagues. They are significantly more likely to consult colleagues than to talk with others involved in the situation. They are significantly more likely to

engage in conversations with those involved in the situation than to look to codes. Finally, dentists are significantly less likely to look to experts than to any other source. Figure 1.

Respondents were also asked to rate each of the six challenges in terms of how important the issue was seen to be, regardless of where they would look for assistance in solving it. Some of the challenges were thought to be highly important while others were seen as mattering less one way or the other. High scores reflected those challenges where a satisfactory resolution was very important. The three challenges having to do with dentist’s income (insurance, sales of practice, and big or novel treatment) were statistically significantly more apt to be considered important than were the other three. This was also confirmed by ANOVA tests with p -values below 0.05. Considering both the order of relevance of decision guidance and the type of issue together, it appears that dentists consult their own judgment on matters that affect their own well-being.

Discussion

The results of this research are consistent with the general finding in the ethics report commissioned by the Board of Regents of the American College of Dentists. In particular, multiple focus groups across the country noted, and often with some concern, that dentists embrace personal rather than profession-wide standards for guiding their relationships with patients. It appears to be the case that many practitioners will only consider alternative touchstones that involve others if their individual standards fail to provide favorable guidance. This is consistent with the general literature on ethics, which shows that individuals who are in a position to substitute personal status or power for negotiated agreement tend to do so (Hegarty & Sims, 1978; Kabanoff, 1991; Diekman et al, 1996). Chambers and Eng showed that dentists engage with patients and staff over disagreements by “talking others into their position” (educating the patient) while they approach conflicts with their peers by “having a conversation” (Chambers & Eng, 1994). This early research found that dentists feel they are more successful reaching agreement with patients than with colleagues.

Dentists have traditionally enjoyed an enviable position of having enormous say in how dentistry is practiced in their own offices. Such an independent ethical foundation is being called into question in recent years. Benefits carriers, government regulation, commercial consolidation, and marketing that gives greater online voice to the public are new influences. In some ways, the growing concern over ethics in dentistry is not the result of more dentists acting

unethically, but appears to be due to others having more say in how dentists act.

The data in this research show that dentists give considerable weight to the standards used by their colleagues. This touchstone should not be confused with codes or the advice of ethics experts. Dentists are guided by what they see their colleagues doing and what they believe the results to be. They are also guided by what they imagine their colleagues might think of them. If a colleague seems to be thriving by advertising and offering cookie-cutter rather than customized care, that may become a standard to be emulated. If they admire a colleague who only practices at the highest level of care and works to build the profession, that will be their touchstone. If other dentists do not seem to be concerned how one practices, that touchstone drops out of consideration.

A lesson to be drawn from the prominence of the effectiveness of one's colleagues' behavior is that the critical factor is perceived success of the potential model (Bandura, 1977). A powerful tool for modifying the ethical tone of dentistry is to reward behavior that is ethical. It is a well-documented law in psychology that a sure way to encourage the wrong kind of behavior is to remain silent and let the bad actors draw reward from other sources (Skinner, 1971). If the profession does not speak out against commercial and other nonprofessional values, good dentists will drift toward imitating colleagues who get conspicuous rewards outside the profession. Many dentists are "leaders" for their colleagues. Unless the professional ones speak up, the others will lead the profession astray.

Codes of conduct, regulations, and rules imposed by business partners such as dental service organizations or

benefits carriers are not often regarded as credible touchstones. Research generally shows that codes of ethics have limited effect on behavior (Bried et al, 1996; Kaptein & Schwartz, 2008). Other research shows that dentists have an imperfect understanding of the code of the American Dental Association (Chambers, in this issue). On average dentists were able to correctly answer fewer than half the questions on a short test of the code. In open-ended responses, a frequent remark was that one's own values take precedence over codes. Part of the reason for this may be the fact that codes are of necessity general. Interpretation is always necessary, and that interpretation is understandably individual. Often codes, rules, and the like only become active players in the ethics of dentistry when interpretations and justifications fail to excuse behavior chosen for other reasons. When codes are seen as enforceable standards, they become obligations or minimum standards (Chambers, in this issue).

Experts are the touchstone of last resort. It is somewhat ironic that part of the push for ethics in dentistry over the past few decades has been to highlight "experts." Their popularity may be due to their seeming stature while they are regarded as being relatively benign. Lawyers and ethicists bring in external standards. Theory from other fields such as bioethics and law are cited. We have added the teaching of ethical theory as a requirement in dental schools, dilemmas presentations at conferences, and journals that feature short, regular columns, and some states are considering mandatory continuing education hours on ethics. These are all well-intended efforts to highlight

the importance of ethics. The current research suggests that practitioners are not paying as much attention to these sources as their sponsors would hope. A case might even be made that putting our attention where practitioners are not looking may be misdirecting scarce resources.

A common trend in the four touchstones discussed so far is the importance of dentists' personal control in ethics. As the options move from self-determination to like-minded friends to public positions of the profession and, finally, to outsiders with an independent claim to authority, the likelihood of using guidance from that source declines. It is possible that publicly supported sources of ethical guidance and expert advisors are resisted because they are such sound touchstones. If a colleague advises an ethical path that is "inconvenient," there is small pressure to follow a difficult path. It is always possible that consulting professional standards or the wisdom of professionals in ethics and law will turn up some credible but unwelcome advice.

That leaves one touchstone yet to consider. One strategy for addressing ethical rough spots is to engage with others who are part of the problem and thus likely to be part of the solution as well. If there is an apparent problem with the quality of work observed by one's colleague or with a patient who appears to be weaseling on payment, some dentists will start by having a conversation with the others involved. But in research on

reporting of justifiable criticism, Chambers (2017) found that dentists are more apt to hint to colleagues suspected gross or continuous faulty treatment than to discuss the situation with patients.

Engaging with others involved in ethical issues without a prior guarantee of getting the resolution one is seeking requires moral courage. Rest (Rest & Narvaez, 1994), for example, makes that an intrinsic dimension of ethics. The difference between spectator ethics and participation ethics is a willingness to get involved. In engagement we might discover that we framed the issue inaccurately or incompletely. It might turn out that a better way to get one's own ethical goals met is to negotiate with others who have their own legitimate ethical goals. To avoid engaging others because one fears the risk of being

It is a well-documented law in psychology that a sure way to encourage the wrong kind of behavior is to remain silent and let the bad actors draw reward from other sources.

wrong is probably both mistaken and a bit unethical. One would not know until the effort is made.

Conclusion

Dentists have a pronounced pattern for which touchstones are most important in guiding ethical behavior. The strongest of these are personal, and the weaker are theoretical and external. It is most likely that improvements in the ethical tone of the profession will come from focusing on practice rather than theory. It is most apt to come from other dentists than from outside experts.

A unique feature of this research was identifying the importance of engagement with others who are affected by our behavior. As it turns out, the major thrust of the American College of Dentists Gies Ethics Project will be a call for conversations among all concerned with making the profession more ethical, including all dentists, leaders in the profession, patients, payers, regulators, commercial interests, and policy makers. All those affected by the actions of dentists and all those whose actions affect the profession should be at the table and should be listened to. As this research demonstrates, to leave out important others would be a bit unethical. ■

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Appendix: Survey instrument for dentists' ethical touchstones.

Dear Colleague,

This very short survey is sponsored by the American College of Dentists as part of its three-year study of values in the dental profession. It will only take a few minutes to answer these six questions, but it will help us understand where dentists look for guidance. It is entirely anonymous and voluntary, but every opinion is worth something. No names, please.

Consider the situations below that might arise in practice. It is possible that you have already faced some of these personally. Reflect back over your professional career and your image of yourself as a professional. What have been your touchstones? How do you usually react when you recognize that there is an issue at stake?

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 University of the Pacific School of Dentistry
 Director, Clinical Judgment Laboratory
 Editor, American College of Dentists

- 5 = Almost in every case
- 4 = Regularly
- 3 = From time to time, as appropriate
- 2 = Seldom, on special occasions
- 1 = Very rarely

A. You notice a pattern of faulty treatment in the work of one of your colleagues, or that a colleague is impaired.

- | 5 | 4 | 3 | 2 | 1 | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My overall sense of professionalism and my personal standards |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A trusted colleague or friend |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specific resources in organized dentistry, look up Code, call hot line |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A professional ethicist, member of clergy, a lawyer, law enforcement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Engage directly with involved others as the first step |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | This is not a major ethical issue that I would spend time considering |

[5 = always get involved; 1 = never get involved]

B. You discover a "possible" insurance loop hole—you think they expect you to bill at a lower rate, but it is still possible to defend billing at a higher rate.

