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The *Journal of the American College of Dentists* shall identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. All readers should be challenged by the *Journal* to remain informed, inquire actively, and participate in the formulation of public policy and personal leadership to advance the purposes and objectives of the College. The *Journal* is not a political vehicle and does not intentionally promote specific views at the expense of others. The views and opinions expressed herein do not necessarily represent those of the American College of Dentists or its Fellows.

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

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Cover photograph: Ethics is not an event; it is a life pattern. Some dentists describe their journeys.

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FROM THE EDITOR

AUTHORITY AND RESPONSIBILITY

As J. R. Ewing said on *Dallas*, "The first time you compromise your ethics is always the hardest. After that it gets easier."

Last week I resigned my position as a director of a local healthcare district board. I am not absolutely certain I did the right thing, and perhaps readers will be willing to share their thoughts.

According to California law, health-care districts are empowered to, among other things, operate hospitals and other health services, organize a medical staff, buy and sell land, and raise money through parcel taxes and general obligation bonds (with voter approval). The five-member, publically elected board does not manage the hospital: it hires, directs, and evaluates a chief executive officer for that purpose.

During the first eighteen months of my service, we made steady progress. Our revenues grew, we formed strategic alliances with a medical group and with a larger nearby hospital, we developed plans and have funding in hand for a \$31 million seismic upgrade that will include a new ER and ORs, a Quality Committee was created, and we held our first-ever board retreat.

But the finances have deteriorated. We just ended the fiscal year with an operating loss of \$6 million on a \$50 million budget (compared with a California average net profit of 2.5% from operations for hospitals). Our revenues have been declining for eight months. Even adding back citizen support from taxes, we were \$1 million

under water. Expenses ended the year at 28% over budget. The sticker price on our building project jumped from \$31 million to \$39 million. A recent feasibility study by outside consultants advised against attempting a capital campaign because the opinion leaders in the community are nervous about the survival of the hospital. During the two years I was on the board we had five CFOs and three comptrollers.

I began to worry and to tell the board and the Finance Committee about my concerns six months ago. I used all my boyish charm, my MBA analytical reasoning skills, and appeals to outside authorities. I showed the steady negative trend lines at board meetings. Ultimately it was suggested that it would be best if I kept my opinions to myself. My board colleagues said they preferred to keep the public picture positive.

So I began to wonder whether the board really should be involved in these matters. It turns out that both state law and the bylaws of our board say that financial oversight, including accounting for the disbursement of all funds, lies with the district's treasurer. That gave me the heebie-jeebies. I was the treasurer. But I was reassured by my peers that the bylaws are being reworked to transfer

financial responsibility to paid employees of the district who are the true experts in these matters.

Here is how I reached my decision to resign. Every dental student knows about crown-root ratios. In the same way, every MBA student knows that authority can be delegated but responsibility cannot. Authority is the privilege of using designated resources of the organization, subject to certain clearly specified limitations. Responsibility is the requirement to stand for making something good if there are problems. Responsibility in the case of district hospitals in California can go so far as directors facing criminal and civil charges for violated one's fiduciary obligations.

The way I see it, a board can delegate (in fact, is prudent to delegate) authority for budget management. The board cannot, however, delegate any of its responsibility for getting and using the information it needs to honor its commitments. The majority of the board disagreed with this position. I resigned.

This same story could be told from the perspective of the relationship between the medical staff and the board. By law, hospital appointments and privileges are granted by boards, and ultimate responsibility resides there for oversight of quality and safety. This relationship is not especially complicated. The principle of dual governance establishes peer review procedures in the medical community and the board

supports those actions that conform to sound protocol.

When the board began reviewing these matters a few months ago, however, we found a pattern of minor irregularities. The week before I resigned, I learned that The Joint Commission, which accredits hospitals, had just visited and issued two citations for inadequate credentialing practices. The board had only been told the commission might come soon, and the findings have yet to be released to the board generally.

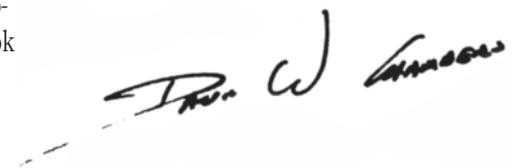
Dentists make private decisions about economic and service dimensions of the care offered to their patients. In a hospital this is a public ethical matter. In administrative, Finance Committee, and board meetings, a policy had emerged that the financial health of the hospital was to be ensured by increasing high-margin surgical cases such as joint replacement and bariatric surgical procedures. Staff and the board would look at the negative variance in operating income and knowingly nod to each other, "We need a few more hips."

At first I was taken aback and probably mumbled something about looking into the care that people most need. From previous research I knew the answer was skilled nursing, home

care, and diabetes management. But over time, it no longer seemed strange to put the hospital's financial health above the interests of patients and the public. As J. R. Ewing said on *Dallas*, "The first time you compromise your ethics is always the hardest. After that it gets easier."

I have been very frank about a personal decision. I have chosen to do so because I know there are many Fellows of the College who sit on boards and face the fiduciary choices of authority and responsibility. Although not commonly discussed, these are deep ethical issues. I hope there are some good letters to the editor in the next issue of this journal explaining that Chambers was probably right to resign or that perhaps he should have taken a different path.

We can all learn from reflecting on our public as well as private responsibilities.



LETTERS TO THE EDITOR



To the Editor,

The Summer 2011 issue of the *Journal of the American College of Dentists* contained a thorough and provocative article covering the ethics of writing off a patient's insurance copayment. One of the four contributors, Dr. Toni M. Roucka, concluded in her section that, "The occasional waiving of copayments for patients undergoing financial hardship can, and arguably should, be done." I write now to express my disagreement with her conclusion.

In her analysis, Dr. Roucka acknowledges that the American Dental Association's *Principles of Ethics and Code of Professional Conduct (ADA Code)* speaks directly and unambiguously to the issue of Waiver of Copayment in Section 5.B.1. This advisory opinion states in essence that waiver of copayment without so advising the insurance carrier is an ethical impropriety because it constitutes a form of deception and overbilling.

However, despite the plain language of this opinion proscribing waiver of copayment, Dr. Roucka offers a contrary view of the ethical propriety of forgiving copayments. To support her position, Dr. Roucka argues first, that the advisory opinion—standing alone—can be taken out of context from the rest of the *ADA Code* and second, that the *Code of Ethics of the American Medical Association (AMA Code)* allows the physician to forgive copayment under

certain circumstances. I address each of these arguments in turn.

Dr. Roucka posits that the advisory opinion covering waiver of copayment must be put in proper context by examining the document (*ADA Code*) as a whole and, in particular, two principles in the *Code*: Beneficence and Justice.

While the notion of context is important in the art of interpreting an ambiguous or conflicting section of a document, the advisory opinion at issue suffers from no such infirmity. But assuming for purposes of discussion that the advisory opinion needs context, one must start with the Principle of Veracity ("truthfulness") under which this advisory opinion falls. This principle tells us that, "The dentist has a duty to communicate truthfully." Specifically, this section notes that the dentist's primary obligations include, in relevant part, "...communicating truthfully and without deception, and maintaining intellectual integrity."

Applying this veracity principle to the advisory opinion on waiver of copayment requires an appreciation of the underlying facts. It is important to recognize that when a dentist submits an insurance form for a patient, the dentist is certifying to the insurance company that he or she is charging a given fee for a specified service. If the dentist waives the patient's copayment, then the dentist is not really charging the fee that he or she certified was being charged. This untruthfulness violates the Principle of Veracity and may be considered fraud on the insurance company.

Ignoring this lack of truthfulness and possible fraud issue, Dr. Roucka looks to the Principles of Beneficence and Justice for contextual guidance.

Under the Principle of Beneficence, Dr. Roucka points out that dentists "have a duty to act for the benefit of others" and that a dentist's contractual obligations, "do not excuse dentists from their ethical obligation to put the patient's welfare first." Having cited these code pronouncements, Dr. Roucka offers no further insight into their proper application or limitations, and as a consequence, the reader is left with the mistaken impression that these general duties (act for the benefit of others and put the patient's welfare first) somehow override or counterbalance the proscription against waiver of copayment. In truth, neither of these two pronouncements can be construed to encourage or excuse the lack of truthfulness or the commission of a fraud by a dentist.

Similarly, Dr. Roucka's use of the Principle of Justice to support her position fails. Here, she points out that dentists "have a duty to be fair in their dealings with patients, colleagues, and society" and that dentists should "seek allies throughout society on specific activities that will improve access to care for all." Again, having cited these duties, Dr.

Roucka offers no further insight into their proper application or limitations, and as a consequence, once more the reader is left with the mistaken impression that these general duties (treat people fairly and work to improve access to care) somehow override or counterbalance the proscription against waiver of copayment. In truth, like the problem with Dr. Roucka's quotes from the Principle of Beneficence, neither one of these two pronouncements from the Principle of Justice can be construed to encourage or excuse the lack of truthfulness or the commission of a fraud by a dentist.

Turning now to the second point, Dr. Roucka cites the *AMA Code's* section on waiver of copayment and notes, in relevant part, that it says "When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment..."

However, this *AMA Code* section then goes on to advise physicians that waiver of copayments may violate insurance policies and may, if routine, "constitute fraud under state and federal law." But even more remarkable is the fact that this section ends with an instruction to physicians that effectively negates its prior sanction of waiver of copayment. The last sentence in this section warns physicians to "ensure that their policies on copayment are consistent with applicable law and with the requirements of their agreements with insurers."

While this self-contradictory advisory opinion in the *AMA Code* may apply to physicians who are members of the AMA, it does not apply to dentists who

are members of the ADA. It must be noted that as a condition of membership in the ADA, a dentist voluntarily agrees to abide by the *ADA Code*. It matters not that another health profession's code of ethics has a dissimilar view on a given factual situation. The ADA dentist is obligated to follow the *ADA Code*. And on the issue of waiver of copayments, the *ADA Code* has spoken clearly and unambiguously.

Dr. Roucka's position that occasional forgiveness of copayment when a patient is experiencing financial hardship may have a noble intent, but it cannot be justified under our *ADA Code* or our existing laws. If a dentist is so moved that he or she wants to help a patient who is undergoing a financial hardship, then that dentist can ethically do so by either notifying the insurance company that the patient is only being charged what the insurance company will pay or, alternatively, that dentist can provide the dental service pro bono. What the dentist cannot do ethically, however, is engage in deception (commit fraud on the insurance form) and attempt to justify this wrongdoing by pointing to the ADA's Principles of Beneficence and Justice or the *AMA's Code*.

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AUTHOR'S RESPONSE

First of all, I thank Dr. Rosen for his passionate and articulate response to my opinion in the Summer 2011 Issues in Dental Ethics section of the *Journal of the American College of Dentists*. Let me clarify for Dr. Rosen my position on this issue. Actually, Dr. Rosen and I are in agreement on this topic... for the most part! I do not advocate for, nor do I believe it ethically permissible for a dentist to waive a patient's copayment at will; essentially committing fraud. In the article, I acknowledged all of the legal concerns and ramifications associated with this practice. The routine and inadvertent waiving of copayments by a dentist is undoubtedly a violation of the Federal False Claim Act.

Having said that, however, there are times when patients experiencing financial hardship need and deserve some compassion. I know Dr. Rosen does not dispute this. This is where the ADA Principle of Beneficence comes into play and offers some guidance on how to fulfill this obligation, although it does not specifically address the issue of copayments.

Where mine and Dr. Rosen's opinions might diverge is in how the *ADA Code* Section 5.B.1 "Veracity" (Waiver of

When confronted with a dilemma concerning a patient who cannot make a copayment for financial reasons, practitioners have the option, and arguably the obligation, to take the simple steps above to alleviate concerns of illegal conduct.

Copayment) coexists with *ADA Code* Section 3 on “Beneficence” and the *AMA Code* Section 6.12, “Forgiveness or Waiver of Insurance Copayments.”

Dr. Rosen states that the *AMA Code* section 6.12 is a “self-contradictory” advisory opinion. I, on the other hand, believe that it is not self-contradictory but in fact more thoroughly considered than the *ADA Code* opinion on the same subject. The *AMA Code* allows physicians some flexibility in this realm. The *AMA Code* acknowledges copayments as a potential barrier to access to care where the *ADA Code* does nothing of the sort. The *AMA Code* offers more explicit guidance on the subject and makes it ethically permissible, under certain circumstances, to waive patient copayments. The *ADA Code* is mute on this subject other than to say “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.” Dr. Rosen is correct when he states that members of the ADA are bound to the *ADA Code*, not the *AMA Code*, but I believe we as a profession could learn something from it. We are all healthcare providers dealing with similar patient issues.

Dentists have the opportunity to provide pro bono care at will to those in need; usually this refers to patients who have no dental insurance and cannot self-pay. I do not believe that Dr. Rosen would refuse care to a patient who could not make a copayment just because he was afraid of “committing insurance fraud”; nor do I believe that he should have to choose not to bill the insurance company just to avoid wrongdoing and take no payment at all. The point is,

there are legal and ethical ways of dealing with this situation. There would be nothing stopping Dr. Rosen from taking the extra time to call the patient’s insurance company to explain the situation. More than likely, the insurance company will grant a waiver of copayment for hardship cases. Some insurance companies, like many Medicaid providers, may have a hardship clause in place in their policies that offer guidelines for handling such situations. The *ADA Code* does not specifically address this issue while *AMA Code* does.

I would hope that from my opinion in the article as well as the other authors’ opinions, readers understand that this is a very complex issue that needs further consideration. There is a distinct difference between the routine waiver of copayments as was the case in the article scenario and the occasional waiver of copayments for financial hardship reasons. When confronted with a dilemma concerning a patient who cannot make a copayment for financial reasons, practitioners have the option, and arguably the obligation, to take the simple steps above to alleviate concerns of illegal conduct. This makes my statement that “The occasional waiving of copayments for patients undergoing financial hardship can, and arguably should, be done,” ethically and legally sound.

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My JOURNEY IN DENTAL ETHICS

Larry J. Cook, DMD, MSHCE, FACD

ABSTRACT

My ethics journal passed through these phases: personal inspiration by those I admire in the profession, struggle to incorporate their ideals in daily practice, working with like-minded colleagues, and formal education and exposure to broader and diverse interests. Now it is time to help others with their journeys.

The introduction to dental ethics and professionalism began very early in my dental career. Upon graduation from the University of Florida College of Dentistry in December of 1979, I was fortunate to receive a few awards and honors. One was a full scholarship to the L. D. Pankey Institute for Advanced Dental Education in Miami, Florida, to attend the institute's beginning course, Continuum I. Pankey's goal in offering scholarships to recent dental graduates had the intention of attempting to "catch them early" in their dental career and provide solid fundamental concepts of clinical dentistry and practice administration, as well as life and practice philosophy.

INSPIRATION

In the summer of 1980, only a few months out of dental school, I attended the institute for the first time. During my C-I week, my class and I were honored to listen to two presentations by Dr. L. D. Pankey. One of Dr. Pankey's presentations concerned creating life balance as a dentist and the ethical practice of dentistry. In his lecture he offered his definition of what a professional, particularly one in the healthcare professions, should be. Dr. Pankey's definition of a professional was "an individual who possesses a specialized body of knowledge and skill, and chooses to use that knowledge and skill for the benefit of another individual, prior to self-interest."

When Dr. Pankey said that the professional dentist "ought" to provide

service to those they served prior to self-interest, he really hit me between the eyes. This challenge caused me more than ever to consider the reasons I had pursued a career in the profession of dentistry. In my introspection, I had to admit that almost every reason I had for seeking a dental career had to do with my perception of what becoming a dentist could do for my family and me. Factors such as, personal income, community respect, self-esteem, and continual learning were the primary reasons I could identify for seeking a career in dentistry. Dr. Pankey's definition forced me to look again at my intentions at their very core as to service to those individuals who chose to give me the greatest of all professional gifts: trust.

