

Journal *of the* American College *of* Dentists

STUDENTS' VIEWS
ON ETHICS

WINTER 2011
VOLUME 78
NUMBER 4



Journal of the American College of Dentists

A publication advancing
excellence, ethics, professionalism,
and leadership in dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD. Copyright 2011 by the American College of Dentists.

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

The 2011 subscription rate for members of the American College of Dentists is \$30, and is included in the annual membership dues. The 2011 subscription rate for non-members in the United States, Canada, and Mexico is \$40. All other countries are \$60. Foreign optional airmail service is an additional \$10. Single-copy orders are \$10.

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

While every effort is made by the publishers and the Editorial Board to see that no inaccurate or misleading opinions or statements appear in the *Journal*, they wish to make it clear that the opinions expressed in the articles, correspondence, etc. herein are the responsibility of the contributor. Accordingly, the publishers and the Editorial Board and their respective employees and officers accept no liability whatsoever for the consequences of any such inaccurate or misleading opinions or statements.

For bibliographic references, the *Journal* is abbreviated J Am Col Dent and should be followed by the year, volume, number and page. The reference for this issue is: J Am Col Dent 2011; 78 (4): 1-68.

Member Publication
AADE
American Association
of Dental Editors

COMMUNICATION Policy

It is the communication policy of the American College of Dentists to identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the College. The College is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in College publications do not necessarily represent those of the American College of Dentists or its Fellows.

OBJECTIVES of the AMERICAN COLLEGE of DENTISTS

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

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

Editor

David W. Chambers, EdM, MBA, PhD
dchambers@pacific.edu

MANAGING Editor

Stephen A. Ralls, DDS, EdD, MSD

EDITORIAL BOARD

Laura Bishop, PhD
Susan Bishop, DDS
Herb Borsuk, DDS
Marcia Boyd, DDS
Fred Bremner, DMD
Kerry Carney, DDS
Theresa Gonzales, DMD, MS, MSS
William Leffler, DDS, JD
Michael Meru, DDS
Peter Meyerhof, PhD, DDS
Kirk Norbo, DDS
Martha S. Phillips
Marsha Pyle, DDS
Cherlyn Sheets, DDS
Philip E. Smith, DMD
Jim Willey, DDS

DESIGN & PRODUCTION

Annette Krammer, Forty-two Pacific, Inc.

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

Business office of the *Journal of the
American College of Dentists*:
Tel. (301) 977-3223
Fax. (301) 977-3330

OFFICERS

Patricia L. Blanton, President
W. Scott Waugh, President-elect
Kenneth L. Kalkwarf, Vice President
Jerome B. Miller, Treasurer
Thomas F. Wickliffe III, Past President

REGENTS

Thomas J. Connolly, Regency 1
Robert A. Shekitka, Regency 2
Geraldine M. Ferris, Regency 3
Richard F. Stilwill, Regency 4
Bert W. Oettmeier, Jr., Regency 5
Carl L. Sebelius, Jr., Regency 6
Steven D. Chan, Regency 7
Rickland G. Asai, Regency 8

Linda C. Niessen, At Large
Eugene Sekiguchi, At Large
Richard C. Vinci, At Large
Stephen K. Young, At Large
Lawrence P. Garetto, ASDE Liaison

2011 ACD ANNUAL MEETING

- 4 Dentistry Is at a Tipping Point—We Need Your Hand (President-Elect's Address)
Patricia L. Blanton, DDS, PhD, FACD
- 8 Optimism Is Part of the Cure (Convocation Address)
Nicole Johnson, MA, MPH
- 11 2011 ACD Awards
- 15 2011 Fellowship Class

STUDENTS' VIEWS ON ETHICS

- 19 Personal Ethical Dilemma: Is the Patient Competent?
Alice Nunes
- 22 Putting Your Money Where Your Mouth Is: The Influence of American
Consumer Culture on Contemporary Dentistry
Annalee Asbury
- 27 Can We Change?
Tyler Beinlich
- 29 Comprehension and Retention of Orthodontic and Orthognathic
Surgery Treatment Information: A Review of Literature
Renie Ikeda, DDS
- 35 The Ethics of Routine Use of Advanced Diagnostic Technology
Renata Khelemsky, DMD

MANUSCRIPT

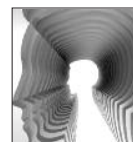
- 40 Retention of Underrepresented Minority Students in Dental School—
One Dental School's Story
*Ernestine S. Lacy, DDS; Barbara H. Miller, DDS; Sheryl A. Hornback, MA;
Ann L. McCann, PhD; and Jayne S. Reuben, PhD*

ISSUES IN DENTAL ETHICS

- 48 The Case of the Pregnant Adolescent
*Bruce N. Peltier, PhD, MBA, FACD; Terry Hoover, DDS, FACD; Pamela
Zarkowski, MPH, JD; and Terry Patterson, EdD*

DEPARTMENTS

- 2 From the Editor
*Lessons in Shifting the Burden:
#2. Competence to Practice*
- 56 Leadership
How to Make Moral Choices
- 64 2011 Manuscript Review Process
- 65 2011 Article Index



Cover photograph: Within
each dental student is an ethical
dentist. This issue features five
perspective examples.

© 2012 pavlen, istockphoto.com.
All rights reserved.

*This issue is supported by the
American College of Dentists Foundation.*

FROM THE EDITOR

LESSONS IN SHIFTING THE BURDEN: #2. COMPETENCE TO PRACTICE

The one-shot format is constitutionally flawed as a means of supporting a conclusion about the skill level of candidates.