- | 5 | 4 | 3 | 2 | 1 | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My overall sense of professionalism and my personal standards |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A trusted colleague or friend |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specific resources in organized dentistry, look up Code, call hot line |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A professional ethicist, member of clergy, a lawyer, law enforcement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Engage directly with involved others as the first step |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | This is not a major ethical issue that I would spend time considering |

[5 = always get involved; 1 = never get involved]

C. Should I sell my practice to an individual whose standards appear "shaky?"

5	4	3	2	1	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My overall sense of professionalism and my personal standards
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A trusted colleague or friend
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific resources in organized dentistry, look up Code, call hot line
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A professional ethicist, member of clergy, a lawyer, law enforcement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engage directly with involved others as the first step
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	This is not a major ethical issue that I would spend time considering

[5 = always get involved; 1 = never get involved]

D. A patient is delaying and trying to get out of payments while still wanting more treatment.

5	4	3	2	1	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My overall sense of professionalism and my personal standards
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A trusted colleague or friend
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific resources in organized dentistry, look up Code, call hot line
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A professional ethicist, member of clergy, a lawyer, law enforcement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engage directly with involved others as the first step
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	This is not a major ethical issue that I would spend time considering

[5 = always get involved; 1 = never get involved]

E. Should I get involved in treating sleep apnea, large reconstruction cases, or other emerging areas of dentistry without receiving extensive, supervised training?

5	4	3	2	1	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My overall sense of professionalism and my personal standards
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A trusted colleague or friend
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific resources in organized dentistry, look up Code, call hot line
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A professional ethicist, member of clergy, a lawyer, law enforcement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engage directly with involved others as the first step
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	This is not a major ethical issue that I would spend time considering

[5 = always get involved; 1 = never get involved]

F. Should I accept Medicaid patients?

5	4	3	2	1	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My overall sense of professionalism and my personal standards
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A trusted colleague or friend
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific resources in organized dentistry, look up Code, call hot line
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A professional ethicist, member of clergy, a lawyer, law enforcement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engage directly with involved others as the first step
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	This is not a major ethical issue that I would spend time considering

[5 = always get involved; 1 = never get involved]

Thank You

Practice Goals: Opportunities and Obligations

David W. Chambers, EdM, MBA,
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Abstract

Opportunities are those situations that motivate activity with little or no upper limit. Obligations are requirements to maintain a minimal threshold, with little incentive above that level. A large survey asked dentists to report their interest in learning either positive or negative information about technical advances in dentistry, economic success, professional ethics, or oral health outcomes. Dentists were most interested in technology, followed by income enhancement. Technology and income were considered to be opportunities. Ethics and oral health outcomes were regarded as obligations, with fixed standards for acceptability.

Would a dentist attend a continuing education program to learn how to adopt crummy technology or to hear about financial schemes that tend to cost practitioners money? How about signing up for a weekly newsletter that listed worthy causes needing money or offered an “Ethical Tip of the Day” intended for those who are ethical but want to attain the zenith of moral status?

Dentists value financial rewards for providing better technical quality dental care and most continue to take advantage of opportunities to make improvements in these areas. Ethics and the oral health of the public in general are also desirable values, but they seem to operate in a different way. Performance below a certain professional and public norm causes concern, perhaps even legal action. There is an obligation to remain above that level, but few dentists are heavily invested in being more ethical than necessary.

Courses and other opportunities to learn about emerging technology or the financial success of a practice often take the format of top performers showing others how they can do even better. Ethics courses frequently include many examples of the bad things others have done with the implicit message that the audience is ethical because it does not engage in these practices.

Introduction and Hypothesis

The study of values is complex and difficult. Very little work has been done for dentistry in this area.

The literature on dentist values is thin and somewhat inconsistent. Most studies are dated and report findings from dental students, not practitioners. On standardized psychological tests, dentists often express a preference for concrete or practical thinking over abstract and theoretical framing of issues (Kirk et al, 1963; Linn, 1968; Manhold et al, 1963; More, 1961; Mozer et al, 1988; Schwartz & Shenoy, 1994). However, a few studies reported a preference for conceptual thinking among dentists (Cain et al, 1983; Heist, 1960; Silberman, 1976). There are studies reporting dentists’ orientation toward economic values (Cain et al, 1983; Heist, 1960; Manhold et al, 1963; McDonald et al, 1985) and toward technical topics (Schwartz & Shenoy, 1994).

Surveys of dentists’ attitudes toward ethics are rare. The 1995 study by Kress and colleagues did not actually focus on differences among dentists regarding how they would react to a common set of ethical challenges. Rather, it was a report of how dentists would rank issues facing the profession. Only the work of Chambers (2015) in this journal has reported that there is a significant

range in the actions dentists would feel appropriate in specific cases, such as sexual harassment or patients attempting to control treatment sequence or skip on payment, and the reasons for their intended actions.

There are at least four problems in trying to be specific about how dentists value ethics. First, there is the matter of relative value. Ethics is only one of many potential action-guiding motives. Next is the matter of scale. Improving the strength of ethics may matter more when there are deficiencies than when one is already comfortably among one's peers. There is also the problem of social desirability in reporting. It is natural to self-report information that makes one look good. Finally, it is important to focus on the range of differences between dentists themselves, as well as on differences in types of problems presented. Why are some dentists oriented more toward ethics than their colleagues are?

The purpose of this study was to test these hypotheses.

1. Dentists orient more toward technique and income when choosing how to act than they do toward ethics and public health outcomes.
2. Dentists see technique and income as opportunities and ethics and oral health outcomes as obligations.
3. There is substantial variation from dentist to dentist in how alternative values are seen.

Materials and Methods

A method sometimes used when surveying public opinion is to ask respondents to report what they believe others like themselves would

say. Besides the obvious difficulty of inferring the character of a generalized other, there will be reluctance to make honest reports, especially of suspected negative motives of one's colleagues. The following question was put to two samples totaling 196 fellows of the American College of Dentists: "Estimate the percentage of dentists who have overdiagnosed or overtreated any patients in the past three months." The average response was 24.6%. But the range of answers was from 0% to 100%, and 63% of those asked declined to answer.

The method used in this project was chosen with a view toward reducing "social desirability bias." The approach takes advantage of another well-known human characteristic known as "attention bias" (Baron, 2008; Ross & Nisbett, 2011). It is natural to orient toward, remember better, and accept as true those things that confirm our established values. Republicans watch Fox and Democrats watch CNN. The media are selected so as to maximize the number of stories or sessions of commentary that offer positive pictures viewers prefer to see and to maximize the air time describing the bad nature of those with whom one disagrees. We seek to confirm positive reports of what we like and negative reports of what we dislike. We avoid information that challenges our values.

A survey form was developed based on this connection between attention and values. Respondents were asked to imagine that they had received a stack of short journal articles from a colleague. The question was, which ones would most command interest and be read. Respondents were only given the titles of the papers and asked how likely they would be to read a paper based on the title. There were eight titles. These covered four theme

areas: (a) technical characteristics of dentistry; (b) dentists' incomes; (c) ethical matters; and (d) oral health outcomes in general. There were two titles per value theme: one suggested a positive report and the other a negative read. For example, one title suggested that new and highly effective technology is being introduced at a rapid rate while the other mentioned that dentists cannot take advantage of technology because they lack the needed training.

The survey is shown in the Appendix. A subsample of respondents also indicated their age, the size of the community in which they practiced, an estimate of the proportion of their colleagues who overtreat, and whether they identified as being general dentists, specialists, educators, or retired.

Data continue to be collected, but this paper will report on 265 dentists who took the survey in seven group settings between 2015 and 2018 in six states. The survey was administered in various settings, including events sponsored by state dental associations, the American College of Dentists, and dental schools. All surveys were completed anonymously and the project was approved by the Institutional Review Board at the University of the Pacific.

Results

The psychometric characteristics of the survey were evaluated by traditional methods. The Cronbach alpha for internal consistency was 0.643—an acceptable value for an instrument with only eight items. Factor analysis was performed with varimax rotation. This resulted in identification of two latent factors. Twenty-six percent of the variance was attributable to a general factor

characterized as preference for reading either many or few articles, regardless of their content. An additional 23% of the variance was associated with interest in either of two types of articles. Approach to technical and income topics comprised one reading pattern, while interest in ethics and oral health outcomes represented a separate pattern.