This experience was my introduction to dental ethics and professionalism. The principle of service "prior to self-interest" remained on my mind and heart during my daily interactions with my patients. Clinical decisions for my patients began to focus on the two ethical questions that must be answered in all clinical decision making: *What should we do?* and *Why should we do it?*



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STARTING THE WALK

In those early days of my career, I truly wanted not only to be seen by others as a consummate ethical professional, but also to know internally that I daily “walked the walk.” Starting my private practice in the fall of 1980 in a small rural community in Northwest Florida provided me with ample challenge for living up to the definition of a professional and truly walking the walk. The inward battle of serving my patients in every situation “prior to self-interest” was confronted daily by the reality of personal issues such as economic debt (educational and practice), a growing family, and a ton of delayed personal gratification for my wife and myself. The desire for a large amount of continuing education was an additional expense. The reality was that my practice was young and growing, but was not really providing the level of income that could easily satisfy all of the “self-needs and desires.” An inward battle existed daily between attempting to stay focused on serving patients prior to self-interest and at the same time having personal needs and wants yet to be fulfilled. As time marched on, the economics of practice and life began to become somewhat better and the walk became less stressful. However, the reflective moments continued to bring me back to the Dr. Pankey’s definition and the question of how to incorporate that goal in every patient encounter.

My continuing education goals have been varied throughout my career. Most of my independent study focused on clinical dentistry, practice administration,

and life philosophy, as well as ethics and professionalism. Thanks to caring mentors and friends, I was fortunate to be welcomed into several outstanding dental academies and organizations which enabled me to continue my professional education, service, and growth. One of the organizations I am honored to be included in is the American College of Dentists. In this organization, I have met some of the current practicing icons in the dental profession from all over this nation and also here in my home state of Florida. One of the most phenomenal blessings I received was to be befriended by three legends in the profession of dentistry who were the leaders in the Florida Section of the College: Drs. Ray Klein, Al Bauknecht, and Lew Walker. These three men approached me a decade ago about taking on the challenge of directing, improving, and overseeing the ethics and professionalism outreach of the Florida Section to dental students, dental residents, and practicing dentists.

WORKING WITH OTHERS

I am certain the three of them did not know that my efforts to grow in knowledge and application in dental ethics and professionalism had begun many years prior. Eight years ago I was named the Ethics Chair for the Florida Section of the College and have been in charge of the ethics and professionalism events for the section over these years. Our events have consisted of ethics workshops with dental school junior students, an ethics essay contest for dental seniors, ethics workshops with dental residents, white coat ceremonies for dental sophomores, ethics and professionalism lectures to dental freshmen, and lectures and workshops with practicing dentists. I do not know why, but this work in ethics and professionalism for my section in the College has become my passion. The effort allows me to travel throughout the year to fulfill my obligations and to

help make sure the presentations will flow well and accomplish their mission, along with the purpose of influencing the ethical thinking of the future dental professional.

Because of the responsibilities I have in my section of the College, the role I play has allowed me to become friends with the leadership at the central office of the College, particularly the current Executive Director, Dr. Steve Ralls. Approximately four years ago, Steve began talking to me about my passion and work in ethics and professionalism. Given the success of the Florida Section, Steve challenged me to consider seeking a degree in healthcare ethics. He pointed out that a degree in healthcare ethics and professionalism could provide me with a much deeper foundation of knowledge and understanding in the subject. Formal training in ethics would broaden my horizons on the subject and create a higher level of credibility with my audience.

From the outset I thought there was no way that I would consider taking on another degree course of study as I approach my sixtieth decade of life. I had all kinds of roadblocks in my mind when I considered pursuing another degree at my stage of life: a full-time private practice to run, traveling several times a year to teach, and being basically “computer illiterate” while knowing that the master’s degree would have to be an online degree. I was already biased against the effectiveness of online learning compared to traditional classroom learning and interaction and thought that maybe I would just be too old to complete with the younger generation that would be in my class. After much consideration and discussion with my wife, I made the leap a few months later, August 2009.

BROADER EXPOSURE

On May 14, 2011, I completed my Masters of Science degree in Health Care Ethics from Creighton University, Omaha, Nebraska. What a fantastic journey the process provided me. I was able to interact on a daily basis with some of the brightest, most committed, competent healthcare professionals in our country. Our class consisted of people from all over the nation including physicians, nurses, ethics writers, healthcare administrators, and me—the only dentist. Sure enough, I was the oldest in the class, but I was able to keep up with the younger members of our class and even challenge them at times as we progressed through the curriculum. Classmates taught me so much in so many ways. My bias against online learning was put to rest in the very first month in the program, because of the intense interaction, challenge, debate, argument, frustration, and fun that I was able to enjoy with my classmates and the first-rate faculty at Creighton. As a graduate program should be, it was extremely demanding, with 30 or more hours a week dedicated to the course work.

I now feel that the degree program not only fulfilled my expectations, but rather exceeded them. Now that the program is behind me, it is easy to say that it was worth the effort, but there were several times through the journey when I felt there was no way that I could complete all of the reading, writing, and discussion that was demanded. Thanks to my wife and a staff who would not allow me to back away, I persevered.

The curriculum that Creighton has formulated in healthcare ethics is an excellent beginning in the basics of ethical thought, principles, and application

within the healthcare arena. The faculty at the university was just incredible in their knowledge and skill in helping each student master the material. Our courses covered topics that included healthcare ethics as it applies in health policy formulation, healthcare research, the law, philosophical bioethics, social and cultural contexts of health care, theories of justice, and practical ethics in healthcare settings. Our final two courses were completed within my community as practicum and capstone courses. All in all, as I look back on the program, I do believe that it has provided me with the foundation I hoped to achieve when I began.

An interesting change occurred through the program. I live in a small rural community in Northwest Florida and was born, raised, and have lived in the Deep South my entire life. You could easily consider me politically and philosophically as a “red-neck conservative” going into the degree program. That is to say my family of many generations has handed down to each succeeding generation the principles of personal responsibility, hard work, and the thought that humans achieve what they have earned and deserved (in most situations). Creighton is a Jesuit university, rooted in the Catholic tradition. Jesuits have been known for their strong support and development of education throughout the centuries. Jesuits also are known for their strong positions in social justice issues. The majority of the faculty of the program, as well as my fellow students, followed the Jesuit traditions. From day one of the program, the conflict between social, political, and religious views of the issues being faced among all involved in the courses was rather strong. Beliefs in social justice meeting the intense view of responsibility brought about fierce ethical debate leading to the appreciation of opposing

An inward battle existed daily between attempting to stay focused on serving patients prior to self-interest and at the same time having personal needs and wants yet to be fulfilled.

This work in ethics and professionalism for my section in the College has become my passion.

views among our peers. I would not say that the debate caused anyone to stray very far from his or her core values, but the change that occurred in me was a much deeper understanding of the issues faced by the truly marginalized and disadvantaged within our society. I also feel confident that my classmates and faculty were forced to grapple with the issues of the fundamental responsibility (as a person is capable) of each individual for his or her own health. The program provided a remarkable 22 months of debate, on a daily basis, of core issues facing all societies. I loved the debate!

NEW CHALLENGES

Going forward, I have concern regarding ethical issues within the profession. Many dental professionals would identify commercialism in the profession, cheating in dental schools, and non-disclosure by lecturers of their industry ties, along with many inappropriate actions by our peers as major ethical issues facing the profession. I agree that all of these are ethical concerns for all of us to face. But a large problem I see is the level of interest (or lack thereof) that the practicing dentist of today has in learning more about dental ethics and how issues in ethics can influence and affect a dentist's everyday life in dentistry. If you attend a major dental meeting anywhere in our nation and see the types of programs that are on the meeting agenda, the programs with the largest number of participants will not be those that have something to do with ethics. I suspect that the average dental professional at first glance considers the field of ethical study to be boring or not a field in which they feel in need of additional learning, since they consider themselves an "ethical" dentist already. Programs at dental meetings about implants, cosmetics, or esthetics will always fill a room. It is

completely understandable that the practicing dentist has a plate very full of major areas within the practice of dentistry that they feel they must spend their continuing education time and finances on. Improving clinical skills and knowledge, the business aspects of running a dental practice, staff relations issues, marketing of the practice, and learning how to build a nest egg large enough to allow for the dentist to eventually retire or move on to another field of interest—all are placing pressure on every dentist's CE assets. Programs on ethics at major dental meetings have not proved to be a great draw due to all of these other issues facing the dentist, and this reality concerns me.

Throughout my journey, I have found that discussions among dental professionals about real-life clinical cases and their individual choices are extremely stimulating and enlightening. The shared view among professionals helps to move us out of our comfort zone and often forces us to consider alternative choices as to what is the "right thing to do." It is the grappling with the issues that helps us to grow and find insight from our peers. At dental schools and in residencies, I have a captive audience for our workshops and lectures, and the participation by the students as we get into the meat of the issues is awesome. It is my firm conviction that if practicing dentists would open themselves to experience well-done ethics workshops or lectures, they would walk away with the feeling that they were glad they attended.

How does the profession get the practicing dentist interested in ethics and ethical learning? I do not know the answer, but I truly believe that for the future of our profession ethical debate and discourse should move to the forefront of the dental landscape. ■

DENTISTRY AND ETHICS by THE ROAD LESS TRAVELED

Chrissy Tiller

ABSTRACT

In what may be a unique educational career path, this current dental student combined predoctoral course requirements with courses and a master's thesis in applied medical ethics prior to entering dental education. This background has led to leadership opportunities in designing and teaching the ethics program in dental school and in the American Student Dental Association. The view of ethics from the students', rather than the practitioners', perspective is certainly formative to the future of the profession.

My road to dental ethics began at a critical point during my junior year of college when self-reflection, family influence, and an opportunity I could not turn down came together. At the time, I was beginning the process of applying to dental schools and fulfilling one of my undergraduate institution's requirements in spirituality. Working diligently through the advanced science requirements for a bachelor's degree in biology at Loyola University in Chicago, I had grown to appreciate the opportunity to take classes in religion, philosophy, language, and other disciplines that challenged the seemingly underutilized creative side of my brain. Continuing full speed ahead toward an acceptance to professional school, I wanted to find a class that would allow me to experience a side of health care that I had not yet explored.

How Choices Find Us

Though I was undoubtedly an ethics novice, I had had some exposure to the topic thanks to my mother, a registered nurse turned hospital administrator, who has sat on an institutional ethics committee for as long as I can remember. When I began to vocalize my intent to pursue a career in health care, we would often discuss cases, without breaching confidentiality, of course, and I was even welcomed as a guest to sit in on ethics committee meetings every so often. Naturally, when a class that investigated moral issues in medicine became available, I jumped at the chance to learn

about ethics in a more formal setting. After just two classes I found myself completely enthralled with the complexities of the topic. My classroom introduction to the ideas, methods, and application of ethics principles within a scientific context was consuming, stimulating, and a welcome change from an education that felt pipelined. Many deep, unanswerable questions and subsequent discussions continually opened the door to an academic world starkly different from the one I had grown accustomed to. I found myself excited to prepare for class, eager to finish assignments, and constantly challenged by a subject notorious for having no right answers. As the class progressed, I began to question my own preparedness for matriculation into dental school. I felt as though my education in ethics had barely scratched the surface, and I no longer felt confident that I was personally developed enough to begin to make such complex decisions as a student doctor.

Standing at this crossroads, I sought the guidance of my mother who, with her wisdom and support, encouraged me to take the time I needed to deter-



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Thanks to my education,
I have found myself
actually living by the
ethic that I intend.

mine the path to my career. She recommended that I speak with the ethicist that sat with her on the institutional ethics committee, and almost immediately the plans for the next two years of my life began to fall into place. As fate would have it, the ethicist turned out to be a philosophy professor in the graduate school where I was completing my undergraduate degree. We communicated back and forth for quite a while, discussing my interests, hesitations, and possible roads to education in both ethics and dentistry. The graduate school offered a unique degree in applied philosophy, which touched on classical theories and arguments but was focused mainly on exploring new age philosophy and contemporary ideas relevant to real world situations. The curriculum was filled with classes in medical ethics that covered everything from end-of-life decisions to consulting for a committee to future ethical issues like genetic engineering and selection. Determined not to let go of either academic interest, I felt myself being pulled toward pursuing this particular master's degree. After countless discussions and a bit of clever scheduling, I decided to postpone my application to dental school for one year in order to take the opportunity to immerse myself in the world of medical ethics. Though not an easy decision, and one that absolutely shocked the general dentist I had been working with for almost five years, I knew that this was the time, this was the opportunity, and this was my chance to take the road less traveled.

COURSE WORK IS IMPORTANT

As the year progressed, classes covering overarching issues in medical ethics gave way to very specific topics of interest. My

classmates and I were given the freedom to tailor our education to the subjects that were most intriguing to us individually, and numerous open-ended research papers allowed us to essentially specialize in an area of applied philosophy. It was at this point that I had the opportunity to steer the topics away from medicine and toward dental ethics. Though many fundamental principles can be applied to both professions, there is no doubt that the many ethical challenges a dentist faces are vastly different from those experienced by medical doctors. When broken down even more specifically, it can be argued that dental students face conflicts different even from practicing dentists and that there is a need to address this critical distinction. With this in mind, I began to play with ideas regarding the dreaded "T" word that every graduate student fears: Thesis.

My interests lie within ethics education and the challenge of building one's strong moral foundation in the practice of dentistry not only from the first day of dental school, but from the first time a young student identifies and distinguishes his or herself as a dental school applicant. Ultimately, I chose a topic very close to home and integrated dental education, student professionalism, and ethical expectations into a paper calling for changes in undergraduate curriculum that aim to expose students who have declared themselves as a "pre-health professional" to theories in ethics, both personal and professional, at a much deeper level before beginning the first predoctoral year. There is no doubt that society holds healthcare professionals to a higher standard of moral maturity due to the trust that is necessarily placed on us because of the services we provide and the subjectivity of our work. This unspoken contract in which society continues to trust dentists individually, and therefore trusts dentistry as a profession,

allows for our professional independence and is critically dependent on the continued pursuit of excellent ethics practice.

Application Is Always at Hand

It was important to me to attend a dental school that shared my views on the importance of an all-encompassing, challenging dental ethics curriculum, and this was a major factor in my selection of the Midwestern University College of Dental Medicine in Arizona. A new school with a progressive, forward-thinking model, it was clear that the vision and plans for a comprehensive ethics curriculum were exactly what I was searching for from my place of education.

Integration of ethics and dentistry began during my first year when we were encouraged, as a class, to write our own ethics code for students. The instructions were open-ended, allowing us to create any code in any format as long as it represented what was important to us as ethical young professionals. A few times a quarter, a group of us would meet to discuss and write the code, which we chose to direct toward the major stakeholders we would be serving as dentists, and we determined thirteen ideals that represent the vast range of moral and professional goals we hope to achieve now and throughout our careers. Beginning every description of an ideal with, "In order to best serve our patients, community, and profession..." we were able to combine traditional concepts such as autonomy, nonmaleficence, and fiduciary duty with modern values such as reputation, tradition, humility, life balance, innovation, and teamwork. Recognizing that the

code was written from the preclinical perspective, we decided to revisit it upon experiencing life as students in the clinic and make amendments as we thought necessary.

My continued experience in ethics education, including the opportunity to lead a small-group ethics discussion at a dental school, has allowed me to begin to build the framework for my career. Currently, I participate in the ADEA/Gies Academic Dental Careers Fellowship Program which, with the unbelievable support from the administration and faculty at Midwestern University, requires me to experience dental education by teaching in the clinic and simulation clinic, giving two lectures on ethics, leading small-group discussion session, and completing a research project. My research project is a seminar- and discussion-based pilot program using practical, applicable cases that highlight ethical challenges faced by student in the preclinical setting. I want to determine the value of the use of focused, relevant topics for students instead of those generally aimed at dental professionals who have been in the field a number of years. The goal is that the students will have a more comprehensive initial foundation in dental ethics and therefore a better sense of its relevance and importance because they can relate to the cases. The preclinical cases are planned to be integrated into the second-year dental ethics and professionalism curriculum beginning this fall.