Table 1 shows the average scores for interest in reading each of the eight articles. Scores of 3.0 indicate an even chance of reading or not reading the article. A score of 4 indicates about a two-thirds chance of reading. The standard deviations are large; every article received both scores of “must read” and “not at all interested.”

Table 2 classifies the approach to various topics in two ways. “Interest” reflects the combined weights for both papers on each of the four value dimensions. “Concern” reflects the difference between potentially positive and negative papers.

Respondents said they would be slightly more inclined to read about technology and ethics than financial matters or oral health of patients. These differences were statistically significant ($F = 3.701$, $p = 0.01$), with all *post hoc* contrasts showing significant differences at $p = 0.05$. All of the gaps between topic groups were individually significant by the Scheffé and Duncan multiple-range tests.

However, the picture is different when considering the personal engagement in these four areas. The extent to which respondents care whether the story is likely to be positive or negative is a measure of concern with which direction the value is trending. Again there was an overall statistically significant

Based on surveys of 265 dentists it appears that dentists are more concerned about the technical and income dimensions of practice than the ethical or oral health outcome dimensions.

TABLE 1. Strength of interest in reading papers in four areas of dentistry as a measure of relative value strength: means (standard deviations), with larger numbers indicating greater interest.

Technique Considerations		
3.580	(1.17)	Rapid introduction of new technology
3.126	(1.21)	Lack of training delays adaptation of emerging technology
Dentists' Income		
3.419	(1.33)	Characteristics of top income earners
3.079	(1.21)	Dentists' incomes predicted to be flat
Ethics		
3.333	(1.05)	Surveys show patients trust dentists
3.379	(1.14)	Dentists disagree on reporting incompetent colleagues
Oral Health		
3.155	(1.10)	Organized dentistry increases emphasis on population oral health outcomes
3.242	(1.08)	Fewer Americans believe they have healthy mouths

TABLE 2. Overall interest and level of concern in four value dimensions in dentistry: means (standard deviations).

	<i>Technology</i>	<i>Income</i>	<i>Ethics</i>	<i>Oral Health</i>
Interest	6.742 (1.83)	6.498 (2.04)	6.711 (1.71)	6.392 (1.80)
Concern	0.417 (1.510)	0.340 (1.45)	-0.048 (1.36)	-0.086 (1.39)

FIGURE 1. Level of concern (value) over dental issues.

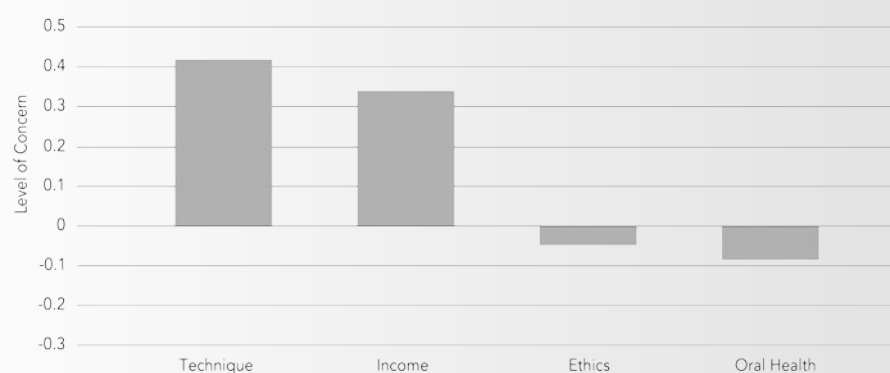
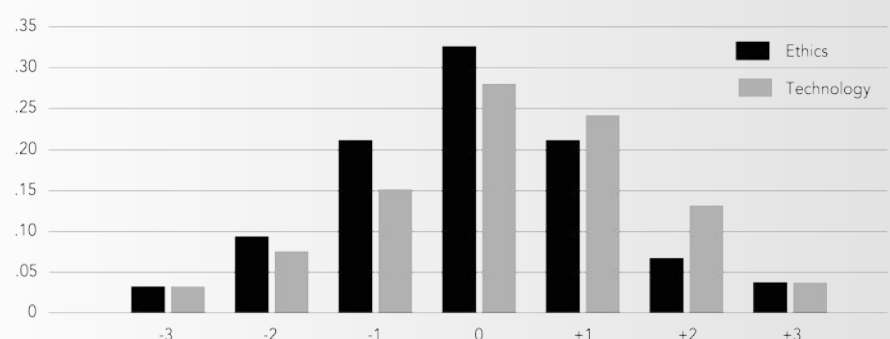


FIGURE 2. Obligation or opportunity for dental issues.



difference ($F = 15.404, p < 0.001$) with all contrasts being significant.

The strength of concern is greater than the strength of interest, and the order of the topics differs. The interest in technique and income impact on respondents' practices is much stronger than concern over issues in ethics or oral health outcomes. This mirrors the result found in the factor

analysis. These effects are shown in Figure 1. The point to focus on is the difference (positive or negative) that each value exhibits from neutral. The greatest level of concern is with technology and income.

The directional measure of concern (above or below the neutral line) tells another story: the extent to which the value is seen as an opportunity or an obligation. Values above the neutral line indicate a preference for seeking positive or confirming information; values below the neutral line indicate a recognition that negative articles

should be avoided. It is expected that there will be a preference for positive information, and this was observed in the cases of technology and dentists' income, as these signal areas of opportunity. It is also expected that attention to obligations—those areas where negative news is more likely than positive news—will be present, but less pronounced.

It is also expected that there will be individual differences regarding whether ethics or technology, for example, are considered to be opportunities or obligations. In Figure 2, it is apparent that the spread on this question is normally distributed. Values to the right in the graph signal preference for positive information. Most respondents were largely neutral with regard to ethics, with slightly more avoiding the negative and thus signaling that ethics is an obligation. By contrast, although also spread, perceptions of technology show that this represents an opportunity.

There were no significant associations for either level of interest or amount of concern over the four topic areas investigated and age of respondents, the size of the communities where they practice, their estimate of the proportion of their colleagues who overtreat, or whether they identified as general dentists, specialists, educators, or were retired. Respondents who completed the survey in a venue sponsored by the American College of Dentists were significantly more likely to report higher levels of interest in reading about all topics, other than dentists' incomes ($p < 0.001$), but there were no differences in their expressions of concern for favorable or unfavorable reports.

Discussion

Based on surveys of 265 dentists in seven settings it appears that dentists are more concerned about the technical and income dimensions of practice than the ethical or oral health outcome dimensions. They are more likely to favor positive reports than negative ones about the first two topics. This would be consistent with classifying the former as opportunities, where further attention promises advantages. Ethics and oral health outcomes tended slightly in the direction of obligations, where a certain level of attention is needed but “adequate.” They were more concerned to avoid the negative than to seek the positive.

The ranking of value concerns across technology, income, ethics, and oral health discovered in this project very nearly matches the distribution typically seen among courses offered and state and regional dental conventions.

This separation into two types of values is consistent with a study reported in this journal (Chambers, 2015) where eight cases were presented to both dentists and patients. Dentists were asked to indicate the likelihood of their engaging in several different actions and patients were asked to state their expectations that their dentist would select various behaviors. Both reported the strength of reasons for their preferred actions. A factor analysis identified a statistically significant pattern of preferences, with dentists oriented toward the technical set of responses or toward control of actions taking place in the office while patients focused on health outcomes.

One hears cynical characterizations of dentists as being motivated by economic gain. For example, the *U.S. News & World Report* surveys have

placed the profession at or near the top in terms of American JOBS and some dental schools and other groups are now creating “success” programs. The annual American Dental Education Association survey of graduating seniors has asked for years what motivated students to seek a career in the profession. The results have been stable and reflect a blend of several values. The top values in 2017 were service (94%), income expectations (90%), and “doing dentistry” (89%). If we identify “doing dentistry” with technology, these results are similar to those reported here. Improving the oral health outcomes in specific communities ranks as a low value, generally less than 25%.

The professions generally have been defined in terms of self-management, specialized knowledge and skill, and service. Increasingly service is being characterized in terms of economic transactions and skill is being replaced by control of technology. William Sullivan (2005), who led the most recent round of studies regarding the professions of medicine, nursing, engineering, law, and the clergy for the Carnegie Foundation for the Advancement of Teaching, identified emerging technology as the greatest threat to professionalism in America. It permits others to “buy into” professional status, spawning the proliferation of “soft professions” and fragmenting traditional values, especially those concerning service. It privileges success over service. Technology also favors an approach based on acute care. Oral health, by contrast, is predominantly a chronic disease.

The distinction between ethics as an opportunity or an obligation has not been considered previously in the literature. It is, however, an established

concept in the psychology and management field. Frederick Herzberg (1968) noted half a century ago that some incentives, such as safe working conditions and freedom from harassment (which he called hygiene factors), affect performance only when they are lacking. Others, such as income and job challenge (which he called motivators), are of little value at the low end but kick in at higher values. There is virtually no limit to how much additional motivators can enhance performance. For the majority of Americans, oral health is in the hygiene category. It only becomes a concern when there is an acute deficit. Ethics, legal matters, and oral health outcomes may function as hygiene factors for dentists.

In October of 2014, at the American Society for Bioethics and Humanities Affinity Group on Dentistry meeting in San Diego, a report was presented on the first 18 months of operation of the American Dental Association’s ethics hotline. Forty requests were received during that period, but none from recent grads. The service was not available to staff or patients. The most common concerns were: (a) determination of when the legal relationship with a patient begins (discharging or refusing treatment); (b) insurance and billing; (c) competition from former associates and associates taking patients when they leave a practice; (d) senior dentists resisting standards of care by associates; (e) delegation of duties; and (f) prescription writing for nonpatients. In almost all cases, the calling dentist was the “victim” of

It is natural to self-report information that makes one look good.

presumed bad ethics on the part of others. The hotline has been discontinued due to lack of use by dentists.

There have been attempts to reposition ethics as a motivator in dentistry. Jim Rule and Mickey Bebeau's book *Dentists Who Care* (2005) is an inspiring collection of stories about dentists whose lives have been dedicated to raising the standard of the profession. In the spring of 2008, the entire theme of the *Journal of the American College of Dentists* was devoted to "positive ethics." There are associations, programs, and awards for charity care, but these tend to have a focus outside the office and other than for regular interactions with patients. There is discussion about requiring courses in ethics for continuing licensure, much like radiation safety instruction for staff. One of the predictable consequences of having a disciplined license is that one will be obligated to receive ethics instruction.

One might be motivated by the opportunity to dig deeply into the intricacies of new technology or explore the fine points of a new way to finance a practice. The prospect of reading a journal article working through the details of dental ethics or the general oral health of Americans would probably strike some as an obligation more suited to others. ■

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Appendix: Survey Form

This research study is part of the ACD Gies Ethics Project. It is voluntary and anonymous. DO NOT PUT YOUR NAME or any identifying information on the form. Dr. Chambers will debrief the findings from others after the forms have been collected. Questions can be referred to (209) 946-7716.

Imagine yourself in your office reflecting on the profession and your dental career. A friend has sent you a list of eight journal articles he thinks raise interesting points that affect every practicing dentist on a daily basis. PDFs of the papers were sent along as well. All of the articles appeared in respected, peer-reviewed journals with high impact factors. They are research studies, not editorials. They are about dental practices like yours. Your friend says they make strong cases backed by data. Each is about six pages long, including graphs and tables.

Because of limited time available, limit your estimates to the reading you would do now, not later.

I am an ADA member, practicing > 30 hrs/wk → I am a little more distant from "typical"

How typical do you think you are of the average dentist? ☐ ☐ ☐ ☐ ☐

Must read now		Not interested			Article Title
5	4	3	2	1	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reasons for divergence in preferred treatment plans is caused by lack of current technical training among most dentists
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organized dentistry to put greater emphasis on population oral health outcomes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dentists are divided over whether to contact colleagues when there is clear evidence of gross or continuous faulty treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Three new factors that distinguish top earning dentists from those who are less successful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New and highly effective techniques are being introduced into dentistry at fastest pace in years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steady recent decline in the proportion of American adults deemed to have healthy mouths
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	National survey reveals public trusts their dentist to have their best interests at heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Why dentists' incomes are predicted to be flat or decline in next decade because of poor business skills

Survey of Dental Ethics Education: 2018

David W. Chambers, EdM, MBA,
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Abstract

A survey was conducted of those who have responsibility for the ethics component of dental curricula in U.S. schools. Background and training of those responsible for dental ethics education were identified, as were methods of instruction, time available for such teaching, methods used, evaluation systems, and aids and barriers to learning ethical habits. Trends in publications of scholarly articles on dental education were also surveyed. Generally, there are minimal teaching and scholarship resources and these have been declining over the past ten years. It is difficult to make the case that there is a true discipline of dental ethics.

It is widely believed that the growing edge of disciplines and professions is the university. This is where each generation of professionals is trained and where scholarship develops and innovations are tested that enhance society. Of course there are other important forces such as professional organizations, the government, industry, and the market place. But any profession that rests on a weak foundation of training and scholarship will be handicapped and eventually pay a price. The central recommendation in the *Flexner Report* on medicine, the *Gies Report* on dentistry, and the *Reed Reports* on law was the same in every case: No profession can excel without a firm educational base.

The data reported here are intended as a compendium of facts relative to teaching dental ethics in schools and to the growth of the scholarly grounded discipline of dental ethics. The formal development of learning to become ethical in general is presented in the main body of the report.

Survey of Dental Educators

A survey was conducted in early 2016 of those individuals responsible for the dental ethics curriculum in U.S. dental schools. Previous studies of this type have focused on counting the number of clock hours and characterizing the format of formal courses in dental ethics in 1982, 1988, 2000, and 2011 (Lantz et al, 2011; Odom, 1982; 1988; Odom et al, 2000). The report by Lantz,

Bebeau, and Zarkowski (2011) provided a wealth of detail about the theories and perspectives and the resources and methods used in these programs.

The focus of the present study was on those individuals who teach dental ethics (their interest and formal preparation), the integration of ethics teaching in the rest of the dental curriculum, and evidence used to evaluate the impact of these courses. A copy of the survey is attached at the end of this report.

Prior to e-mailing the survey, a note was sent to 62 dental school deans asking them to identify the individual on their faculty responsible for ethics instruction. With several follow-up phone calls, ten deans did not make such a person available. Of the 52 nominated individuals, 49 responded, for a return rate of 94%. Fourteen of the respondents were also interviewed by phone, either because they asked for that option on the survey or because their responses were of special interest.

Responses

Responses are presented in descriptive format, usually percentages of responses to both structured and unstructured questions. A summary observation is offered for each question or set of related questions.

Who Teaches Dental Ethics and Why?

Observation: Those teaching dental ethics come from a variety of backgrounds and have sketchy training.

TABLE 1. Professional background of those teaching dental ethics.

13 %	DDS, DMD, DH
17	Psychology, social work
7	Philosophy, bioethics
7	Law
4	Basic science
4	Divinity
2	Education

Dental ethics programs in schools are primarily in the hands of dentists or dental hygienists who put themselves forward for this responsibility as a supplemental activity to their other teaching or administrative duties. None has this as a full-time responsibility, and few have formal training in ethics (Tables 1-5).

Of programs reporting formal dental ethics courses, the range was from 10 to 131 hours.

Sixty percent of programs have ethics instruction in either three or all years of their programs.

Dental students often feel that the time devoted to ethics instruction is excessive (Wanchek et al, 2018). On a list of courses, time devoted to selected areas of education and training: ethics 11% excessive, second only to biomedical sciences.

The clock hours for dental ethics in various past years were recorded from the previously published papers identified at the beginning of this section.

“Thread” approaches to teaching dental ethics are grounded on the premise that there is no identifiable formal teaching because “ethics is taught everywhere.” This includes expectations for mention in oral diagnosis and treatment planning courses, natural activity in the clinic, guest speakers, and White Coat Ceremonies and class orientation programs. The nature of ethics content and consistency across students is impossible to characterize (Table 6).

TABLE 2. Path to teaching dental ethics, influences.

31 %	Chance opportunity, asked to do it, “just fell into it”
24	Always had a personal interest in the good of the profession
19	Part of administrative responsibility, position description of dean (such as student affairs)
15	Chance to fix some of the problems seen as a practitioner
11	“I am just helping out temporarily”

TABLE 3. Preparation for teaching dental ethics.

48 %	Reading, “on-the-job training,” workshops
24	Formal degree or certificate program
12	Mentors
8	Legal training
8	None

Eighty-two percent of respondents said they began learning about ethics after accepting responsibility for the dental ethics program.

TABLE 4. Time commitment to the dental ethics program.