Conclusion

While I am hesitant to boldly state that choosing to take one particular class as an undergraduate has changed the direction of my life, there is no doubt that the continued intrigue that class sparked has sent me down a path I could not have predicted. For me, ethics is not just a

list of theories or philosophical jargon written by idealists. Thanks to my education, I have found myself actually living by the ethic that I intend. I have learned to listen to the subconscious stomach drop that I get when a situation just does not seem right. I treat my patients to the best of my ability and with a sense of ethical awareness that has begun to shape the practitioner that I am and my professional reputation. I encourage students, for the long-term independence and success of our profession, to become a presence within organizations like the Students for Professionalism and Ethics Association (formerly known as SCOPE) and the American Student Dental Association. Collective, organizational accountability will help to ensure that dentistry remains a trusted, ethical profession. I encourage dental professionals to seek continuing education in ethics, to discuss challenging cases, to write for journals, and to remain excellent mentors for those of us who will follow. With a world of professional uncertainty ahead, I feel confident knowing that a foundation in dental ethics will provide me with the guidance I need to lead a successful life and career. ■

ETHICS IS HOW YOU RESPOND TO LIFE

Joseph Graskemper, DDS, JD

ABSTRACT

A practicing dentist with a law degree describes how early life and career events shaped his view toward ethics in the dental profession. He has combined these life lessons, ethical theory, law training, and practice management experience into a course for dental students that emphasizes the complex, integrated nature of practice.

Early in my life I saw many people in need and was shown by those around me how to help them.

In my career I encountered people whose lack of integrity disappointed me. Although these things cannot be ignored, I was determined not to join them. Today I am looking for ways to pass on what I know about the complex interactions between ethics, law, and practice management to the next generation of professionals.

EARLY LESSONS IN ETHICAL SENSITIVITY

My ethics journey began long ago in high school where, through my parents' and high school mentors' guidance, I began to understand the importance of being ethical. It was heavily impressed upon me to respect others even if not agreeable, treat all with dignity even if you think it is not merited, and help those in need without expecting appreciation. While at Xavier University, (Cincinnati, Ohio), I took great interest in philosophy and theology: two big cornerstones of behavior guidance. With a minor in each, my interest has constantly grown with my reading many philosophical life guidance books over the years since.

Other early experiences that affected my philosophical and ethical outlook included a couple of summer jobs while in college. The first was working as an attendant in the hospital of a state mental institution where I took care of patients

and helped on shock treatments, doing minor surgical procedures, and holding patients while they died. The second was working as a diener (the one who removes the requested body parts for the forensic pathologist) in a county morgue doing autopsies from crib deaths, homicides, and suicides; a truly life-death view changer. Between these two experiences I have seen life at different levels: the totally infirm and death at all ages. Life is fragile and your time may be limited more than you expect. As they say, "Carpe Diem!" My early experiences left me with the view that all individuals must be respected. I have carried this viewpoint into the courses I now teach by emphasizing that we as dentist do not just treat teeth, we treat people. Hence, we must treat our patients as equals in the "co-diagnosis" of their dental needs.

Other experiences that had an impact were my personal involvement in helping those in true need. In high school I taught religion classes to handicapped children. While in dental school I helped treat handicapped children and eventually ran the program which was outside of the dental school. We treated children with multiple sclerosis, cerebral palsy, and spina bifida at the Easter Seals offices in Columbus, Ohio, on weekends with a faculty member present. Recently, I served as chairman of the Board of



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Directors for a very large Long Island nonprofit organization called Maryhaven Center of Hope. It helps all special individuals, including the most severe cases, through their own schools, housing, and work places.

LESSONS FROM BROKEN TRUST

Personal life experiences have also contributed to the interest in the ethical behavior of dentists. Being a very trusting individual, I thought almost everyone lived honestly, especially professionals. I expect that a person will fulfill his or her obligations when they are made, even if circumstances change, because it is more important to keep one's word, based on a mere handshake, than to dishonor that veracity, fidelity, or obligation commitment. This was found not to be the case for many individuals I have had contact with personally and professionally. Developing a large multi-specialty (ortho-dontist, oral surgeon, prosthodontist, periodontist/implantologist, endodontist), fee-for-service (no insurance accepted) dental practice while in law school in San Diego, California, was an ethically challenging experience.

I was amazed by the reaction of most of my colleagues at the time. All thought I was crazy to undertake such an endeavor of going to law school while working full-time and developing a multi-specialty practice: no encouragement but rather animosity and confrontation. After approximately 20 years in La Jolla, California, I sold everything and moved to Long Island, New York, to be closer to family. There I started from scratch a

small practice in Bellport, New York. Since I had a family to provide for and the person who bought my San Diego practice decided not to honor the contract, I accepted many types of dental insurance. This was a whole new experience with a totally different type of patients and business model. The ethical conflicts that arise from insurance involvement are never boring and constitute a true ethics learning experience.

I also sought an opportunity to volunteer at Stony Brook School of Dental Medicine. At the interview with the head of the department, he literally threw my résumé on his desk and the first thing he said was "Am I supposed to be impressed?" I was totally taken aback by such a confrontational comment. I was only there to volunteer one day a week! After four years of volunteering and seeing that the school was hiring part-time the very residents I taught, I asked if I could be paid. I was told it was not possible. That was an ethically challenging situation for me since I truly love teaching in the classroom and on the clinic floor. I decided to give my notice if not paid and was eventually hired part-time.

The big lessons in ethics are seldom encountered in a classroom. They come from real life. And the final exam is not the way you talk about what happens; it is how you respond.

My early experiences left me with the view that all individuals must be respected.

Because there are many crossover issues between law, ethics, risk management, and practice management issues, I began to incorporate a decision-making process into the various problems that occur in a dental practice.

Building a More Ethical Profession

I have found that honesty and truth always win out in the long run. Having a strong philosophical/theological/ethical base has allowed me to remain positive with patients and those around me. I am now trying to pass this on to the next generation of dentists. Living your life, not just professionally in the office, but actually living ethically in your daily routines and encounters with others, allows you to be successful on all levels of living. This is something I have tried to pass along to dental students.

Having a law degree and a lot of experience, I was asked to take over the dental law course at Stony Brook School of Dental Medicine. Two years later I was asked to incorporate the existing ethics course into the dental law course. Based on what I learned from reading and taking classes, I condensed the two courses into one. I found that there was a void between the individual presentations of these subjects. I renamed the courses Professional Responsibility I and II to better describe the course material. Because there are many crossover issues between law, ethics, risk management, and practice management issues, I began to incorporate a decision-making process into the various problems that occur in a dental practice. It became obvious that ethics, law, and practice management cannot be taught in a vacuum as separate concepts; thereby leaving the dental school graduate to

integrate all the information while trying to make the right decisions chair-side with a very forceful and taxing patient. Rather than having just ethical discussion or just legal or just practice management discussions, I ask students to apply all the impacting rules, regulations, and concepts to achieve a true practice solution. This was so well received by the students that I started to put all the material into a guidebook. This resulted in my writing the book *Professional Responsibility in Dentistry: A Practical Guide to Law and Ethics*, which is published by Wiley-Blackwell.

SOME UNFINISHED BUSINESS

One of the largest ethical issues facing dentistry today is unfettered, unfiltered advertising, especially on Web sites and social networks like Facebook, Twitter, etc. Having been one of the first dentists to advertise in Southern California and a previous owner of a dental advertising company, I have been closely in touch with the progress of dental advertising. From ethically correct dental advertising, under strict ethical guidelines, the industry has taken on a merchant-like quality where exaggeration is leading to puffery. This greatly undermines the profession.

There is also the ethical compromise that some dentists lapse into by promoting cosmetic and implant dentistry in the interest of income and not based on patient needs or even wants. Examples are a patient who is happy with the small diastema between her front two teeth being talked into and sold eight porcelain veneers; and the patient who is happy with his denture and is eating

well without any problem being sold sixteen implants. Many of the current dental journals give a lot of attention to this, with many articles on how to sell big dental cases and “taking your practice to the next level.” I believe that new practitioners with heavy debts are especially vulnerable to this pitch. Pressures to have the latest and greatest dental office with the latest and greatest equipment add to the weight of financial strain for the dentist, hence making practice management an integral part of professional responsibility.

Another situation that is problematic is the steering and stealing of patients that is creeping into the referral process. This “cronyism” referral pattern is becoming more prevalent as there are more family dental teams and the economy is soft. The problem is not only lack of respect for the referring dentist but also an infringement on the dentist-patient relationship affecting the patient’s autonomy and trust and confidence in the referring dentist.

On the larger level of the profession as a whole, we must be aware of the impact of multiculturalism. Many cultures do not have the same emphasis on ethical behavior accepted in American culture. There is no easy answer to address this matter. However, attempting to bring ethics into various legal and practice management of scenarios makes the proper ethical reasoning understandable and applicable to the practicing dentist.

CONCLUSION

Ethics is not something one adds to practice, like deciding to use new bonding agents. It is something one lives by and for. Those who claim to be ethical in their treatment of patients, but treat employees and others they encounter unfairly do much damage to the professionalism of dentistry.

To properly help new dental students to professionalize their interaction with others, not just patients, there should be integration of professional responsibility in schools from orientation day to graduation day. Starting with a full introspection of where the individual is on the ethical scale and once there is a basic uniformity of ethical understanding, we should build on that understanding throughout the four years of dental school to incorporate all they will interact with. Therefore, there will be growth ethically and professionally from self to colleagues and staff, to other adjunct dental personnel to those outside of the dental arena including family, friends, and the public. This will ultimately culminate in a total integration of the application of ethical concepts, legal rules and regulations, and risk management, and practice management principles and guidelines. This would allow the dental student to assimilate many diverse concepts into an integrated understanding of what is professional responsibility, ethically and legally, and to pursue a successful, rich life. ■

This will ultimately culminate in a total integration of the application of ethical concepts, legal rules and regulations, and risk management, and practice management principles and guidelines.

ETHICS AND THE 'SEASONS OF MY LIFE' AS A DENTAL EDUCATOR

David A. Nash, DMD, MS, EdD, FACD

ABSTRACT

Perhaps the first comprehensive ethics program in American dental schools was created in 1990 at the University of Kentucky by then dean David Nash. Nash recounts the emergence of his personal and professional interest in ethics using the structure of Daniel Levinson's book *The Seasons of a Man's Life*. Each season brings tasks of evolving and deepening ethical engagement. Being ethical is important; helping others to be so is special. Nash still teaches the course.

Søren Kierkegaard, the early nineteenth century Danish philosopher, was correct: "Life can only be understood backwards; but it must be lived forwards." We can only really understand who we are as a human being as we look retrospectively at the lives we have lived. And that is why I was happy to accept this opportunity to reflect on my engagement with the discipline of ethics during my life as a dental educator. The editor has requested a personal narrative; therefore, I will respond with a memoir.

I have chosen to include in the title of my comments the expression "seasons of my life." I appropriate this expression from Daniel J. Levinson's best-selling book published in 1978, *The Seasons of a Man's Life*. In the book, then Yale University Professor Levinson reports on his ten-year study of the male life cycle, documenting at least four "seasons," as well as transition periods between each: (a) childhood and adolescence; (b) early adulthood; (c) middle adulthood; and (d) late adulthood. One of the remarkable findings of his research is that all men go through the same basic stages of the life cycle. Even more astonishing was his finding that they do so at approximately the same ages. Levinson's book has been widely read and cited. I found it helpful in my understanding of the "seasons of my life," when I read it in middle adulthood. I continue to find it valuable as I reflect on my existence in late adulthood.

Metaphorically connecting the seasons of the year and the seasons of the human life cycle provides a useful trope. I will use the metaphor in reflecting on my pilgrimage with ethics in my life as a dental educator.

FORMATIVE YEARS: SPRING

Ethics is that branch of the discipline of philosophy that studies morality. The philosopher and theologian Paul Tillich defined ethics as the "science of the moral." Ethics seeks to answer the question "How should I behave?" Morality is behavior focused—how humans behave in social interaction.

My formative years were spent in a family with a strong collective moral conscience deriving from religious commitments. Moral instruction, though not necessarily ethical discourse, was an integral dimension of my childhood. My father was a biblical studies professor for a Christian college in a small community. I was immersed in the tenets of Christian morality from birth. Such an environment, without doubt, set the stage later in my life for more serious intellectual consideration of the basis for human secular morality.

For Levinson, ages 17-22 are transition years from the era of childhood and adolescence to young adulthood—



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the college years. My collegiate education, though in science in preparation for becoming a health professional, was in a small Christian liberal arts college, thus continuing the values orientation of my familial environment. In my sophomore year I registered for an introductory philosophy course; the only formal philosophy course I would take for credit until 30 years later. It was only later in life that I would come to realize that a written exercise in that course had become enormously influential in my intellectual quests. The professor asked us to write an essay entitled: “What is human nature?” The question has continued to haunt me. “What does it mean to be?” And, the corollary question “What does being mean?” It could be suggested that the first question is one of philosophy, the second one of religion.

Early Adulthood: SUMMER

Spring gradually transitions during the collegiate years to Summer—early adulthood. Early adulthood was launched for me when I enrolled in the College of Dentistry at the University of Kentucky. I had a phenomenal dental education at UK. Kentucky was a new school at the time, with many innovative ideas about dental education being implemented by an extraordinarily talented faculty. My education at Kentucky between 1964 and 1968 opened doors of opportunity for me that would never have been opened based solely on my personal credentials. Kentucky had a strong Professional Conduct Code. Academic

integrity was emphasized. I can honestly say that I was unaware of any of my classmates ever being guilty of academic dishonesty.

I spent two summers while at UK as a summer research fellow in the Department of Community Dentistry, chaired by Dr. Wesley Young, a leader in public health and the community dentistry movement. Dr. Young, as well as the UK faculty, labored diligently to sensitize students to the needs of society. Social sensitivity was a component of the expression that guided the college’s culture then: the education of dentists who are “biologically oriented, technically capable, and socially sensitive.” My experience in such a milieu molded later efforts in my professional life in advocating for access to oral health care for children. The quality of my dental education at Kentucky and my professorial role models, as well as my father’s life as a professor, influenced my eventual decision to pursue life as a dental educator.

The distinguished developmental psychologist, Erik Erikson, characterized this period of life as one in which the psychosocial task of developing intimacy is critical. He suggested that the failure to achieve an intimate relationship with another leads to isolation. I resolved that task successfully with marriage to my wife, of 45 years, Phyllis. Levinson suggests that early adulthood is a major

I can honestly say that I was unaware of any of my classmates ever being guilty of academic dishonesty.

“settling down” period; settling down to family and work life. After completing graduate studies in pediatric dentistry at the University of Iowa, and teaching pediatric dentistry at Louisiana State University for three years, I arrived at West Virginia University as chair of the Department of Pediatric Dentistry in 1973, at 31 years of age, and continued my “settling down.” By then Phyllis and I had two daughters. Essentially all of the children’s formative years were in Morgantown, where I remained for 14 years, and where my substantive biography in ethics begins.

The Midlife Transition

The transition from early adult life, where the focus is on establishing a career and rearing children, to middle adult life is so critically important as to deserve its own heading. This discussion will prove to be the longest in this memoir, for reasons I expect you will come to understand. The midlife transition is a time when serious personal introspection and reflection on life come to the fore. This has been understood by thoughtful observers for centuries. Aristotle has been noted as suggesting that a human could not really begin to think about ethics until approximately age 40, due to a lack of significant enough life experiences. Michel Montaigne, the French philosopher, “lost his bearings in midlife and was reborn.” It was in “midlife” that Cervantes’ Don Quixote abandoned his routine and began searching for chivalric adventure. Dante identified himself as lost in the woods “midway on life’s path.” Levinson identifies age 40-45 as the approximate time of this transition to middle adulthood.