45 %	< 10%
16	10 - 20%
10	20 - 30%
4	30 - 40%
10	40 - 50%
4	> 50%

TABLE 5. Clock hours in the formal dental ethics curriculum.

22.8: Average curriculum hours for dental ethics (about half of 1% of the typical dental curriculum)

31 %	First year
15	Second year
19	Third year
15	Fourth year
22	“Thread” (not a formal part of the program)

TABLE 6. **Activities in formal dental ethics courses.**

61 %	Didactic instruction (one-to-many)
39	Group activities
18.2	Number of cases discussed involving situations in practice
6.5	Number of cases discussed involving situations in dental school
Seventy-six percent of schools report having a Student Professionalism and Ethics Association chapter.	

FIGURE 1. **Proportion of dental schools reporting free-standing dental ethics programs.**

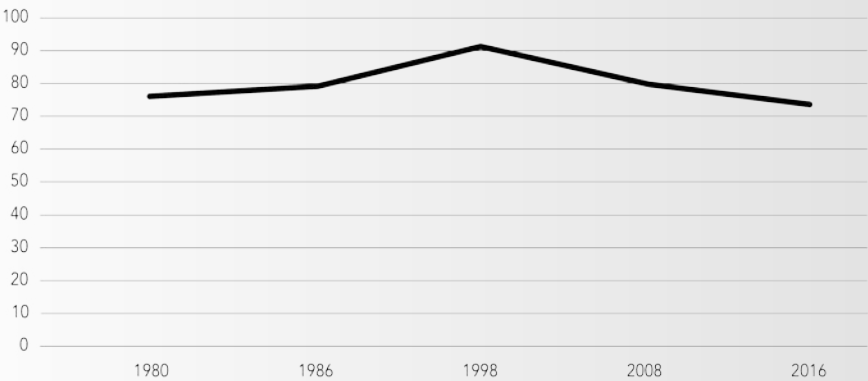


TABLE 7. **How are students evaluated in dental ethics courses?**

[Multiple evaluation methods are used: what proportion of programs use each of these methods?]

50 %	Attendance, participation
45	Multiple-choice and other exams
45	Written cases reports, analyses
19	Self-reflection
10	Student ratings of the course
5	Presentations, group skits

TABLE 8. **How are students evaluated for ethics in the clinic?**

[Multiple evaluation methods are used]

48 %	No evaluation
24	“Professionalism” is part of the daily grade
5	Competency tests for ethics
5	Incident reports

Evidence of Impact of Ethics Education Programs

Observation: There is no firm evidence that ethics education programs have an impact (Tables 7-10).

Issues in Teaching Ethics in Dental Schools

Observation: Students’ lack of ethical knowledge or reflective skills is not considered to be a problem in the school or later in practice (Tables 11-13).

The Dental Ethics Literature

Observation: The literature in dental ethics does not reflect a distinct and cumulatively growing discipline.

It is possible to sketch a picture of dental ethics as a discipline by summarizing the literature in this field. There are literally hundreds of case analyses where a particular situation is taken as a dilemma and interpreted from the perspective of various normative standards. There must be even more editorials inveighing against various specific abuses or urging one’s colleagues to take a higher tone.

The literature of concern here includes peer-reviewed papers structured on the standards of empirical research or philosophical argumentation. A Google Scholar search was conducted on “dental ethics” and “dentistry, academic integrity.” Papers judged to be part of the “discipline of dental ethics” published between 2000 and 2018 were selected. These papers are characterized below and listed in the Appendix.

Seventy-four papers met the inclusion criterion. These fell roughly equally in three topic categories: (a) experiences teaching dental ethics—topics and method; (b) theoretical papers intended to define the

boundaries and nature of dental ethics; and (c) empirical studies describing the incidence of interesting practices and questionable behaviors, especially of students.

Figure 2 shows the trend in publications for the period 2000 to 2015 for educational method, theory, and empirical publications in dental ethics. The historical pattern is similar to that seen for clock hours of instruction in dental ethics. There was a rise in academic work on dental ethics, peaking about ten years ago and then declining. That pattern, combined with the tiny number of papers published compared with other disciplines, makes it difficult to speak of a free-standing and sustaining discipline of dental ethics.

Google Scholar reports the number of citations for each paper published. Papers that described experience with various, usually innovative, methods or social issues covered in dental ethics courses were referenced by other scholars an average of 21.3 times. Articles intended to define the field of dental ethics or distinguish it from other branches of ethics or bioethics were referenced only 10.2 times on average. Reports of surveys or counts of ethical incidents were cited most often. If a paper mentioned behavior such as volunteering or presented catalogues of ethical issues identified by students, such papers were referenced by other scholars an average of 17.2 times. The literature on cheating in dental schools was more popular, being cited an average of 46.3 times per published paper. This confirms a general impression that the profession is interested in questionably ethical conduct among students.

The 74 articles studied were authored by 51 individuals or teams. There were only two cases where authors were on more than one team,

TABLE 9. How does the school evaluate the level of ethical performance of students?

86 %	There is no system in place for such an evaluation
10	Ethics councils investigate complaints
7	"Informally"
5	Ethical rounds

TABLE 10. How does the school evaluate the ethics of its graduates?

83 %	No such evaluation
10	Self-report surveys

TABLE 11. Salient characteristics affecting how dental ethics is taught and practiced in schools.

<i>Positive Factors</i>		<i>Negative Factors</i>	
10	Dedicated and knowledgeable speakers and facilitators	10	Clinical requirements create wrong incentives for students
9	Support from chairs and administration	9	School appears to sanction commercialism
7	American College of Dentists, state organizations, American Dental Association resources	4	Clinical faculty are poor role models
4	Student-led organizations	3	Ethics course director does not have enough time
		3	Mechanism for handling ethical violations is a mystery or does not exist

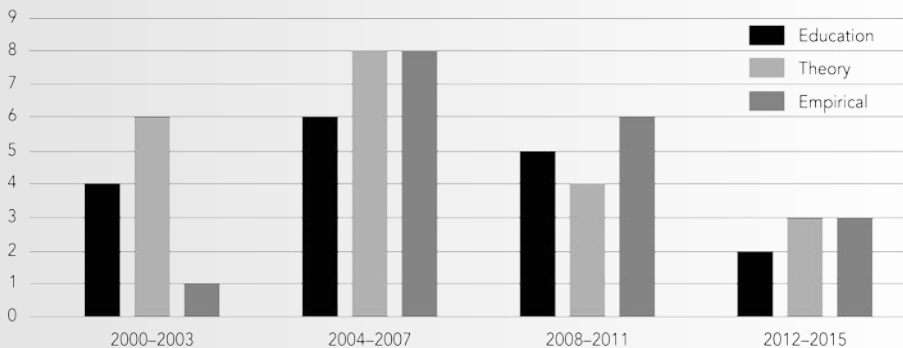
TABLE 12. What are the major ethical issues?

<i>In Dental Schools</i>		<i>In Practice</i>	
25	Cheating on written tests	21	Overtreatment
14	Pressure for clinical productivity, requirements	14	Commercialism, marketing, production
8	Faculty present diverse treatments for cases	14	Serving only those who can pay going rate
8	Lack of civility, professionalism	13	Professionalism with respect to patients
7	One-shot initial licensure examinations	8	Fraud, cheating
6	Showing respect for patients	6	Low quality standards
3	Quality of students	5	Alternative practice models based on nondentist control
3	Substance abuse	3	Educational debt
3	Educational debt	2	Substance abuse

TABLE 13. Where does the responsibility lie for improving ethics in dentistry?

- 9 Leadership in organized dentistry
- 3 Human nature of students and practitioners
- 2 The schools

FIGURE 2. Numbers of publications in dental ethics by topic and publication date



most joint authorship being the result of working together at a single institution. Forty-two authors (83%) published a single paper during this period. Only one author published in each of the four time segments studied and only one author wrote in the three areas of education, theory, and empirical studies.

The list of publications in dental ethics was cross-tabulated with the survey data on teaching ethics in dental schools. Twelve cases of individuals affiliated with hygiene programs or dental schools outside the United States were set aside. Of those remaining, 25% of papers were

published by individuals who teach dental ethics. Of those who teach dental ethics, only 12% have published.

Reflections

Unlike periodontics, oral diagnosis, or care for patients with disabilities, there is no academic discipline of dental ethics. Much of the formal curricular content is borrowed from bioethics or based on personal interpretation of codes. The cadre of those who teach ethics turns over regularly and consists of those whose predominant relationship is with practice or teaching in other subjects. Evaluation of the impact of ethics instruction is often informal and there have been no rigorous studies of the effect of dental school experiences on ethics in practice. The trend in the past decade has been toward reducing the number

of hours devoted to ethics and to “integrating” it into the educational program as an assumed responsibility of everyone, regardless of their training or interest in the field.

The literature in ethics is predominantly personal opinions about isolated practices about which there is concern, with a somewhat more formal genera of selected cases (dilemmas) analyzed from the perspective of normative principles. The peer-reviewed literature contributed by scholars making cumulative advances to the field is small and decreasing. ■

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Appendix A: Survey Used to Collect Information from Those Who Teach Ethics in U.S. Dental Schools

Ethics Project: Survey of Dental Ethics Educators

Name: _____ School: _____

E-mail address: _____ Phone number: _____

Questions about you...

1. Self-describe your role in dental ethics.
2. When did you first start thinking of yourself as being interested in ethics? Was there a specific trigger?
3. How have you prepared yourself to teach dental ethics?
4. In addition to your role in ethics, what else do you do—teach other subjects, practice?
5. What proportion of your time are you acting as an ethicist? _____
6. How do you engage in ethics outside of teaching at your school?
7. What help do you need to be a more efficient dental ethicist?

Questions about the ethics program at your school...

Curriculum	Total clock hours	Hrs in small group work	# Cases for issues in practice	# Cases for issues at school
First year	_____	_____	_____	_____
Second year	_____	_____	_____	_____
Third year	_____	_____	_____	_____
Fourth year	_____	_____	_____	_____

Is there a SPEA club? Is it active?

Changes to ethics curriculum in past five years

Tracking Outcomes...

How do you monitor the success of your program?

1. Students in ethics courses
2. Students' ethical behavior elsewhere in the school
3. The overall ethical tone of the school
4. Graduates once they are in practice
5. What help and resources do you get to support your ethics program?
6. Is there any structure or practice, outside of your teaching, in place in your school that supports or detracts from what you are doing in teaching ethics?
7. Is there any structure or practice, outside of your teaching, in place in dental practice that supports or detracts from what you are doing in teaching ethics?

Ethical issues facing the profession...

List the three top ethical issues in your opinion

In the school...

A

B

C

In dentistry...

A

B

C

What could be done by you and the profession to address these?

General comments...

Please e-mail your response to me at dchamber@pacific.edu or call me at (415) 929-6438.

Check as appropriate:

- ☐ There is more I would like to say. Let's set up a time for a more in-depth phone interview
- ☐ If the survey is not clear, we can set up a phone interview or you can e-mail me for clarification
- ☐ I am not the one you want to be talking to here. I have passed this request on to

_____ at (e-mail) _____

Appendix B: Bibliography of Dental Ethics Publications, 2000–2018

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Apologies are extended to authors who were not identified in the computerized search and to those whose work was judged to represent case analysis or advocacy for a specific topic or practice when the author had a different purpose in mind.

Ethical Attribution Effect Hypothesis

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Abstract

A body of literature in social psychology on the “fundamental attribution error” has established that the motives for behavior are attributed to ourselves and to others in a complex fashion, depending on whether the behavior is viewed as positive or negative. A parallel and balanced form survey was completed by 62 dentists to test the hypotheses that personal positive moral behavior and negative performance by others are attributed to the actor’s character and that negative personal outcomes and positive performance by others are attributed to circumstances. The results confirm these hypotheses. These findings suggest that professional ethics could be better strengthened by focusing on building supporting situations in the profession rather than attempting to change human nature.

Despite there being no published evidence to support this view, it is often heard that young dentists are less ethical than more established ones because of their educational debt (Chambers et al, 2002). (It is possible that dentists two or three generations before said much the same thing.) In the absence of a stable yardstick to measure these sorts of claims and without any reasonable body of data, the problem appears to be fundamentally one of perceptions. And perceptions are facts that can be measured.

When it is judged that a particular practitioner performed below standard it still remains to answer questions about why that happened. Was it because of incompetence or a weak moral foundation (characteristics of the dentist)? Or was the undesirable outcome heavily influenced or even compelled by circumstances? For example, the patient may have been uncooperative, the materials defective, or a staff member may have misidentified the patient or procedure. When we make ethical judgments, we typically go behind the behavior in an effort to understand its causes.

Sometimes we have the opportunity to resolve these “character or circumstances” problems if we can make the right kind of multiple observations. If the practitioner is associated with repeated cases of substandard work under a variety of circumstances, we feel confident in calling this a case of questionable character. By contrast, if multiple practitioners are experiencing difficulties in similar instances, we

lean toward explanations in terms of circumstances.

Parallel logic applies to exemplary performance as well. If a dentist exhibits technical excellence or leadership or service across multiple situations, we attribute this to something special in the practitioner. If the quality of care in one military dental unit is consistently outstanding or the proportion of dentists in a state who support organized dentistry is routinely above the national average, we attribute that to circumstance (the program or leadership in the state) and not to individual dentists.

The theory that underlies this pattern is one of the best-established in the field of social psychology. Virtually every textbook in the field contains a discussion of what is known as the “fundamental attribution error.” The original research was done by Edward Jones and Victor Harris (1967). They asked subjects to comment on the attributes of a person who had written an essay about Fidel Castro. Opinions regarding the writer changed if subjects were told that the writer could have written anything he or she wanted or if the topic had been assigned. Since then, hundreds of papers have demonstrated that we attribute different motives to others depending on how much control we think they had over their performance (Malle, 2006).

The label “fundamental attribution error” entered the field a decade later

(Ross, 1977). The construct is now fairly well understood. The issue is one of interpreting the source or reason for observed behavior (character or circumstances). Two factors have influence over this interpretation: (a) who performed the act; and (b) whether the performance is regarded as positive or negative. These two factors interact as shown in Table 1.

Bertram Gawronski (2004) summarized the evidence on the fundamental attribution error where respondents were asked to judge the character of others based on their moral behavior rather than their skill or values. "A common finding in this paradigm is that perceivers generally attribute immoral dispositions to immoral behaving targets even when they learned that situation factors have a strong impact on the tendency to engage in immoral behavior" (p. 201).

This line of research is suggestive, but it fails to test the full fundamental attribution error model. It leaves out attributions of one's own moral character. There have been no studies of the fundamental attribution error as it applies specifically in dentistry.

The research reported here tests two hypotheses.

1. Dentists will attribute positive moral behavior to their own ethical character and their own negative moral behavior to circumstances.
2. Dentists will attribute the positive moral behavior of others to circumstances and others' negative moral behavior to the ethical character of others.

Materials and Methods

A survey was conducted to test multiple examples of short descriptions of moral behavior encountered in dentistry. These incidents were expressed as short phrases, such as "A student is near the bottom of the class and regularly cuts corners in some areas of patient care because..." or "Someone you have heard of keeps getting on various committees in the component society and state association due to..." These are examples of negative and positive behaviors attributable to others. Negative and positive personal incidents would include: "If you take a 'temporary' position in an office with high pay for volume and marginal quality on a quota system, it would be because of..." and "You attend a health fair screening sponsored by the local component when a friend asked you to." For each such incident, respondents were asked to indicate on a five-point scale the degree to which they felt the behavior described should be attributed to the character of the actor or to circumstances.

The items were developed in pretests with 24 potential situations. The ten incidents eventually selected were chosen because they elicited a range of attitudes regarding how ethical the behavior was thought to be. Very obviously unethical behavior and cases of exemplary conduct were excluded. Two items were retained but not scored. One dealt with justifiable criticism and the other with overtreatment. These were included in the survey as distractors and attributed to distant acquaintances.

Two versions of the survey were prepared (see the Appendix). One contained two items each for positive and negative behavior attributed to another and two positive and two negative items attributed to the person

completing the survey. The second version of the form contained the same behaviors, but attribution to "self" was switched to "other" and vice versa. This was necessary to prevent bias caused by making some items more praise- or blame-worthy. Each item served as its own control.

Sixty-two dentists completed one or the other version of the survey in a continuing education setting devoted to dental topics. Ethics was not a theme in any testing situation. Thirty-two respondents completed one version of the survey. Thirty completed the survey with reversed attribution of agency. The research was approved in the exempt category by the Institutional Review Board at the University of the Pacific.

Results

Because of the pairing of incidents, the total set of responses was balanced. So there were 62 cases with positive and negative outcomes attributed to self and other. A score of 10 indicated that an individual judged both items in that 2 x 2 cell as entirely attributable to the character of the agent and a score of 2 indicated that the behavior was attributed entirely to circumstances.