I can identify age 38 (1980) as the year my midlife transition began. Professional and family life had settled somewhat and I began to more seriously and critically consider life assumptions that I had held through early adulthood. The precipitating event was a sabbatical I was able to arrange in order to conduct educational research in The Netherlands, research supported by an NIH Fogarty International Fellowship. The family was off to Holland for an extended period—our first trip to Europe. My host at the University of Nijmegen, Dr. A. J. M. (Fons) Plasschaert, became a dear colleague, and today is one of my closest friends. What an awakening it was for a kid from the Appalachian foothills of eastern Kentucky to encounter the culture of the Dutch. They did things differently! As I am sure happens with many individuals, once having had the opportunity to travel internationally—the mind is opened to new possibilities, and to a challenging of former assumptions—ideas about life and culture that had just been taken for granted. It happened to me. That sabbatical experience launched my midlife transition. I returned to the United States with a renewed determination to better understand human nature, and my place in the “great chain of being.”

Shortly after my return from Holland in the Autumn of 1980, I commented to our educational psychologist at West Virginia University, Dr. Jack Hutton, that I was puzzled by an observation I was making about some of our graduates. A couple of individuals who had been outstanding students, gifted intellectually and clinically, were developing reputations in practice that would characterize them as charlatans. Yet some of our graduates who had struggled, one taking more than the customary four years to complete the curriculum, were developing excellent reputations as clinicians and becoming leaders in the profession. Probably somewhat startled by what he

perceived as my naiveté, he commented that such was not a surprise as there was empirical evidence—to which he referred me—that clinical performance among health professionals is most closely correlated with the trait of integrity—not with intellect or learned skill. As I was committed to educating “good” dentists, I began to understand, in a new and more profound sense, that learning biomedical and clinical dental science and being skillful in clinical techniques are necessary but not sufficient conditions, for being a “good” dentist. Thus my interest in professional ethics in dentistry was sparked.

In the summer of 1982, Dean W. Robert Biddington, always a kind and encouraging supporter of my professional development, generously funded my participation in a weeklong workshop at Colorado College in Colorado Springs entitled Professional Ethics, sponsored by the Hastings Center, a major United States bioethics think tank. Following my sabbatical, it continued my life-changing experiences. Ironically, it also happened to be the summer I turned 40! There I would meet individuals whose insights would further the process of transforming my thinking. The first evening, at a wine and cheese social, I met the former director of campus ministries for the United Methodist Church. During our conversation I told him of my religious background, including the theological questions with which I had been struggling. He suggested that on my return home I should read the writings of the theologian/philosopher Paul Tillich. I did—I consumed Tillich. He changed my entire orientation to theology and religion. And, the change derived from a chance meeting! Speakers at the workshop included individuals

who would later become colleagues, so helpful in my thinking about ethics: Dr. Daniel Clousser, who had the distinction of being the first philosopher appointed to a medical school faculty in the United States, and who also established the Department of Humanities at the University of Pennsylvania School of Medicine; Dr. Bernard Gert, professor of philosophy at Dartmouth College, author of the book, *Morality: A New Justification of the Moral Rules*, whose paradigm for thinking about moral behavior I still use in the dental ethics courses I teach; and William May, whose article “Code, Covenant, Contract or Philanthropy” was required reading for the workshop. While May was a challenging read, he deepened my understanding and appreciation of the sociological concept of profession, as well as what it means to be a learned professional. Understanding dentistry as a classical learned profession has permeated my thought, speaking, teaching, and writing ever since.

Permit me a note of sentimentality. The Colorado Springs workshop began on the evening of July 4th, Independence Day. That afternoon, while waiting for the initial session, I visited a local mall and happened to purchase a relatively inexpensive watch. After wearing the watch for many years, it took on the status of a valued memento of my inaugural professional development experience in ethics. I finally had it engraved to reflect the new found intellectual independence I gained beginning July 4th, 1982 at Colorado College. It is on my wrist as I type. Yes, I know—I am a romantic!

I was serving as an officer of the Supreme Chapter of Omicron Kappa Upsilon (OKU) in 1982-83. I suggested, and the Executive Committee agreed, that we promote the concept of human values and ethics education in dentistry by conducting a symposium at the American Association of Dental Schools

(now the American Dental Education Association) annual session in March 1983. My new found colleagues, Dan Clousser, Bernie Gert, and William May, all agreed to speak at the symposium entitled, “Human Values and Ethics Education in Dentistry.”

In the summer of 1983, I had the privilege of attending a second major weeklong workshop on ethics—Georgetown University’s annual Intensive Bioethics Workshop. Whereas the Colorado College program had focused specifically on professional ethics, the Georgetown workshop expanded my horizon by broadly dealing with issues of bioethics. There I sat at the feet of such notable bioethicists as Dr. Edmund Pellegrino, Dr. Tristram Engelhardt, Dr. Robert Veatch, Dr. Tom Beauchamp, and Dr. Laurence McCullough.

In 1984, OKU again sponsored a symposium at the AADA annual session, this time with the title, “Professional Ethics in Dental Medicine.” Guest speakers were individuals I had met the previous summer at Georgetown—note a pattern here! Drs. Engelhardt, Veatch, Beauchamp, and McCullough all participated. Their addresses were subsequently published in a special issue on ethics in the *Journal of Dental Education* in April 1985.

Probably as a result of my role in organizing ethics programs for OKU, though I never knew for sure, I was invited to write an article on professional ethics in dentistry for a new journal on health care that Case Western Reserve University was launching. I accepted, and my first article on professional ethics, “Professional Ethics in Dental Medicine,” was published in 1984, in the second issue of *Health Matrix*. The

Learning biomedical and clinical dental science and being skillful in clinical techniques are necessary but not sufficient conditions, for being a ‘good’ dentist.

article was dedicated to the memory of Dr. Wesley Young, my University of Kentucky community dentistry professor. I elaborated on that initial article on ethics by writing a more complete critique of the American Dental Association's *Principles of Ethics and Code of Professional Conduct* that was published in the *Journal of the American Dental Association* in October 1984.

When I returned from sabbatical in Holland in 1980, I had enrolled in a doctoral program in higher education administration at West Virginia University, where I was teaching. I concluded my studies and research and was awarded the degree in 1984. In retrospect, I believe I completed my "midlife transition" that year, and at age 42 entered full middle adulthood—autumn. Harvest time.

Middle Adulthood: AUTUMN

Activities in the midlife transition had not only resulted in an expansion of my intellectual horizon, but also my professional one. In the autumn of 1986, I was asked to interview for the deanship at my alma mater, the University of Kentucky. In March 1987, I assumed that position and remained in it for ten years, until 1997 when I returned to my customary role as a professor of pediatric dentistry. Being the dean of a college of dentistry offered numerous challenges; however, it also afforded many opportunities. Among the opportunities was being able to develop a curriculum in

professional ethics for student dentists. In 1990, I began phasing in a multiyear professional ethics curriculum of approximately 48 clock hours in length. The curriculum's goals and content were described in a 1996 issue of the *Journal of the American College of Dentists*. While adjustments have been made over the past 21 years, the essential elements of the curriculum are still intact. I remain the course director and instructor for the courses. In 1997, I began offering the curriculum in a modified fashion as a correspondence course for members of the profession through the Kentucky's continuing dental education program.

To deal with the increasingly complex ethical issues associated with hospital-based care, hospital ethics committees began to emerge in the early 1980s. In 1994, the director of the University of Kentucky Hospital realized that the UK hospital needed to establish such a committee. He was a close working colleague and aware of the College of Dentistry's comprehensive professional ethics curriculum. He asked if I would establish the committee and chair it. From 1994 until I stepped down from the chair's position in 2005, my understanding of bioethics and the issues of intensive care and end-of-life issues grew significantly. It was intellectually challenging to develop new hospital policies related to ethics, and emotionally difficult to manage complex case consultations on a regular basis. Teaching grand rounds and seminars for hospital staff came a little easier, as I was, and am, primarily a teacher.

Healthcare reform became an issue in the early 1990s with the election of William Jefferson Clinton as the President. Advocacy for access to health care, including basic oral health care, is grounded in moral argument—an

argument for social justice. I had the opportunity to speak and write on justice and health care during this period. The theme of access to oral health care would reemerge vigorously in 2000 as a result of the *Surgeon General's Report, Oral Health in America*. That report documented (among other issues) the disparities and inequities in oral health, and access to oral health care, between the economically advantaged and the economically disadvantaged. Since the appearance of the *Surgeon General's Report*, I have focused much of my energy on advancing moral arguments for expanding the dental workforce to help improve access to care, specifically for our most vulnerable population, our children. The change model for which I have advocated is the school dental nurse, now designated a dental therapist, who has cared for the children of New Zealand since 1921.

I had been grappling with the nature of human existence all of these years—as well as issues of ethics; actually intimately and integrally related concepts. As the issue of human nature had first arisen in a philosophy course, I determined to formally revisit philosophy. In 1990, I began enrolling in philosophy classes regularly on our campus—sometimes for credit, other times only auditing.

In 1995, through an announcement in the *Chronicle of Higher Education*, I became aware of a six-week National Endowment for the Humanities/National Science Foundation workshop at Dartmouth College entitled "Integrating Human Nature and Human Nurture." I

applied, and no doubt as a result of the gracious and generous comments of one of my University of Kentucky philosophy professors was one of the 25 fortunate individuals selected to participate. What an experience it was! We were taught by some of the nation's truly outstanding biologists, primatologists, psychologists, philosophers, neuroscientists, and anthropologists, who had been recruited as guest lecturers. Finally, answers, or if not answers, avenues to answers for my many questions about existence as a homo sapiens were emerging. Research in the field of evolutionary psychology has burgeoned in the past 30 years, enabling us to effectively grapple with the biological origins of our humanity. A requirement for participating in the workshop was that individuals return to their respective universities and develop teaching materials on the subject. The course I developed has been offered through the Department of Behavioral Science of our College of Medicine, and is entitled Evolutionary Biology and Human Behavior.

In June 2010, I attempted to address, in writing, the issue of human nature—the question that had remained with me since college. I published an article in the *Journal of Dental Education* entitled, “Ethics, Empathy, and the Education of Dentists.” The article was my attempt to unite my understanding of human nature and ethics, and appropriate that understanding to the task of educating the “good” dentist, the original goal I had when I first became intrigued with ethics and dentistry 30 years previously. I had come full circle.

LATE ADULTHOOD: WINTER

According to Professor Levinson, I have already passed the late adult transition, and, approaching 70 years of age, am

well established in late adulthood—winter. Unfortunately, the research of Daniel Levinson on the human life cycle was cut short by his untimely death. His research extended only through middle adulthood, the autumn of life. He did speculate that late adulthood was a period of helping foster adult development in others, of being a mentor. I suspect that my colleague Dave Chambers had such an intention in mind in asking for reflections on one's life pursuing an understanding of ethics.

MOVING FORWARD

Erik Erikson, referenced earlier, characterized life as existing in “eight ages.” The polarities of the psychosocial tasks of his last “age” of life are “integrity versus despair.” Can individuals review their lives as ones in which they actualized their potential—were able to be all they could be—to use Abraham Maslow's expression. Or, must they acknowledge that their lives had been ones of missed opportunities or unrealized potential.

In the introductory professional ethics course I teach to student dentists, one session is entitled “The Ethics of Aspiration.” I spend two hours with our first-year students reviewing the perspectives of philosophers and psychologists, both ancient and contemporary, who have addressed the topic of the well-lived life. In the winter of one's life, one can profoundly hope to be a mentor. ■

Since the *Surgeon General's Report* appearance, I have focused much of my energy on advancing moral arguments for expanding the dental workforce to help improve access to care, specifically for our most vulnerable population, our children.

THE DYNAMISM OF PROFESSIONAL AND BUSINESS IDENTITIES

Martin R. Gillis, DDS, MAEd

ABSTRACT

Dr. Martin Gillis, a practitioner in Nova Scotia, was worried about the intrusion of commercial values in dentistry. Rather than complain, he sought advanced training in medical education, focusing on methods for revealing the practical influences of the school and practice environments on value formation. Today he teaches part-time and serves as an oral health liaison for diabetes with the International Diabetes Federation, in addition to his practice. He shares his thoughts about the issues facing the profession being similar to those in play more than 100 years ago and how our character is shaped by the way we choose to respond to economic pressures.

I graduated from dental school in 1991, a product of Dalhousie University's Faculty of Dentistry and green as the grass in the world of professional dental practice. After four years of dental school, I could not wait for my professional career to begin in the "real world of dentistry," putting into practice what my professors and instructors taught me as a student.

As time went by I became increasingly aware of the profound influence industry has on our profession. There were the monthly visits to my office by various industry representatives displaying an unending array of improved products for patient care and new technologies which would revolutionize my practice, placing me shoulder to shoulder with all the progressive-minded dentists of the day. This was the advent of aesthetic dentistry, the beginning of the age of the extreme makeover, where vital bleaching and porcelain veneers ruled the day. Each day in the mail there were countless flyers, brochures, industry sponsored publications pushing product, offering rebates and rewards, patient testimonials preaching how their porcelain smile changed their lives, and continuing dental education cruises where one could transform the practice while getting a tan. This was a whole new world, far removed from the principles of patient care I received in my education at dental school. This new world did not feel right.

I think the issue of industry influence on our profession was for me the core of the ideological debate regarding

dentistry's identity as a business or a profession. My unease with dental industry was similar to the uncomfortable feeling I had towards dentists marketing to patients, but I felt industry marketing to dentists posed a greater threat to our profession. While advertising to patients was largely considered taboo by most in our profession, it seemed the insidious tactics used by industry went largely unnoticed and in time became an accepted part of dentistry. From the day I graduated until the financial crisis almost two decades later, dentistry rode the wave of economic growth during these market-friendly days. When the bubble burst in September 2008, world economies changed, prosperity turned to hardship, and in dentistry, the pendulum began to swing away from the market-driven philosophy. The focus was returning to the importance of preventing and treating oral disease because there was not much to smile about.

GRADUATE STUDIES

In the years following graduation I became increasingly involved in organized dentistry. Through my provincial dental association I helped develop the Nova Scotia Dental Association's policy



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on corporate sponsorship. In 2003 I returned to Dalhousie as a part-time clinical instructor teaching third- and fourth-year students. I enjoyed both endeavors, but I needed to take a step back from association activities in 2005 when I began graduate studies in education. I enjoyed teaching, but I felt that because I had no formalized training in education, being a dentist was not good enough for me to give the students the educational experience they deserved. I was flying by the seat of my pants, delivering curriculum without having any idea about curriculum theory, design, or delivery. So in September 2005, I began part-time graduate work in curriculum studies at the Department of Medical Education in Dalhousie's Faculty of Medicine.

I initially pursued the course-based master's degree, but during a research seminar on qualitative methods it occurred to me that I could finally get some answers about industry's influence on the dental profession by undertaking a thesis. When looking back, one tends to forget the time and effort put into developing the research question, the thesis proposal, the interviews, the transcription, the data analysis, writing the thesis, the thesis defense, and condensing the thesis into a journal article (Gillis & McNally, 2010), all this while maintaining a full-time dental practice. I was passionate about this topic because without passion there would not be the drive to bring it to completion. I also owed much to my thesis committee,

Drs. Mary McNally, Bill MacInnis, and Joe Murphy, and my family for their great support along the way.

One of the tasks in undertaking any thesis is to develop a solid knowledge base in order to use appropriate methods to provide answers to the research question. I chose qualitative research, using grounded theory methodology to pursue the themes associated with industry influence on dental education. In order to have some perspective of the issues surrounding this topic, a comprehensive literature review was done. In this case it was important to know the history of the dental profession in Nova Scotia and of dental education at Dalhousie, and also to have an appreciation of the broad elements of curriculum theory.

I applaud Dr. Oscar Sykora for completing an exploration of the early days of the dental profession in Atlantic Canada with his book *Maritime Dental College and Dalhousie Faculty of Dentistry: A History*. Dr. Sykora provided a detailed picture of the struggles faced by dentists in the late nineteenth and early twentieth century to organize the practice of dentistry into a regulated profession and to formalize and advance the standard of care by establishing professional dental education. Learning our history made me appreciate how great accomplishments can be achieved when there is the collective will and the effort to advance one's profession. We shape the profession that influences us.