Means and standard deviations for four combinations of agent and moral behavior are shown in Table 2. Results are displayed graphically in Figure 1. Table 3 for the two-factorial ANOVA shows the results of testing for interaction.

Considering all scored items without regard to agent or positive or negative behavior, the average score was 5.291 (SD = 1.941). A perfect balance between character and circumstances would have produced a score of 6.0. Although the overall results are near the balance point,

there is a slight but statistically significant ($p < 0.01$) edge toward explanations in terms of circumstances.

Considering only those incidents where respondents answered as the moral agent, there was a strong tendency to see positive behavior as flowing from one's character and negative behavior compelled by circumstances. The t-test value for this difference was $z = 4.940$, $p < 0.001$. This difference is reflected as the vertical distance between the end points of the two lines on the left of the accompanying graph.

A similar pattern appeared on the right of the graph, but the poles are reversed. Respondents perceived positive behaviors of others as being attributed to circumstances and negative behaviors as flowing from others' character ($z = 3.423$, $p < 0.001$). This effect was stronger than for self. Personally favorable attribution of moral performance was greater for self than the attribution effect for others. This was tested by the ratio of squared t-values ($F = 2.083$, $p < 0.05$).

Discussion

Both hypotheses were confirmed. Dentists in this study attributed positive moral behavior to their own ethical character and negative moral behavior to circumstances. At the same time they attributed the positive moral behavior of others to circumstances and negative moral behavior to the ethical character of others. The former effect was slightly but significantly stronger than the latter. Overall there was a slight, but significant, tendency to attribute moral incidents to circumstances.

The clear disordinal interaction between agent and type of behavior shown in the graph and the ANOVA

TABLE 1. Fundamental attribution error matrix.

	<i>Self as agent</i>	<i>Other as agent</i>
Positive performance	Character	Circumstances
Negative performance	Circumstances	Character

TABLE 2. Means and standard deviations for combinations of agent and type of moral behavior.

	<i>Self</i>	<i>Other</i>
Positive	5.660 (1.512)	3.896 (2.484)
Negative	3.501 (1.842)	5.313 (2.012)

FIGURE 1. Ethical attribution.

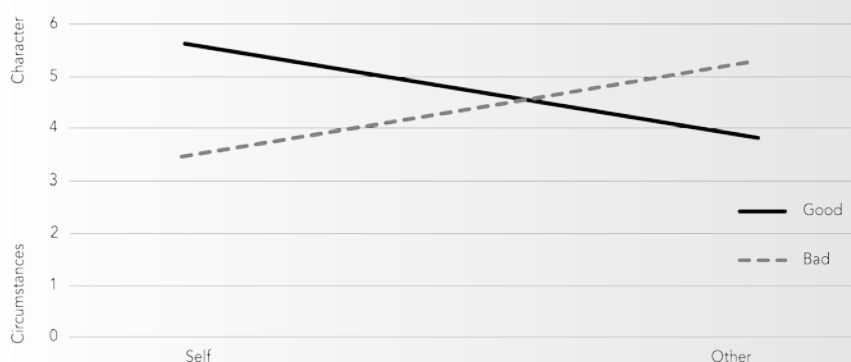


TABLE 3. The two-factor (agent and positive or negative behavior) ANOVA.

	<i>MS</i>	<i>F</i>	<i>p</i>
Self/Other	6.974	1.753	0.187
Positive/Negative	3.271	0.822	0.365
Interaction	225.851	58.782	<.001
Error	3.979		

Dentists in this survey study attributed positive moral behavior to their own ethical character and negative moral behavior to circumstances.

results is unusual in the literature. Research on ethics that considers only whether one is the agent or is judging others, without taking into account whether the behavior is positive or negative, will draw an incorrect conclusion that there is no effect. Similarly, assessing whether positive or negative moral behavior is attributed to character or circumstances will also draw an incorrect conclusion that there is no effect. Judgments about the sources of moral behavior are complex.

This research is consistent with the previously reported literature (Bierbrauer, 1979; Miller et al, 1974; Pietromonaco & Nisbett, 1982; Sabini & Silver, 1983; Safer, 1980). It is a logical extension of social science into dentistry.

These findings are also in line with other social science findings on moral behavior. For example, Hartshorne and May (1928) found that the perception of what is acceptable behavior varies across individuals. Someone may steal from the group resources but not from a friend. And the opposite is true for others. In the current research virtually all incidents were rated by some at both ends of the scale available.

A research team led by Daniel Ariely (2009) has explored the personal side of interpreting our own behavior in the most positive light possible. A number of studies (Ariely, 2012; Mazar & Ariely, 2006; Mazar et al, 2008) have shown that it is human nature to take more credit than we deserve and to excuse ourselves for fairly routine small transgressions. For example, more Americans confess to

cheating on their taxes than the number who vote in most elections (Gabor, 1994). Rhode (2018) lists several reasons given for such adjustments between what we do and the reasons we give for doing so. For example, it is thought that the good we have done that has been unrecognized needs to be balanced. We claim, perhaps correctly, that we know more about the actual circumstances of our behavior than do others. We fear that others are taking advantage of the system. We know in most cases that the cost to others to inspect and control our biased attributions is greater than what we are dealing ourselves under the table. This research demonstrates that dentists engage in typical human behavior in giving an optimistic interpretation of the motives for their own behavior.

This project is not intended to present a cynical perspective on dental ethics. It would be irresponsible to consider this study as justifying a view that dentists act unprofessionally. The question is how moral behavior is interpreted, and then what can be done to improve professionalism based on the personal interpretations of where ethics comes from.

These results do support a nontraditional position that hoping for large improvements in moral behavior as a result of telling others about morality is likely a dead letter. Most dentists believe they are already ethical. Formal ethics instruction, especially of the theoretical type, required courses in ethics for licensure or as remediation for disciplined licenses, and editorials may not be enthusiastically received by those required to listen to such messages. Suggesting that others pay more attention to their character may look promising to others. It takes a view of ethics from the right-hand side of the

graph presented in Figure 1. From the perspective of those being lectured to, who will position themselves on the left-hand side of the graph, this approach would not be effective.

It is not exactly correct to refer to a fundamental attribution “error” in this case. Selective attribution of the forces that drive moral behavior is a natural effect. “Circumstances” in this case does not refer to random fluctuations in the environment. Volunteering for a health fair because a colleague asks you to or promoting questionable practices on the continuing education circuit are circumstances that can be changed by professionals. This research suggests that these indirect ethical improvements have significant potential. Some of the ways more positive context would help all dentists include: peer support, clear practice standards, listening openly to colleagues, collecting accurate data on collective moral behavior, building dental skills so more of practice is successful, leadership and role models, aspirational codes, transparency, toning down the rhetoric and praise given financial success, and arrangements that are fair for all parties.

There is evidence that attention to circumstances can have a positive effect on ethics. Leavitt and colleagues (2012) measured the ethical attitudes of Army medics in two settings. In one, the medics performed an ethics task in uniform in a briefing room. They did better on a parallel task when they were in scrubs in a hospital. Chambers (2016) measured ethical attitudes at a meeting of an organization respected for its attention to ethics and again with the same individuals in their private practices. The situation that implied that ethics matters produced the most positive ethical responses. ■

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Appendix: Survey Forms

Form A

Described below are ten examples of things some dentists do sometimes.

Rate each on a scale from 1 to 5 depending on whether you think the behavior is...

1 = Entirely a matter of character, it is the way the person would always act because of who they are

5 = Entirely a matter of circumstances, the situation carries great weight in cases such as this

All *All*
Character *Circumstances*

1 5

☐ ☐ ☐ ☐ ☐

Reason a well-respected dentist in the community reports another dentist to the state board for gross and continuous faulty treatment is because of...

☐ ☐ ☐ ☐ ☐

If it happened you promoted an innovating treatment with weak evidence but great income potential on the continuing education circuit, that would be due to...

☐ ☐ ☐ ☐ ☐

Someone you have heard of keeps getting on various committees in the component society and state association due to...

☐ ☐ ☐ ☐ ☐

If a dentist takes a "temporarily" position in an office with high pay for volume and marginal quality on a quota system, it would be because of...

☐ ☐ ☐ ☐ ☐

You attend a health fair screening sponsored by the local component when a friend asked you to

All *All*
Character *Circumstances*

1 5

☐ ☐ ☐ ☐ ☐

You are near the bottom of the class and regularly cut corners in some areas of patient care because...