Ethics is a part of the formal curriculum, but it is also an aspect of dental education which is open to many unplanned curricular experiences via the hidden curriculum.

The theme of style versus health may be the principal driver in how the public views our profession because of media's influence in branding the smile as the iconic image of dentistry.

To gain an understanding of curriculum it was important to understand the psychosocial aspects that underlie the culture of the institution that delivers this curriculum. I realized that it is not so much the formalized curriculum, but the unarticulated hidden curriculum that has profound influence on the educational experience of students and the development of professional identity. Professional dental education is an enculturation process whereby one is transformed from a layman into a professional. This is not a mystical process but one that is accomplished through the formal and informal curricula. Ethics is a part of the formal curriculum, but it is also an aspect of dental education that is open to many unplanned curricular experiences via the hidden curriculum. It is important to create positive educational experiences that allow students to respond appropriately to the pressures and influences surrounding dental practice. This enables students to develop an ethical awareness and ability to critically evaluate the issues that face our profession. This is vital to upholding the integrity of dentistry without violating the social contract with the public we serve. We must always place the needs of our patients ahead of business interests—a difficult challenge we face daily to be financially viable in order to offer the best possible care for our patients.

It is important not to underestimate the power of the hidden curriculum because it transcends undergraduate and graduate studies into the realm of professional development and continuing dental education. Arguably, the hidden curriculum is more prevalent outside the walls of academe because of the multitude of continuing dental education courses taught in non-academic settings, free from the checks and balances of

academic policy and regulation found in dental schools. This is why importance must be given to developing critical thinking skills via courses teaching evidence-based dentistry. Such a rationale should also extend to the ethics curriculum in order to challenge students to think critically about the issues that face dentistry and shape the public's perception about our profession.

The American philosopher Robert Pirsig stated "The only Zen you can find on the tops of mountains is the Zen you bring up there." Ethics is a competency that can be developed during our educational experiences in dental school and throughout our careers. I think we all have within us the ability to develop and grow the traits and qualities consistent with the ethics and morals of our profession.

IS HISTORY REPEATING ITSELF AGAIN?

Recently the Canadian Dental Association's Branding Working Group reported some worrisome findings of a survey in which dentists and the general public were asked about their perceptions of the dental profession and oral health (www.cdaadc.ca/en/members/patient_communications/research). Some of the growing perceptions are: the public does not trust dentists as oral healthcare leaders; dentists are viewed as business people and not as doctors; the cosmetic aspect of dentistry raises doubts about the value of dentistry and the motives of dentists; dentistry is viewed as a commercial service and not as a health care service; and dental insurance coverage takes priority over the recommendations and advice of a dentist.

I am disappointed but not surprised by society's current view of the dental profession. This point of view could be expected based on the influence of industry on our profession. The theme of style versus health may be the principal driver in how the public views our profession because of media's influence

in branding the smile as the iconic image of dentistry. Elective cosmetic dentistry motivated by market forces takes attention away from the prevention and treatment of oral disease. Public messaging focused on the aesthetic has created public expectations directing dentistry toward the realm of commercial enterprise and away from its place as a healthcare profession.

The place dentistry finds itself today parallels the position in which dentistry found itself in during the late nineteenth century. At that time dental care was largely performed by itinerant dentists, glorified snake oil salesmen, traveling from town to town “treating” and selling their wares to an unsuspecting public. In the province of Nova Scotia, dentists were beginning to receive professional training in American schools such as the Philadelphia Dental College and the Baltimore College of Dental Surgery with curricula that focused as much on the science as on the art of dentistry. Dentists who returned to Nova Scotia to practice saw the need to protect the public from the harm inflicted by the untrained practitioners whose motives were driven by financial gain, not public service.

The passage of the Dental Act in 1891 and the incorporation of the Provincial Board of Dental Examiners began the regulation of dentistry in Nova Scotia and barred the door to practice by charlatans who preyed upon the public. The first president of the board, Dr. Alfred Chipman Cogswell addressed the annual meeting of the Nova Scotia Dental Association in 1891 on the topic of ethics. The message he delivered 120 years ago has equal relevance today. He spoke of ethics as the “science of moral duty” and explained that it is our con-

science that guides us in our profession and enables us to “live up to the moral teachings and principles of moral duty.” Cogswell described ethics as the conscience elements of “honesty, fair dealing, patience, kindness, unselfishness, sincerity, and loyalty to duty.” He described the dentists who practices contrary to ethical duty as those who “cast aside all the decencies and ethics of professional life, exclude themselves from membership in respectable societies, and fasten the stigma of quack to their reputation, trusting to the gullibility of the public for what they call success.”

Sykora (1991) noted that the creation and regulation of organized dentistry in the late nineteenth century could not stand as the basis of the profession. It was the formation of a school of higher dental learning that became the real basis for the dental profession. This was achieved in Atlantic Canada in 1912 with the convocation of the first graduating class from Dalhousie’s Faculty of Dentistry. History may be repeating itself because it will require professional associations to work in concert with academe to right the ship of public perception. The three guiding principles uncovered as ways to offset industry influence on dental education: health over style, evidence over anecdote, and public interest above profit, could serve as a starting point to facilitate change.

PRAXIS

You never know where the road will take you. For the past few years I have been the dental representative for the International Diabetes Federation (IDF). My role has been to assist in the development of educational resources for dissemination to multiple audiences and to facilitate partnerships with other organizations (FDI World Dental Federation and the National Diabetes Education Program) to connect oral disease and diabetes. Finding sustained funding is one of the primary concerns

facing nongovernmental organizations such as IDF and FDI to advance issues such as the relationship between oral disease and diabetes. Global federations have crowded agendas, making it difficult to devote funding to every worthy project. Often this creates the need to secure external funding from industry and philanthropic organizations or else risk shelving projects. Industry has provided valuable support with educational grants which have helped develop the diabetes-oral disease relationship and move this agenda forward. The risk in such endeavours is shared proprietorship and control of projects and the dependence of these initiatives on precarious industry sponsorship. The need is for solid funding from multiple sectors including industry, government, philanthropy, and the NGOs themselves. This will allow organizations to plan strategically for the future and pursue endeavours which are protected from financial insecurity.

In addition to the global financial crisis, 2008 saw the World Health Organization release its five-year action plan against noncommunicable disease (NCD) (WHO, 2008). The WHO identified cardiovascular disease, cancer, diabetes, and chronic respiratory disease as the NCDs which in 2005 accounted for 60% of all deaths globally, a number projected to increase to 77% by the year 2015. The UN high-level meeting on NCDs in September 2011 marks a watershed moment for addressing the international health crisis of NCDs. The NCD Alliance, led by the four global federations representing diabetes, heart disease, cancer, and respiratory disease is leading civil society action to help shape the final UN

political declaration. The four overarching actions of the outcomes document are: (a) leadership and international cooperation; (b) prevention; (c) treatment; and (d) monitoring, reporting, and accountability. Adoption of this action-oriented outcomes document by UN member states will commit nations to address the epidemic of NCDs.

How will oral diseases, the most common and the fourth most expensive NCD to treat (Hobdell et al, 2003), be positioned in plans for future action? The importance of oral disease as it relates to the broader NCD agenda can be found by addressing how improvements in oral health will be beneficial to the NCD partnership and ultimately society as a whole. Garcia and Tabak (2011) note that advances in oral health cannot be achieved in isolation from overall health; there needs to be a comprehensive view whereby oral health is integrated within the broader view of general health. They state that oral health needs to “be at the table” to harness the intellectual and financial resources from multiple sectors and “once at the table” demonstrate the skills of the oral health community to help solve global health problems.

The call to action to fight NCDs is a unique opportunity for the dental profession to take steps to renew our public image and regain the trust which has been lost during the times of market-driven dentistry. We are leaving an era

of cosmetic-oriented, elective dentistry and entering an era dominated by dental public health in the fight against oral disease. There is a difference between taking ethical responsibility for what dentists do personally in their offices and the higher sense of being ethical by assuming leadership for the health of patients and all those with oral disease.

Conclusion

Today we face similar concerns to those our profession faced over a century ago. The economic boom that promoted a market philosophy in the dental profession may have created serious cracks in the public's perception of our professional integrity. Now, with global fiscal restraint due to changing world economies and the global epidemic of oral disease, there is renewed interest in the cornerstones of dentistry, the prevention and treatment of oral disease, and an opportunity to restore public confidence in the dental profession. In the late nineteenth century dentists rose to the challenge of dealing with the issues that undermined the public's trust. Now, in the twenty-first century, we need to take action again.

The obstacles and issues we encounter in our profession will not fix themselves. If there is concern about the events and circumstances that surround you, address them the best way you possibly can. In my case, I felt graduate studies would give me a broader knowledge base in order to improve my understanding of the position of dentistry in society and how our profession could deal with external influences such as industry. This track may not be for everyone, but I feel it is within everyone to advance our profession for the benefit of dentistry and the public we serve. We cannot

expect to keep our fingers crossed and hope things will work out for the best. It is a dangerous approach to just let things happen without control and thus risking uncertain outcomes. We must make things happen and guide our profession back to its previous status, remove the disconnect we currently face with society and restore diminished public confidence. In the words of A. C. Cogswell, “Leave your ‘footprints on the sands of time’ that others following may be encouraged to press on.”

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COMBINING PRACTICE WITH ETHICS

Kevin I. Reid, DMD, MS, MA, FACD

ABSTRACT

As a dentist at the Mayo Clinic in Rochester, Minnesota, the author has found it easy and rewarding to combine specialty care in orofacial pain with ethics training for complex case management

I trace my interest in ethics and philosophy to my graduate work in clinical psychology. This interest was encouraged even further by a professor at the University of Kentucky, College of Dentistry.

I completed five years of formal training in orofacial pain, the last three of which were in pain research at the National Institutes of Health. My intent was to establish a career not only as a clinician but also as a clinical researcher. But my career became weighted heavily in clinical care, and I began to realize that my ability to engage in the scholarly work of experimental pain research was not likely to come to fruition. For that reason, I elected to pursue a graduate degree in biomedical ethics for the purposes of focusing my scholarly efforts on the ethics of orofacial pain diagnosis and treatment. In addition to my graduate degree in biomedical ethics (MA), I have consistently read the ethics literature and have attended the intensive bioethics course at Georgetown University at the Joseph P. and Rose F. Kennedy Institute of Ethics. Other mechanisms of informing my interest in biomedical ethics have included participating in several committees at Mayo Clinic including the Ethics Council and the Clinical Ethics Service.

My graduate degree in ethics was completed at the Medical College of Wisconsin. The majority of it was

Web-based, although I did spend time on campus in seminars. It was incredibly stimulating. The coursework encompassed a broad range of ethics topics from the philosophy of bioethics to ethical issues in the end of life. My final paper was an ethical analysis of diagnosis and treatment of temporomandibular disorders.

From my perspective, one of the most profound issues that has come to influence the practice of dentistry, and other healthcare professions, is the drift from a healthcare ethic to a business ethic. My concern, which is particularly in the area of orofacial pain and temporomandibular disorders, is that practice is often unnecessarily aggressive, invasive, and expensive, and sometimes runs counter to contemporary scientific literature. I am interested in how the primacy of patient welfare may be subjugated to the primacy of dentist profit.

With training in several fields, it is a challenge for me to keep up with the literature. But this is one duty I embrace through reading and continuing education work. It is an ethic of any profession. This has been done primarily through my research and reading, though my



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From my perspective, one of the most profound issues that has come to influence the practice of dentistry, and other healthcare professions, is the drift from a healthcare ethic to a business ethic.

graduate training and exposure to ethics from many perspectives has had a profound influence on my practice. I am committed to the concept of honoring patient autonomy and am dedicated to my role in terms of facilitating that autonomy, particularly when it comes to treating patients with chronic pain.

The study of ethics has made me a much more contemplative person with respect to my influence on my patients, most of whom are quite vulnerable. My understanding of the profoundly important issues of nonmaleficence from a broad perspective and respect for patient autonomy has become the guiding focus of my daily work when it comes to interacting with patients. It has also opened a broad horizon of intellectual stimulation for me, for which I am very thankful. In addition, I have become exposed to a wide range of biomedical ethics issues and activities, the opportunities of which would have never arisen had I not pursued this education. For example, I am the chair of the Transplant Ethics Committee at Mayo Clinic Rochester; I am a member of the Ethics Council; I am an executive member of the Program in Professionalism in Bioethics at Mayo Clinic Rochester; and I teach in the medical school ethics curriculum.

I believe that enhancing professionalism fundamentally requires a commitment to teaching ethics in an interesting and provocative way in undergraduate dental schools. Dental training is so technically focused and is so condensed that attention to the important issues that are germane to ethics and dentistry are often subjugated to the technical training. It is crucial that dental school faculty model ethical behaviors but this sort of modeling of course is not always available for students nor is it uniformly apparent in the dental school environment. In addition, I believe that we should make efforts to create more ethics conferences and congresses and that a dedicated journal to address ethical issues in dentistry would be beneficial.



My Life AS A DENTIST AND ETHICIST

AN EXPERIMENT IN CREATIVE NONFICTION

K. K. Quick, DDS, PhD

ABSTRACT

In a certain sense, we become the synthesis of our life experiences, and our professional identity is woven into a personal life story. A dentist with a PhD in Health Services Research and Policy who teaches clinical dentistry and ethics reflects on some of the moments that have combined to make her who she is.

VERACITY AND THE PEAS

I was ten, maybe eleven... sometimes you learn from the experiences of others. Eating vegetables was big at our house, but not a problem for me. I was a weird kid, loving veggies, hating chocolate and peanut butter. My brother, on the other hand... chicken nuggets, hot dogs, candy bars... he was another story. Peas: no way. Once he was left with a plateful at the table (not the first kid to have this experience). Mom and I cleaned the kitchen, loaded the dishwasher, and wiped down the counters, and there my brother sat—staring at those peas. It was amazing how long he could sit there. In my memory, it was at least half an hour, maybe even longer.

Eventually my brother came smiling into the family room. “I’m done!” he says. The plate was clean. He set it next to the sink. Not a pea in sight. Secretly, I was impressed. He really hated peas. Mom went into the kitchen to add Brother Tom’s plate to the dishwasher and in the course of this activity—emptying the garbage or something—several peas were discovered on the floor. He missed the bin. Busted—was he ever. That was trouble (with a capital T) alright, but not for failing to consume those little green balls. He was in trouble for lying about it. The lesson was veracity.

Ethics, right, wrong—it is something we learn as kids, from our families, right? Is every family like mine? Probably not.

Maybe we can learn it in school, on the playground, from teachers. The fact is we learn it from many places—churches, synagogues, mosques, temples. We went to Sunday school, youth group, and Fellowship for Christian Athletes, I have no idea if that even exists anymore, and certainly I have grown to know that one need not be Christian to act ethically in the world.

In the eleventh grade, I wrote my research paper (the one you write for that course that is supposed to teach you how to succeed in college) on euthanasia and the Holocaust. I made lots and lots of note cards. I read Elie Wiesel (that wasn’t even mandatory reading back then).

DISCLOSURE AND THE FAMILY BUSINESS

At this point, I would be lying if I said dentistry was not in the picture. Full disclosure: My father is a dentist and my brother (the kid who hates peas but today is an outstanding professional), is also a dentist. My father was an amazing professional (retired about five years ago). I didn’t realize how amazing until I went to dental school, until I found a job, until I got into academia. For all the summers, all the emergency after-hours dental visits I worked with him assisting, I really did not get what he was doing. There was the technical piece. There was



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the business piece. But it was the human piece—the piece that was about relationships and people—that was (and is) so amazing.

How many people do you know who when asked about why they chose to be a dentist say, “I want to help people”? How cliché is that? How necessary is that?

ENVIRONMENTAL FACTORS AND A LIBERAL EDUCATION

Fast forward a bit—in college now. My biology professor is requiring a research paper of some sort. I could write about bacteria designed to clean up oil spills, a new species of fungi, or the reproductive habits of bees. I decided on war—more specifically biochemical war strategies and what that could do to our environment. I wrote about napalm (they used it during the Vietnam War to take out jungles). Napalm turns out to be a nasty carcinogen, and the repercussions of this chemical are still being felt.