☐ ☐ ☐ ☐ ☐

Some dentists volunteer occasionally at the dental school to be around the best and brightest is...

☐ ☐ ☐ ☐ ☐

If someone you had heard of was performing a molar endo for the first time in years after watching a short video "course," that would be because of...

☐ ☐ ☐ ☐ ☐

Your favorite teacher suggests performing slightly more care than the patient expects based on his judgment that it is in the patient's best interests

☐ ☐ ☐ ☐ ☐

Everyone was watching as you agreed to contribute to the group's charity fund

Form B

Described below are ten examples of things some dentists do sometimes.

Rate each on a scale from 1 to 5 depending on whether you think the behavior is...

1 = Entirely a matter of character, it is the way the person would always act because of who they are

5 = Entirely a matter of circumstances, the situation carries great weight in cases such as this

All
Character

1

☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐

All
Circumstances

5

Reason a well-respected dentist in the community reports another dentist to the state board for gross and continuous faulty treatment is because of...

A dentist who knows the evidence is weak regularly promotes an innovative treatment approach that has great income potential on the continuing education circuit due to

You find yourself getting on various committees in the component society and state association due to...

If you took a "temporarily" position in an office with high pay for volume and marginal quality on a quota system it would be because of...

A dentist attends a health fair screening sponsored by the local component when a friend asked him to

All
Character

1

☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐

All
Circumstances

5

A student near the bottom of the class regularly cuts corners in some areas of patient care because...

The reason for you to volunteer occasionally at the dental school to be around the best and brightest is...

If you were performing a molar endo for the first time in years after watching a short video "course," that would be because of . . .

Your favorite teacher suggests performing slightly more care than the patient expects based on his judgment that it is in the patient's best interests

Everyone was watching as a colleague agreed he would also contribute to the group's charity fund

Code of Conduct of the American College of Dentists



Section 1.

The Code of Conduct speaks very clearly about what is required of a Fellow of the American College of Dentists:

- a. A Fellow shall abide by the principles of ethics of the American Dental Association or equivalent professional organization. A Fellow shall always act in a manner that brings credit to the dental profession and the American College of Dentists.
- b. Fellows shall be removed of Fellowship upon being judged in violation of the Principles of Ethics of the American Dental Association or equivalent professional organization by the governing body of that organization.
- c. The American College of Dentists holds that: The solicitation of patronage by false, deceptive, and misleading advertising is unacceptable and shall be grounds for removal of Fellowship or other disciplinary action (see Guidelines for Advertising by Dentists¹).
- d. The American College of Dentists holds that it is the obligation of every Fellow to be a competent professional committed to lifelong learning. It is the responsibility of every Fellow to keep abreast of contemporary developments within the profession. It is a moral and ethical imperative that a professional responsible for the health and well-being of others discharge that responsibility to the best of their ability.
- e. Fellows share an obligation to serve their profession and contribute to its progress according to their abilities and resources. These efforts may be acknowledged by honoraria.
- f. Fellows have an obligation when involved in continuing education or other professional endeavors to disclose relationships with commerce, journalism, or any other entity where nondisclosure or incomplete disclosure may lead to a misrepresentation of facts.
- g. Fellows shall be removed of Fellowship if convicted in civil or criminal court of an action which discredits the dental profession or the American College of Dentists, or following revocation of license by a licensing agency. Fellows may be removed of Fellowship following censure or suspension by organized dentistry or a licensing agency.
- h. Fellows shall be removed of Fellowship when they do not fulfill those obligations of Fellowship as set forth in the Bylaws², Code of Conduct³, or henceforth determined by the Board of Regents.
- i. Fellows may use the title "Fellow, American College of Dentists," or alternatively "Fellow of the

American College of Dentists,” on letterhead, business cards, and in biographical summaries, provided this is done in a dignified and professional manner and is consistent with other provisions in the Code of Conduct. The title shall not be used in the direct solicitation of patients or for strictly commercial purposes. Use of Fellow, American College of Dentists or Fellow of the American College of Dentists on the Internet is permitted only in a biographical summary on a dentist’s own website. If the title is used, it must appear on a page within the website that is strictly informational and not commercial in nature.

- j. The title “Fellow, American College of Dentists” is conferred on all members of the College and is abbreviated F.A.C.D. It is understood that Fellowship is an honor, but it is not a degree. The conferring of Fellowship in the College may be announced to the public in accord with guidance provided by the Executive Director.
- k. Fellows shall use the F.A.C.D. abbreviation in the accepted manner. The use of the F.A.C.D. abbreviation following the professional degree is limited as follows:
 - 1. The abbreviation may be used together with academic or professional degrees on the Title Page of textbooks.
 - 2. The abbreviation may be used in College registers where faculty listings are presented, together with other titles and degrees.
 - 3. When submitting a paper for publication in a professional, non-proprietary journal, a Fellow may inform the editorial board of Fellowship in the College and at the editor’s discretion, the abbreviation may be used following the author’s name.
 - 4. The abbreviation may be considered for use in non-commercial contexts that only involve dentists or other professional colleagues and do not involve patients. The overriding principle is that the abbreviation shall not be used in any commercial context such as advertising, solicitation of patients, or personal or professional promotion. This restriction will normally exclude the use of the abbreviation on stationery or professional cards. The abbreviation should not be used in or on office doors, office buildings, nameplates, signs, directories, announcements, appointment cards, advertisements, telephone books, or websites.

The purpose of the Code of Conduct is to uphold and strengthen dentistry as a member of the learned professions.

5. The abbreviation may be used in educational settings where the course, seminar, or meeting is sponsored by conventional dental schools, organized dentistry, or organizations representing recognized specialties.
6. Any contemplated use of the abbreviation shall comply with the spirit of the *Principles of Ethics and Code of Professional Conduct* of the American Dental Association.
7. The abbreviation should not be used when signing a professional register except in foreign countries where such recognition is expected.
- l. Sections may only use the seal of the American College of Dentists as part of official correspondence. Any other contemplated uses require the prior approval of the Executive Director. The seal may not be used by individuals other than those serving in an official capacity.
- m. Pledge for Acceptance of Fellowship and affirmation of the Responsibilities of Fellowship will be required of all new Fellows.

Section 2.

The Code of Conduct also speaks very clearly about what is required of an Affiliate Member of the American College of Dentists:

- a. An Affiliate Member shall always act in a manner that brings credit to the dental profession and the American College of Dentists.
- b. Affiliate Members shall not portray themselves as Fellows of the American College of Dentists.
- c. The American College of Dentists holds that it is the obligation of every Affiliate Member to be competent and committed to lifelong learning. It is the responsibility of every Affiliate Member to keep abreast of contemporary developments relative to their profession.
- d. Affiliate Members are encouraged to serve the dental profession and contribute to its progress according to their abilities and resources. These efforts may be acknowledged by honoraria.
- e. Affiliate Members have an obligation when involved in continuing education or other professional endeavors to disclose relationships with commerce, journalism, or any other entity where nondisclosure or incomplete disclosure may lead to a misrepresentation of facts.
- f. Affiliate Members shall be removed of membership if convicted in civil or criminal court of an action which discredits the dental profession or the American College of Dentists, or following

revocation of license or similar credential by a regulatory agency. Affiliate Members may be removed of membership following censure or suspension by a professional organization or a regulatory agency.

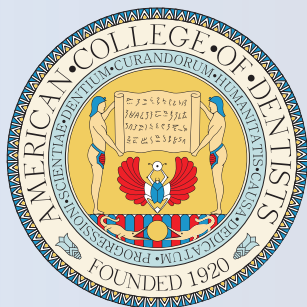
- g. Affiliate Members shall be removed of membership when they do not fulfill those obligations of membership as set forth in the Bylaws, Code of Conduct, or henceforth determined by the Board of Regents. Affiliate Members may be removed of membership if their actions discredit the dental profession or the American College of Dentists.
- h. Acceptance of Section 2 of the Code of Conduct will be required of all Affiliate Members.

The preceding statements constitute the Code of Conduct of the American College of Dentists. The purpose of the Code of Conduct is to uphold and strengthen dentistry as a member of the learned professions.

The Code of Conduct was amended October 1996, October 1999, April 2004, October 2005, October 2007, and October 2010. ■

Online Sources

- 1 <https://www.acd.org/about-us/policy/advertising>
- 2 <https://www.acd.org/about-us/bylaws>
- 3 <https://www.acd.org/code-of-conduct>



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