The next year, the topic was recombinant DNA and the human genome. This is probably going to date me a bit, but this was early human genome project or maybe even before. I thought I wanted to be a geneticist—stem cells, embryonic development, all of that. There were too many questions. I guess I was not going to be a geneticist. Still, I liked thinking about all of the issues and conflicts.

I took all the pre-med courses and a lot of English literature and writing. I traveled to Japan. I found Kobo Abe, one

of Japan's great literary talents. I read *Secret Rendezvous*. It is a story of a husband whose wife is taken away in an ambulance that was not called for. He follows the ambulance to a huge underground hospital and begins a very strange search for his wife. The husband's interaction with medicine and systems raises many questions of ethics, progress, and science. I wanted to write like Abe.

THAT WHICH WAS DENTAL EDUCATION

Then there was dentistry. It was something I knew about. I could make things with my hands. After all, I did make that tiny knitting basket for my dollhouse by knitting on toothpicks. Surely I had the hand skills. I liked people. My dad loved dentistry. Looked good to me.

That is where I found myself. Cutting preps. Waxing crowns. Talking to classmates who wondered why I cared about bioethics and did not just focus on the practice I would have one day. They taught us ethics and professionalism. There is no “right” answer, but there are the good, the better, and the best.

I finished dental school. I got a job—actually a couple, two or three.

There was no time for writing.

FINDING A MENTOR

I sampled some grad school courses while working. I met Art Caplan in one of his bioethics courses. We talked ethics. We talked career. I was not going to be an epidemiologist or a philosopher. Law was an option, but I would have to take out yet another loan. “You need to interact with people.” That is what I heard Art say. And indeed, I do.

I began my journey to a PhD in Health Services Research and Policy. I learned to do research. Economics, sociology, psychology all seemed mushy

compared to the chemistry I studied in undergrad. I learned econometrics. I learned policy. I earned a grad minor in bioethics and wrote about reproduction and genetics. They needed people who could communicate science to regular folks. I could do that. Not like Art, but I could do that.

I kept seeing patients. I collected data. I analyzed. I wrote. I finished. In the end my thesis was about decision-making (something I wasn't particularly good at, but I thought it was essential to the practice of both medicine and dentistry).

I connected with some writers and started in fiction.

WHO AM I?

I am a dentist with a PhD in Health Services Research and Policy and a minor in bioethics. I am a clinical group leader in a dental school. I teach comprehensive care dentistry, and I teach ethics to dental students.

HOW DO I DO THAT?

I share what I know, the years of helping my dad, the years of being a student, and the years of treating patients. There is always a story. There is always something to learn. My students know this. If it is not my story, it is someone else's. It is theirs. We share our experiences, and I learn from my students as much as they learn from me and from each other. I hope they will carry it forward into their practices and into our profession.

I write short-short fiction. It is a skill that comes in handy in ethics. Writing scenarios is a breeze, and that is what starts all the discussions. There is always a story, and this is mine. ■

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THE CHALLENGES OF ORAL-BASED DIAGNOSTICS IN EXTENDING THE ROLE OF DENTISTRY AS A HEALTH CARE PROFESSION

PROPERTY RIGHTS, PRIVACY, AND INFORMED CONSENT

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ABSTRACT

Saliva may be a legal and ethical counterpart of other bodily fluids in diagnostic testing to blood and urine, with regard to its role in diagnostic testing. Two paradigms that have been proposed in the literature to address these challenges are reviewed in this paper. The first is centered on ownership and property rights to saliva, including financial compensation from commercially developed products using saliva. The commodification of saliva as property is also discussed. The second paradigm is related to privacy and the potential for genetic discrimination, given the unwarranted disclosure of confidential information. The management of saliva specimens from dental patients and research participants will also require the implementation of innovative approaches to obtain informed consent.

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Advances in the use of rapid diagnostic testing with oral samples (saliva, oral mucosal transudate, and buccal brushings, for example) have led to the identification of a wide array of pathogens, gene products/mutations, and other biomarkers. An increasing amount of data is thus becoming available at the point of care. Many research groups are developing oral-based tests with high sensitivity and specificity for diagnosis of both oral and systemic diseases (Park, et al, 2009; Xiao & Wong, 2011). These currently include (but are not limited to): caries; periodontal diseases; infectious diseases, such as HIV, HPV, HCV, tuberculosis, malaria, and schistosomiasis; diabetes mellitus; breast and pancreatic



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Concerns about privacy do not necessarily lead to the acceptance of a property paradigm.

cancer; chronic obstructive pulmonary disease; and acute myocardial infarction.

Greenberg and colleagues (2010) have reported that dentists consider medical screening of patients important and are willing to incorporate it into their practices. These advances will reshape dental health care delivery and thereby dramatically redefine the future role of the dental healthcare practitioner.

Another application into which the biotechnology industry has poured large investments involves decoding the DNA obtained from a submitted "spit kit" to assess a person's genetic risk for a wide range of diseases (www.navigenics.com). This industry has ushered in the era of retail genomics. By providing saliva in a vial, customers are becoming early adopters of personalized medicine, with therapy potentially tailored to individual diagnoses.

Preliminary results from oral fluid screening tests in a dental setting will likely lead to more referrals and follow-up of patients to physicians and nurse practitioners for confirmative diagnosis and treatment and will further align dentistry and medicine in the provision of healthcare and the promotion of public health. However, challenging ethical and legal issues will be raised related to patient care and research that depart from the traditional scope of dentistry. Who will be conducting these tests? Who will properly counsel subjects on such testing, including the correct interpretation of the test results and referrals of patients to physicians and other allied health care professions for further evaluation and treatment? If the dental professional assumes such a role, then he or she must be properly trained not only to educate patients about their results from screening tests but also to act as the liaison between patients and other healthcare professionals.

Misinterpretation of test results is likely without proper counseling and education of patients (Matloff & Caplan, 2008). Furthermore, any salivary test can easily lead to patient home testing.

Saliva has unique advantages in comparison to blood as a diagnostic fluid. It is noninvasive, safe, requires no phlebotomist, can be self-collected, and is excellent for field studies, particularly for special populations at both ends of the life spectrum (pediatric, geriatric). Do we also need to establish different forms of consent from patients whose saliva is stored in biobanks for subsequent clinical care or research investigations? Procedures for obtaining routine informed consent in the dental practice setting must change with biobanking of saliva specimens. If there is ultimately a successful commercial product, identified initially as a biomarker in oral fluids through biotechnological advances in testing, then what rights does the donor have to the profits from that salivary specimen? Increasingly, forensic science is also relying on oral fluid samples for DNA analysis. Furthermore, salivary samples, unlike blood, are easy to obtain without the individual's knowing that he or she has actually donated a sample, for example, from a drinking glass, cigarette butt, or bite. How can safeguards be put in place to prevent unwarranted disclosure of confidential information? What are the challenges in obtaining these samples, storing them, and making them available for criminal documentation and evidence in court?

Blood and urine have been subjected to a large variety of diagnostic tests with associated ethical and legal considerations—a counterpart may now be found in saliva. If saliva is to fulfill a similar role, it should perhaps be granted those same protections (Vernillo & Wolpe, 2010). Two paradigms thus emerge from such testing of oral fluids. One is centered on ownership or property rights to a salivary specimen; the other focuses on

privacy rights, including consent and confidentiality.

THE PROPERTY PARADIGM

Even though oral fluid is not similar in its makeup to a tissue or solid organ, it can provide analogous types of information about individuals that courts and the general public deem worthy of protection, for example, in paternity determinations. Therefore, the same kinds of questions that are raised vis-à-vis tissues and body parts can also be raised regarding fluids such as saliva. Should a patient or research participant have the right to control what will be done with his or her oral fluid and to receive financial compensation when it is put to research, diagnostic, or therapeutic uses, as is the case for blood, tissues, and body parts? Does a person thus own his or her oral fluid? Do persons then have repatriation rights to their saliva sample in claiming financial compensation? If a research investigator interested in developing products from oral fluid analysis ensures that the research participant is adequately informed about the potential for a commercial market, does that also constitute adequate protection of the research participant's (or clinical patient's) legal and ethical rights?

A comprehensive discussion of the jurisprudence, legislation, and legal theory development in the area of property rights for human cells and tissues is beyond the scope of this paper. However, two landmark cases that raised issues related to personal biological materials law and property rights to one's tissues or cells, should briefly be mentioned: *Moore v. Regents of the University of California* (Menikoff, 2001) and *Hideaki Hagiwara v. Regents of the University of California* (Andrews, 1986).

MOORE V. REGENTS OF THE UNIVERSITY OF CALIFORNIA

In *Moore v. Regents of the University of California*, John Moore was treated for hairy cell leukemia by his physician, Dr. David W. Golde, at the University of California Los Angeles (UCLA) Medical Center. Test results revealed that Moore's cells would be useful for genetic research. Golde removed Moore's blood, bone marrow, spleen, and other tissues. Given the nature of Moore's leukemia, splenectomy was a necessary procedure. However, Golde did not inform Moore of his plans to use the cells for research. After Moore underwent surgery, Golde had falsely told Moore that he needed follow-up treatment and required further tests at the UCLA Medical Center. Over the next seven years, Golde took blood and tissue samples from Moore and retained Moore's spleen for research purposes without Moore's knowledge or consent. Golde patented a cell line using Moore's cells (human T lymphoblastic Mo cell line) from Moore's excised spleen. Golde received substantial royalties from licensing the technology, including cash and stock options. Moore learned of Golde's activities and sued in state court on 13 counts, including a claim for conversion, claiming that his blood, tissues, and cell line so developed for research purposes were his tangible personal property.

For a claim to conversion, Moore needed to establish an actual interference with his ownership or right of possession. Clearly, Moore had not expected to retain possession of his cells, so did Moore retain an ownership interest in them anyway? The court doubted such an interest existed. First, there was no precedent in support of Moore's claim. Second, California statutes drastically limit any continuing interest of a patient in excised cells/spleen by requiring that they be destroyed after use. Third, the subject matter of the patent that Golde had developed (i.e., the Mo cell line and

the technology and products derived from it) could not be Moore's property. However, the court did establish that a reasonable patient would want to know that his physician's professional judgment might be impaired by an independent economic interest. A cause of action can thus lie under the informed consent doctrine as a breach of fiduciary duty on the part of the physician to disclose material facts to his patient.

The Moore case did not address fluids or tissues that still remained a part of the body. What if an investigator collects saliva and finds a protein with an inhibitory activity against caries; purifies it; and ultimately develops a patent that produces an even more potent inhibitor than the original protein? The saliva, unlike the excised spleen, is still part of the body and still secretes that original protein. Does a patient or research participant therefore have repatriation rights to claim financial compensation from a stored specimen of oral fluid, particularly if the patented protein derived from it is commercially valuable? Furthermore, if an investigator discovers another valuable product from a patient's or research participant's saliva (the same stored specimen), then must separate and additional informed consent be obtained?

HAQIWARA V. REGENTS OF THE UNIVERSITY OF CALIFORNIA

Hideaki Hagiwara, a postdoctoral student in biology at the University of California San Diego, suggested to his faculty mentor that a human monoclonal antibody be made with cancer cells from Hagiwara's mother. Once the modified cell line had been created in the laboratory, Hagiwara felt that his family had an economic interest, because he had

In an age in which the market rules, the tendency to commodify any object that has commercial value is virtually irresistible.

proposed the project and his mother had provided the original cells. A settlement in the case was ultimately reached which gave the University of California the patent, and the Hagiwaras, an exclusive license for the cell line in Japan and Asia.

Although neither of these two cases appears to embrace the property paradigm, both are suggestive of an economic interest that the original donors of bodily tissues and cells retain, even if the monetary value of those tissues and cells only arises as a result of extensive manipulations by biomedical scientists. But the court in the *Moore* case sought to protect that economic interest indirectly by insisting on the donor's right to informed consent—which is suggestive of the privacy paradigm.

THE PRIVACY PARADIGM

Concerns about privacy do not necessarily lead to the acceptance of a property paradigm. The right to privacy of personal genetic information and safeguards against its unwarranted disclosure or manipulation of that information can in fact be separated from the proposed status of saliva as biological property and its attendant rights. Concerns about violation of privacy have emerged with advances in modern genetics. DNA is ubiquitous and contains the same information regardless of the source. Thus, human tissues, blood, and body fluids, including saliva, came to be recognized as storehouses of information about their respective donors. Obtaining this genetic information has been greatly facilitated through advances in modern biotechnology, and marketing and testing of blood and saliva are now widely available.

What safeguards could be implemented for biobanking oral fluid specimens to prevent unwarranted disclosure of confidential information or discrimination, e.g., genetic risk for a

disease? Nearly 30 years ago, Siegler (1982) commented prophetically that confidentiality is a decrepit concept, based upon the fact that psychiatrists tacitly acknowledged the impossibility of ensuring confidentiality of medical records by choosing to establish a separate, more secret record. That view has since been substantiated by advances in the field of information technology and computer based storage systems. Such systems contain personal information about donors and the retrieval systems required to access those data have also become increasingly complex. It is impossible to guarantee absolutely the security of private information (Perrow, 1999).

Breaches of confidentiality are more likely to occur when the storage technologies become more complex, rendering the protection of genetic privacy a much greater challenge. Meeting that challenge will require a much better understanding of why breaches of confidentiality occur and why it is virtually impossible to prevent them. Such an understanding, however, should lead to a better position from which to argue that certain technologies should be abandoned and that others, such as computer-based medical records systems (which cannot be abandoned because of their fundamental role in current society), should be modified.

Respect for a person's autonomy will require that clinicians and research investigators inform their patients or research participants, respectively of their rights to property and privacy regarding any body part, including oral fluid (Beauchamp & Childress, 2008). If a biomarker from a patient's oral fluid is financially compensable, then failure to adequately inform the person about a potential share in profits may represent

a violation of his or her property rights; it certainly represents a violation of the patient's right to informed consent. Even in the face of great biomedical and commercial interests, patients retain the right to control their persons, that is, to refuse participation in new biomedical developments by refusing the usage of their cells and tissues. Stored samples of tissues such as blood or oral fluids also involve an informational privacy interest because a person's genetic endowment and risks for certain diseases are expressed in his or her genes. When individuals voluntarily grant others some form of access to information about themselves, such as their genetic profile, or decline such access, that act is an exercise of the right to privacy, not a waiver of that right.

REVISITING PROPERTY RIGHTS

In an age in which the market rules, the tendency to commodify any object that has commercial value is virtually irresistible. The market revolves around trading goods and services, which in turn presumes that the goods being traded are owned.

A telling example of the market's tendency to commodify even what in principle cannot be commodified is the air we all breathe. Nobody owns the air that surrounds our earth, or even a particular cloud of air. A country can lay claim to air space, but not to the air itself. If the air cannot be owned, neither can somebody claim a right to do with his own air what he sees fit, such as polluting it. Indeed, we all are morally obligated not to pollute the air. Hence, it seems utterly odd to say that some people own a license to pollute, and can even buy or sell such a pollution license. But this is exactly what so-called "cap-and-trade" mechanisms seek to achieve: Companies can buy or sell the right to pollute from one another.

In a similar vein, the market has led to a commodification of the human body. While in principle the human body cannot be bought or sold, at least not since slavery was abolished, the economic value of parts of the body has pushed this foundational ethical boundary ever further, such that in many jurisdictions, body parts of various kinds can now be traded. Women are paid considerable sums of money for "donating" their eggs. The Ethics Committee of the American Society for Reproductive Medicine (2007) considers payments exceeding \$10,000 inappropriate, but that has not stopped the sale of eggs at much higher amounts. Real money—millions—is made not by fertile women but by the biopharmaceutical industry, when the industry turns, as happened in the case of Moore (Menikoff, 2001), individual cells into cells lines, producing an endless supply of like cells and an endless supply of the valuable organic products produced by these cells.

Now that saliva has become a body part of significant commercial interest, the temptation to commodify it is most powerful. Moreover, unlike body parts such as female eggs and Moore's spleen cells, saliva tends to be discarded liberally by people in the form of spit. One person's trash is another person's treasure. So why not consider saliva, at least once it has been expectorated, a commodity, to be traded by anybody who is willing to collect the spit? There are evident economic advantages to considering spit a form of property. Property is a widely and effectively used concept in commercial exchanges, and one can therefore reasonably expect that it will result in effective and just exchanges of body parts such as saliva as well.

Moreover, the law favors the concept of property when regulating trade. As we have already seen, such considerations played a decisive role in *Moore v. Regents of the University of California* (Menikoff, 2001), and in many subsequent court

decisions about the commercial status of body parts. But on further reflection, it becomes clear that there are far more examples suggesting the human body *cannot* be considered a form of property in the legal sense of that term.

The right to property is actually a multifaceted right. If someone is said to own something, it typically means that person has all or most of the following rights: (a) possession; (b) exclusive use; (c) management; (d) income; (e) consumption, donation, sale, waste, or destruction; and (f) immunity from expropriation.

When we apply these six constitutive rights to the human body, it becomes evident that people do not typically enjoy all six of them vis-à-vis their own body. Consider, for example, the right to its income. Prostitution tends to be illegal in most jurisdictions. Consider the right to waste or destroy one's body. While the law tends to shy away from prohibiting life-threatening dangerous behaviors, whether dangerous sports, bad diets, or unprotected sex, self-mutilation is widely considered pathological and some countries legally prohibit sadomasochistic practices. Suicide, or at least rendering assistance in suicide, is illegal almost everywhere. Whereas most property upon abandoning it on the curb side can be seized and used by others as their property, this is not true of the human body, not even once it has died. Even if postmortem organ donation is allowed, it would be highly improper and probably illegal for the mortician or the surviving family members to strip the corpse of its gold fillings.

Or consider the right to sell. The sale of body parts tends to be illegal in most countries, and there are even restrictions

on the gifting thereof. Some countries, such as the United State, do allow the sale of body parts that are regenerative or in overabundance, such as skin, blood, sperm, and eggs, suggesting these are property. But that raises questions about why eggs are, and eyes and kidneys are not. Why is the fact that a woman has lots of eggs but only two eyes and two kidneys decisive for the moral status of those body parts? The fact that most people have fewer hats than socks does not mean hats are not property. Moreover, a person can generally survive with one functioning kidney, and certainly without any functioning eyes. In short, the United States position appears inconsistent.

Note that all of the statements made so far, both those in favor and those against considering body parts a form of property, share one, seemingly trivial characteristic: we usually talk about body parts using the verb “to have” or some possessive pronoun. Much like I “have” a car, which is “my” car, I “have” an arm and “my” leg is not “yours.” What is true about any body part is true about saliva as well. Indeed, except for true lovers, most people want to have no part of somebody else’s spit. All the aforementioned legal subtleties notwithstanding, these linguistic considerations appear to support the idea that human beings *own* their body. While we might want to legally restrict their property rights, much like owners of land are limited in what they can do with their property, such restrictions do not invalidate the application of the property paradigm outright.

But on closer inspection, the linguistic argument in favor of property rights is deceiving. In the statement “this is

my arm,” the word “my” is called a possessive pronoun, but so it is in the statement, “that is *my* mistake,” or “this is *my* first name.” But I evidently do not “own” the mistake or the name. Likewise, when I emphasize that “he *has* a crush on her” or “she *has* compassion for him,” neither the crush nor the compassion are forms of property. The reason I cannot truly be said to own my arm, mistake, name, crush or compassion is that all of these are actually partial descriptions of my identity. They describe *me*.

It is often said that “the clothes make the man.” But that statement is only metaphorically true. My appearance may change and hence my perceived identity. But my real identity does not change when I swap my clothes or stand naked in the shower. My clothes do not identify me. In contrast, my body does. It is not the sole identifying factor, but it is an identifying factor. I am, in essence, a “corporeal being.” I do not really “have” a body; I “exist” in bodily form. To claim otherwise turns the “I” in “I have two arms and two legs” into one of mere spirit, a ghost in the machine. Understanding body parts as property requires a dualistic anthropology. For the owner must be different from what is owned; so the owner of body parts must be a non-bodily entity.

There is grave risk in cap-and-trade legislation; not because such legislation restricts the freedom to pollute and hence hinders economic progress, but because it commodifies what should not be commodified. When we treat the air as a form of property, to be used, bartered, and wasted at will by those who have gained or simply claimed ownership rights to it, we inevitably change the fundamental moral status of the air. Once we begin to buy and sell body parts, whether kidneys, eggs, blood or even spit, thereby changing the moral

status of the human body, it becomes very difficult to justify any limits to the free exercise of an owner’s property rights.

A NEW APPROACH TO INFORMED CONSENT

The requirement of informed consent is based on respect for the inviolability and integrity of the human being (Knoppers & Laberge, 1989). It is defined as a patient’s voluntary authorization of a medical procedure or participation in research based on his or her understanding of the relevant information provided and is based on the principle of respect for autonomy that acknowledges the ability of the patient to comprehend knowledge, weigh alternatives, and form judgments (Beauchamp & Childress, 2008). Informed consent must be obtained for all research and is subject to stringent conditions of communications of risk. Traditionally this referred to risks of physical harm; however, nowadays, genetic research may result in the possibility of psychological and social prejudices, which may ultimately affect the rights and freedoms of the participant.

The most important substantive point is that patients must be given the chance to consent for their saliva to be used for research purposes and the level of consent that is required will depend on what the research is, primarily whether or not the material will be strictly anonymous rather than made anonymous through coding. Additionally, a patient may withhold consent altogether, even for completely anonymized use of his or her tissues, cells, or fluids. Finally, the key argument for opting-in is that it is important for patients to understand that they will not be contacted further whatever the results of the research. Of course, if there is any intent for further

contact, then all of the usual provisos relating to research ethics come into play.

On the one hand and because of the unknown variables involved in research and development, it would be impossible to formulate any sort of binding contract that patients could consent to as part of their overall consent to participate in a study. Therefore, if they do wish to participate, it must be clear that it will have to be for reasons other than a potential financial windfall. On the other hand, to offer the prospect of such a windfall could itself be seen as coercive, though potentially more so, as offering patients a lot of money up front to participate in the research study.

In the past, not much attention was given to the innocuous consent forms for routine blood and tissue sampling. The wording on these forms was usually general and open, and permission given to use, conserve, and destroy samples, depending on the needs of the researcher, was also without patient notification. Often no attention was paid to the specificity of consent in research to DNA investigations such as genetic risk determination. Consent forms have now evolved into more complex, technical, legal, and protectionist documents striving for individual rights and familial and societal obligations. Whenever practical there should be a clear distinction between diagnostic testing and research. Genetic testing should not be added to an existing research study without consent. The basic paradigm of genetic individuality needs to be expressed and integrated into consent forms. Regardless of specific disease-oriented research or clinical care, all consent forms related to genetic molecular diagnosis should respect three basic principles that constitute a solid basis for shared responsibility and patient participation: individuality, confidentiality, and freedom of choice (Knoppers & Laberge, 1989).

To ensure valid informed consent is obtained, the participant must be provided with information on the following:

- Specific use of the data—if samples are to be stored or used in a form that allows them to be linked to individuals, possible future research should be explained in terms of types of studies that may be done, the types of diseases that could be investigated and the possible impact of the research on them personally. If samples are completely de-identified, however, then an individual may have no linkage, and thus, no repatriation rights to that saliva specimen, e.g., claims to potential financial compensation. Donors must always be given the option of specifying that their sample may only be used for the research project already planned, and when no longer required for that purpose it should be destroyed. It is the responsibility of the custodian to ensure that all uses of a sample are in accordance with the consent obtained from the donor (Medical Research Council, 2005).
- Time scale—duration of the study
- Future use—when obtaining informed consent to take a sample of saliva for research, it is important to allow for the fact that it might be subsequently useful for new experiments that cannot be foreseen. Therefore, unless a sample will be fully used up by the initial project or cannot be stored, a two-part consent process is recommended, whereby the donor is first asked to consent to the specific experiments already planned and then to give (or withhold) consent for storage and future use for other research.

Once we begin to buy and sell body parts, whether kidneys, eggs, blood or even spit, thereby changing the moral status of the human body, it becomes very difficult to justify any limits to the free exercise of an owner's property rights.

- If there is a possibility that secondary use may include genetic research, this must be included in the explanation of possible future research when consent is obtained even if the samples are to be made anonymous and unlinked.
- Short- and long-term implications
- Information for participants should include an explanation of how surplus material will be destroyed or disposed of when no longer required
- If samples are exported or shared, the custodian of the collection is responsible for all contact with the donors. Donors must be made aware that other researchers might use their samples, including if appropriate, scientists working for commercial companies. Participants must be reassured that all secondary use will require approval by an ethics committee and that no tests on samples that can be linked to them individually will be done without their consent.

There has been debate as to whether the principle of consent can be met in every research situation. Consent requirements can depend on the study (prospective or retrospective) to be conducted and on the category (identified, identifiable, coded for anonymity, anonymous) of samples to be banked. It is recommended that different sites in the same research study should modify the consent forms to reflect the specific services and include information that is deemed necessary for participant understanding.

Comprehensive counseling is an integral part of obtaining informed consent and to assist with decision-making, thereby improving participant's autonomy in deciding whether to participate in the study. Researchers and healthcare providers should make every effort to fulfill the ethical requirements of informed consent.

Conclusions

The rapid advances in the biotechnology applied to oral fluid testing will likely redefine the profession of dentistry in the provision of health care and its interface with clinical and basic science research. Ethical and legal protections have been ascribed to blood due to the extensive testing of blood for medical and legal purposes. Saliva may thus be offered similar protections. Paradigms of property and privacy emerge from a wide array of oral fluid testing and novel strategies must thus be developed to obtain informed consent from dental patients and research participants. To accomplish these goals, everyone in dentistry, including both practitioners and academicians, must become aware of, and adapt to, the rapid developments in the biotechnology of oral diagnostic testing and its broad based implications. ■

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ETHICS FUNDAMENTALS

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ABSTRACT

Ethics is about studying the right and the good; morality is about acting as one should. Although there are differences among what is legal, charitable, professional, ethical, and moral, these desirable characteristics tend to cluster and are treasured in dentistry. The traditional approach to professionalism in dentistry is based on a theory of biomedical ethics advanced 30 years ago. Known as the principles approach, general ideals such as respect for autonomy, nonmaleficence, beneficence, justice, and veracity, are offered as guides. Growth in professionalism consists in learning to interpret the application of these principles as one's peers do. Moral behavior is conceived as a continuous cycle of sensitivity to situations requiring moral response, moral reasoning, the moral courage to take action when necessary, and integration of habits of moral behavior into one's character. This essay is the first of two papers that provide the backbone for the IDEA Project of the College—an online, multiformat, interactive “textbook” of ethics for the profession.

Ethics is about what is right and good. Only we humans are concerned to live in a world where care is taken to bring about the flourishing of both ourselves and others, including those we have not met personally. It is what makes us special. That is why it is human nature to strive to live moral lives.

Aside from acting morally because it is “the right thing to do,” everyone benefits from living in an ethical world. When patients believe that dentists have the patients’ best interests in mind they extend trust to the professional as a whole. This increases the likelihood that patients will seek care, makes it possible to provide treatment without having to justify every activity, and allows dentists to organize professionally to promote high standards.

It is also known from research in corporate America that companies that have a reputation for high standards enjoy greater customer satisfaction, fewer law suits from employees or customers, more customer and staff loyalty, higher profits, and even have employees who are physically healthier. Ethics promotes personal, community, and practice flourishing.

1. Varieties of the Right and the Good

There is actually a family of behaviors that address the right and good in related ways. Ethics is one approach, but so is behavior that is legal, charitable, professional, and moral. All are desirable and generally cluster together, but there are differences of emphasis.

1.1 Legal

Others decide for you what is legal and impose penalties when the rules are broken. Dentists do not decide what is legal and they accumulate no points for following the law (points are only subtracted for breaking it).

Here are some examples of breaking the law. “Upcoding”: submitting an insurance claim for more highly reimbursed procedures than the ones actually performed; negligent practice that results in injury to a patient; or failure to report suspected child abuse. The “standard of care”—the minimal level of treatment given patients by dentists in a community—is actually a legal construct. It is defined by the jury in malpractice cases.

Civil disobedience, disregarding the law in order to make a point, is a risky position for professionals. The high road is to participate in politics, either in Political Action Committees or by becoming a political candidate.

1.2 Charity

Volunteer and charity work are essentially the flip side of legalism. Dentists decide what they want to give and there are only points added for participation. No one blames others for not going beyond expectations.

Charity includes mission trips and volunteering at local health fairs. It is unreimbursed and underreimbursed care (pro bono work), and even general

good citizenship. America is among the most generous nations in the world. The American Dental Association estimates the value of dental care for which dentists are not fully compensated at about 5% of all dental care. That is an amount roughly equal to the total federal and state dental contributions for Medicaid, prisons, uniformed services, Indian Health, and others.

As a general rule, professionals are both legal and charity minded. But there are a few dangers in this direction. So-called “Robin Hood” practices involve illegal redistributions of the wealth. A dentist may post-date an insurance claim to make it easier for the patient to get reimbursement for an otherwise uncovered procedure. This is illegal, but very charitable. (It also contributes to the dentist’s financial and reputational bottom line, makes the dentist an arbiter of worthy causes, and is all accomplished with someone else’s money.)

1.3 Professionalism

Groups from the United States Senate to the local plumbers’ union make rules governing the behavior of their members. These rules guide how members are expected to behave toward each other and toward others. Such “codes of conduct” are often written down, but there are always numerous informal rules that can only be learned on the job. Informal rules have the advantage of making it easy to spot someone who does not belong. Professional codes are usually aspirational, meaning that they define a generalized ideal rather than hard-and-fast criterion that cause someone to be sanctioned.

For example, the *ADA Code of Professional Conduct* (not the *ADA Principles of Ethics*) states that patients who have been referred to a specialist

should be returned to the referring general dentist upon completion of specialty care. The code also states that a dentist who observes gross or continued faulty care on the part of a colleague is expected to report that fact. Professional codes also contain statements about how professionals should treat patients. For example, a compromising condition in the patient’s mouth should be explained to the patient, even when the dentist was responsible for causing the damaging situation.

Codes of professional conduct were historically known as Codes of Professional Etiquette because they govern the relationships among practitioners. They are developed by professionals and are for their use. Patients and public entities are not invited to participate in the creation or updating of professional codes, nor are they expected to comment on them.

1.4 Ethics

In its pure form, ethics is the study of right and wrong, good and bad. This is an academic pursuit, largely confined to departments of philosophy in universities. Bioethics or the ethics of dentistry would be properly termed “applied ethics.” It is about reflecting on principles and learning to give good reasons for behavior. On this view, moral philosophers and bioethicists work to define what is ethical and practitioners seek to clarify how these principles apply in various situations.

1.5 Moral Behavior

Moral behavior is patterns of action that are consistent with the best theories of ethics. It is about individuals and particulars. We might ask ourselves: If we were on trial, accused of being ethical, would there be enough evidence to get a conviction? Ethics defines the theoretical context; moral behavior is the evidence. When con artists, cops, and politicians go bad, they are counting

on everybody else following the rules. Morality is about action, not knowledge of the rules. Professors of ethics can cheat on their husbands. Dentists who are being sued for violating standards of professional conduct probably know the state practice act better than the most morally upright dentist.

In the end, the moral dentist is the one whose actions bring about healthy patients, harmonious practices, positive communities, and a stronger profession. They are the ones who would be most missed, not because of what they always said, but because of what they always did.

Moral practitioners behave legally, charitably toward all, professionally, and act from a firm theoretical grounding in an ethical framework. But it is their life pattern of moral behaviors that sets them apart as being the ones we all want more of.

2. Ethical Analysis

Obviously the task of building a moral community in dentistry is not simple or easy—otherwise it would have been done by now. Sometimes there is disagreement over whether a particular action leads to a necessary good; sometimes there is disagreement over what to do when something rotten is found. Ethics is an art, and a group performing art at that.

The field that covers dental ethics is called bioethics or professional ethics. As a discipline it is barely 30 years old. The goal of bioethics is to offer guidance to healthcare practitioners and policy makers about how to act. The center of the approach is something called the practical ethics syllogism. With roots all the way back to Aristotle, the practical ethics syllogism works something like this:

Principle: All ethical healthcare professionals strive to benefit their patients.

Analysis: In the current situation, action A would provide a net benefit to the patient.

Moral behavior: If Doctor D is an ethical healthcare professional, he or she will do A in this situation.

Notice in this form of ethical reasoning, there is a major premise or principle that encompasses practitioners, patients, and situations generally. But that is insufficient to guide action in all cases. Particular situations are ambiguous and difficult to interpret, there are complicating and even conflicting factors; there may be exceptions. Consequently, there is a second step where the principle is analyzed and interpreted in the specific context. So ethical training must be more than learning how to spell non-maleficence; it must also include building skill in interpreting complex situations in the light of general principles.

2.1 Ethical Principles

The major premises in ethical analysis have been developed by philosophers. In bioethics, there are four generally accepted principles (autonomy, non-maleficence, beneficence, and justice); there is one additional one (veracity) that dentistry has embraced.

2.1.1 Autonomy means self-determination. Literally, the Greek origin of the word is “to give oneself the law.” Legally, patients have complete say about what can be done to their bodies. They must give permission, called informed consent, for any act of the dentist or office staff. Sometimes this principle is referred to as respect, and that is a useful perspective because it reminds us that we decide on behalf of others at our own peril and in doing so we diminish others.

Not everyone is entitled to full autonomy. Children, the mentally incompetent, and others for whom the court has identified another as the decision maker (e.g., convicted felons)

are examples. These cases can be tricky, varying from state to state in the legal sense. It is almost never the case, certainly, that patient’s lack of autonomy transfers any authority to the practitioner.

Neither should the principle of patient autonomy be misunderstood as meaning that dentists are ethically bound to do whatever patients request. Especially, when dentists can see that a patient is requesting something that, in the dentist’s opinion would harm them, the dentist acts morally by denying the request. (That does not extend, however, to the dentist being allowed to decide what should be done instead.) The principle of autonomy applies to respect for the dentist, and every member of the dental team, just as it does to patients and to patients’ families.

2.1.2 Nonmaleficence means avoiding actions that cause unnecessary harm. It is a double negative principle, and thus not always the same as beneficence. The only way to guarantee no harm is to perform no care: there is always risk in any treatment. Practically, the principle of nonmaleficence is about negligence; it means abstaining from exposing patients to unreasonable and unforeseen risks. Framed in positive terms, non-maleficence involves becoming highly competent, knowing the science behind what is being done, being in tune with the standards used by one’s colleagues, and engaging the patient in understanding and choosing the level of risk they are comfortable with.

2.1.3 Beneficence means providing a benefit or helping others. This is a positive obligation: others must be net better off for their contact with dentists than they would be otherwise. Excellent reconstructive work would probably

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not qualify as beneficence if the patient were overcharged relative to receiving the same quality of care for a lower fee or with greater convenience. There is an implied contract between society and professionals: the profession is granted a limited degree of autonomy and self-governance in exchange for benefiting the public. (It is actually assumed that professional self-governance will automatically magnify the level of benefit.)

Beneficence can be confused with paternalism. Both principles intend to provide benefit for patients. In beneficence, the patient participates in and ultimately determines what benefits they most value. In paternalism, the practitioner makes that decision on behalf of the patient. Naturally, the maximal net good by means of the principle of beneficence and by the principle of paternalism are usually the same action. But that is not always the case. And when there is a conflict between these two principles, the practitioner must choose.

2.1.4 Justice means that the benefits and the burdens in society are fairly distributed. Ideally, it is unjust to charge one patient more for a procedure than is charged to a different patient for the same procedure or to make it more difficult for one class of patients to be treated than another. (Practically, this is done all the time throughout American society.) There are so many ways for classifying or categorizing each case, that every effort to be fair leaves some room for individuals who are dissatisfied with the outcome to voice a complaint. That is why the justice system has so many lawyers. It remains, however, an aspirational principle to treat everyone as fairly as possible and especially not to treat groupings of individuals solely for the sake of increasing one's own benefit.

2.1.5 Veracity means not misleading or allowing another to be misinformed or misled. This is just a little larger and more flexible than telling the truth. If a dentist lists credentials that create an impression in the patients' mind that specialty training has been completed or that a procedure has a high success rate despite only saying "clinically proven," the patient is justified in making a choice they would not otherwise make if they had the full story. That is a violation of the principle of veracity. A good test of the principle is to ask: Does the practitioner stand to gain personally by withholding any information that could reasonably be made available?

The first four of these principles are enshrined in the bioethics canon and were first introduced by Tom Beauchamp and James Childress in their 1977 book *Principles of Biomedical Ethics*. This is sometimes called the "Georgetown Manta" for the fact that Beauchamp and Childress worked at the Kenney Institute for Ethics at the University of Georgetown. Other principles such as fidelity and privacy have been identified. Dentists should be aware that this is primarily a healthcare ethics perspective. Moral philosophers in universities generally do not work with this framework.

2.2 Analysis of Principles

The excitement in ethics does not come in debates over principles. There is near universal agreement that justifiable criticism of gross or continuous faulty work by colleagues is "right" and that false and misleading advertising is "wrong." Issues arise in the application of the principles. There are some practitioners who claim never to have seen cases of colleagues' work that was so faulty as to require criticism. There really are shades of interpretation in what is misleading in advertising. The principles are abstract; their application is concrete,

but open to interpretation.

And to make matters worse, there can be conflicts among the principles themselves. Patient autonomy fights with nonmaleficence. Beneficence in being able to help one patient fights with justice in not being able to help all patients. Where two (or more) principles can be read as framing a particular situation but favor contradictory actions, we call this a moral dilemma. The term comes from the Greek word *lemma* meaning a stock, halfway proof of part of a theorem that can be used in many settings as a shortcut in parts of various proofs. Hence two stock part proofs or a di-lemma.

Ethics education is generally understood as training in how to apply principles. (Many philosophers would take exception to this definition as incomplete.) All such education takes place in actual communities where cases are discussed and analyzed from a common perspective, thus teaching how to interpret ethical situations and properly apply the principles. That is what happens in our early family training and in kindergarten where author Robert Fulghum said he learned everything important in life. It takes place in a midrash, a kibbutz, seminary, the military academies, law school, and dentistry. Even where there is overlap in principles, the traditions of interpretation are unique to the community where interpretation is learned.

A novice earns recognition as a member of the community by mastering the art of correct interpretation of ethical principles within the group. An important part of becoming a dentist is learning how to see things as dentists do. The meaning of gross and continuous faulty care has to be learned. There are shades of fault, there are ranges of circumstances

in which care is given, there are nuances of professional relationships, there are procedural options. No dental student could be expected to master the interpretation of ethics while still a student. Certainly no non-dentist could understand it. Obviously, a few practitioners do not get it either.

The standard in teaching ethics in dental schools is the case method or ethical dilemmas. Students rub their tentative interpretations up against those of their colleagues and some experienced veterans. The overwhelming majority of ethics publications on ethics in the dental literature are cases, with analyses.

This approach to ethics training goes back to Aristotle in the fourth century BC. Now called “virtue ethics,” the model is designed to qualify one for membership in the community of one’s peers. Virtue ethics is now the standard taught in America’s business schools. Aristotle expressly limited ethical reasoning to free-born males of mature age and excluded slaves and women as being incapable of ethical reasoning. Physicians and lawyers, as well as other professions exclude the lay public, politicians, or insurance companies from learning or contributing to the conversation about professional ethics to this day. All professions struggle with the proper boundaries between professionalism and ethics.

3. Becoming a Moral Person

So far, we have a workable grip on ethics, especially on ethical reasoning and talking about ethics. But we need to push on to the moral behavior of practitioners. What does it mean for dentist to exhibit a consistent pattern of actions that promote the right and the good in practice?

An abbreviated answer is that professionals who become aware of possible doubts about whether what they are doing is ethical can engage in reflection grounded in ethical principles and the interpretative habits of their community

of peers. Sometimes this approach will also be used to assess specific moral acts of one’s colleagues.

A fuller answer is provided by the moral psychologist James Rest. Rest proposed a Four Component Model of moral development. This goes beyond reasoning on specific isolated ethical challenges. His model has been tested in many disciplines, including dentistry, and there are short, paper-and-pencil tests for measuring one’s profile on the four components of the model. Although there are four parts to the model, it has been demonstrated that one can begin building moral strength at any point, and double back part way through the path as needed. Research shows that the components are trainable and that moral growth is possible well into the thirties and longer.

3.1 Moral Sensitivity

The Cambridge moral philosopher Simon Blackburn notes that very few people are actually bad by nature, but many are ethically blind. The first component in moral development is to cultivate the habit of seeing the moral dimension in situations around us. Few dentists, for example, agree that where they choose to locate their practice is an ethical decision. This decision does, however, have profound and persistent influence on who they treat and what kind of care is provided. Many professionals assume that the cost of new regulations and patient safety procedures should automatically be passed through 100% to patients without stopping to ask whether this is an issue involving justice or whether regulators are making laws

The principles are abstract; their application is concrete, but open to interpretation.

because they think consumers are taking advantage of providers. Is informed consent a legal matter or an ethical one? Are there ethical overtones to insurance, Medicaid, and emergency call?

Rest's point on moral sensitivity is simply that all opportunity for ethical growth is blocked in areas where the opportunity is not first recognized.

3.2 Moral Reasoning

The second component is the familiar skill of sorting through what is at stake in an ethical problem, locating the relevant principles, finding whose interests are at stake, tracing out consequences, narrowing down the alternatives, and deciding which is the preferred course of action. This is the abstract part of ethics and stops just short of actually doing anything. Sometimes we react quickly, framing the problem as another example of situations we have seen before. Occasionally we wrestle with novel and complex matters that challenge us to recognize something new. But in all, we are trying to solve an intellectual problem.

This is the part of the Rest model that has been most fully developed. He built his approach on earlier work that showed that as we grow in age, we naturally change the overall approach we take to solving the intellectual aspects of complex ethical problems. Young children tend to equate the right and the good with what those in authority approve or punish. Older children and teens more typically opt for an analysis in terms of the standards of those in their community. In maturity, and only for some, does ethical reasoning take on the character of systematic

working with principles. Rest refers to these three levels of moral reasoning as preconventional, conventional, and postconventional. These are categories of approaches to reasoning, not rightness or goodness. A dentist could be perfectly ethical following the trend of professional colleagues or end in a really indefensible position by concocting an elaborate theory from new cloth.

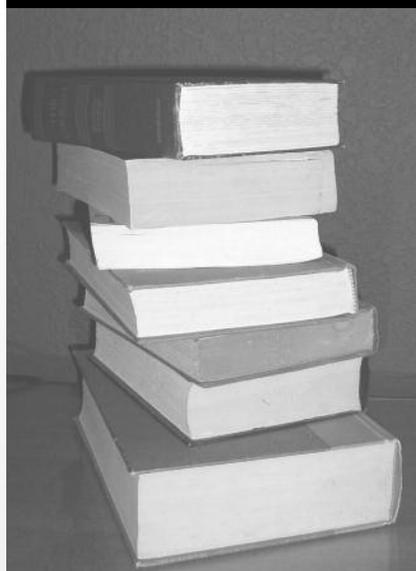
3.3 Moral Courage

Just as there are individuals who are hypertensive to ethical abuse in the world but cannot figure it out, there are those who have worked through sound understanding of right and wrong and remain paralyzed when required to take action. Moral courage refers to the interpersonal communication skills and political and personal connections as well as the willingness to take personal risks to engage in moral behavior. This, of course has to be understood as direct moral action in support of strong moral reasoning. It does not count to engage in character assassination or bellyaching.

3.4 Moral Integrity

Some people are known as being especially upstanding. They were troubled by an issue, they worked it through, and then took action. Those who do this predictably, who make a general habit of it, who can be counted on to work for a world that is right and good exhibit moral integrity.

RECOMMENDED READING



It is a challenge to define the “essential literature” in dental ethics, but an effort has been made below. Each reference marked with an asterisk is about five pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in 20 minutes rather than 20 hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on ethics; a donation of \$50 will bring you summaries for all the 2011 leadership topics.

Tom L. Beauchamp and James F. Childress (2009)
Principles of Biomedical Ethics.
 (6th ed.)*
 New York, NY: Oxford University Press.
 ISBN 0-19-533570-5; 417 pages; about \$60

This is the classic text in bioethics. It successfully bridges from academic moral philosophy to practical cases of healthcare practice and policy. The four principles of respect for autonomy, non-maleficence, beneficence, and justice are introduced by Beauchamp and Childress. The book has three sections: introduction to moral reasoning, full exposition of the principles, and a concluding discussion of the role of moral theory. The principles are used to anchor discussion of relevant issue in health care (informed consent and refusal of care for respect for autonomy, for example). Veracity has been picked up as a fifth principle by dentistry.

Chambers, D. W. (2011)
Developing a self-scoring comprehensive instrument to measure Rest’s four-component model of moral behavior: The moral skills inventory.

Journal of Dental Education, 75 (1), 23-35.

Description of the development of a short paper-and-pencil instrument for measuring the four components (sensitivity, reasoning, courage, integration) in Rest’s Four Component moral model for dentists. The paper includes the actual, self-scoring instrument.

W. Brad John and Charles R. Ridley (2008)

The Elements of Ethics for Professionals*

New York, NY: Macmillan. ISBN 0-230-60391-2; 213 pages; about \$23

This book us an inventory of 75 ways professionals can go wrong, explanations of unfortunate consequences, and exhortations to avoid these errors of conduct. Each section begins with a short case. The book is organized around eleven primary themes: (a) taking the high ground (matters of integrity), (b) doing no harm (matters of nonmaleficence), (c) according dignity (matters of respect), (d) benefiting others (matters of beneficence), (e) exercising caution (matters of prudence), (f) caring for others (matters of compassion), (g) seeking fairness (matters of justice), (h) promoting autonomy (matters of self-reliance), (i) being faithful (matters of fidelity), (j) delivering your best (matters of excellence), and (k) making ethical decisions (matters of sound judgment). Codes are necessary but insufficient as guides to moral behavior: (a) problems are complex, (b) fluid, (c) professionals encounter conflicts between professional obligations and other, personal obligations, (d) being ethical is a continuous process, and (e) humans are fallible as decision makers.

Joseph Reimer, Diana Pritchard Paolitto, and Richard H. Hersh (1982)

Promoting Moral Growth: From Piaget to Kohlberg (2nd ed.)*

Long Grove, IL: Waveland Press. ISBN 0-88133-570-3; 285 pages; about \$20.

Kohlberg used observations of psychological development of boys and young men to develop a theory that the cognitive capacity to reason about moral issues develops through two stages at the pre-conventional level (rewards and punishments) to two stages of a conventional level where morality is considered

RECOMMENDED READING

in light of social norms. He also suggests two additional stages at the postconventional level based in philosophical reasoning, although there is little evidence that this is obtained by many individuals. The authors began working with Kohlberg in 1976 teaching moral development.

STANDARD TEXTS

Ozar, D. T., & Sokol, D. J. (1994)

Dental ethics at chairside: Professional principles and practical applications.

Washington, DC: Georgetown University Press.

Rule, J. T., & Veatch, R. M. (2004)

Ethical questions in dentistry.

New York, NY: Quintessence books.

Graskemper, J. P. (2011)

Professional responsibility in dentistry: A practical guide to law and ethics.

Hoboken, NJ: Wiley-Blackwell.



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