Dr. R. P. Thomas made these remarks at the meeting of the National Association of Dental Examiners: “Dental education has reached a state of perfection where the schools can be entrusted with determining who shall be eligible for public service.” Certainly, at one point in the evolution of the profession, that was a goal shared by the educational and licensure communities and by the profession and the public. But perhaps Dr. Thomas was a few years ahead of his time. The meeting where he spoke took place in 1938.

Licensure boards predated dental schools as indispensable protectors of the public from unqualified individuals who are self-declared as meeting professional standards. During the formative years of dental education in the first half of the twentieth century, examiners and schools were partners in the task of defining what dentistry should be. The early issues of the *Journal of Dental Education* are largely given over to collaborations on this project. But we did not finish our work and the partnership fizzled.

Currently, licensure boards work with state legal structures for the regulation of commerce and with testing services to secure the funds they need. We hear little today of the original goal of defining the standards of what it means to practice dentistry at the highest level of professional competency.

Recently I have noticed a pattern in discussions in the national committees

I participate in. Bad-mouthing “some elements in the profession” is becoming a new art form. It must make some feel good to do that because I am certain it does little or nothing for the general level of patient health. Among the complaints I hear are lack of scientific basis for treatment options; poor judgment or overly narrow and routine treatment; greed leading to practices that are overly commercial or of questionable legality; and personal problems, such as substance abuse, inappropriate relationships with staff or patients, and practicing beyond one’s skill level. I do not recall hearing much about less-than-perfect root planing and amalgam or composite restorations.

There may be some wisdom in a one-shot, live-patient test of mechanical skill under artificially circumstances. This is the “independent assessment of a minimal standard” argument: if we are uncertain about what students routinely do two years before graduation, how could they be expected to be competent overall? There are ethical issues with the boards placing candidates in positions of moral hazard and their unwillingness to accept responsibility for the patients of candidates the boards fail. Otherwise it makes good sense—provided that two conditions are met: the testing must be done right and it must not be a substitute for doing something more in need

of being done. The current initial licensure system resembles one's accountant coming into the office and looking at enough billing records to find an error and then concluding that the entire office is incompetent or illegal but failing to provide information on new tax laws.

While testing agencies claim to have psychometric credentials, there are no published data showing candidates who fail one-shot initial licensure examinations are poor practitioners; but there is abundant evidence that a number of those who pass should not have (as their licenses are later suspended).

What examining agencies point to is the internal consistency among their raters. That misses the point. A veteran practitioner may have a bad outcome (untoward event subsequent to an appropriate procedure). If three colleagues gather around the patient and agree that the situation did not turn out well, that is good evidence that the colleagues are well trained but not good evidence that the practitioner lacks competence. The one-shot format is constitutionally flawed as a means of supporting a conclusion about the skill level of candidates.

Beginning in the early 2000s the California State Board and the Western Regional Examination Board were locked in a struggle to see who could be tougher. For two years students could take either board and some took both. This provided a nice test to determine whether students would perform consistently on two supposedly identical measures of clinical skill in amalgam

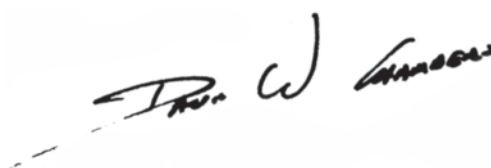
and composite restorations and scaling and polishing on live patients. They did not. The common variance on the restorative procedures was less than 10%. The correlation for scaling and polishing was actually negative.

According to historical records, the failure rate on initial licensure examines has remained constant for decades. It is a perfect certainty that such a pattern will result from an unreliable system. But perhaps there is a quota system; or maybe schools or candidates have been slow to learn how to prepare for or take a critical test. A highly probable factor is that the standard for acceptable dentistry is continuously being raised. It should be. And this means that the candidates of today are better when they graduate than were those who examine them.

Three-quarters of a century ago one could say with a straight face that the knowledge and skills one possessed at graduation from dental school would be serviceable through a dentist's career. That is an indefensible position today. Continued competence is both a larger issue and a more neglected one than is initial competence. The dental schools have largely been sidelined in the continuing education business by commercial interests and even by organized dentistry

that has embraced the economic benefit of this enterprise. The examining community should not be similarly silent in both defining and assessing the total impact of all practicing professionals on patient health.

The arguments that the boards are unethical (in terms of live patients) and psychometrically indefensible have been made, heard, and ignored. We should ask instead that the examining community return to the original challenge of defining and assessing the competence of the entire profession to deliver oral health care to current standards. Their logical partner in this business is the schools, not the testing agencies.



DENTISTRY IS AT A TIPPING POINT—WE NEED YOUR HAND

Patricia L. Blanton, DDS, PhD, FACD

ACD PRESIDENT-ELECT'S ADDRESS

October 11, 2011
Las Vegas, Nevada

It is an honor for me to address you today as incoming President of the American College of Dentists. Having grown up in Northeast Texas, it was not uncommon to see a turtle on top of a fence post. My father was quick to remind me it did not get there by itself. In reality, none of us got here today without the support of colleagues, peers, and mentors who advanced our professional development.

Just as you have your personal lists of those to thank, please allow me a moment of personal privilege to acknowledge my supporters. My heartfelt thanks to President Tom Winkler and fellow Officers, Regents, and Past Presidents of the College for their encouragement throughout my terms as Regent, Vice President, and President-Elect. Let me acknowledge as well Dr. Steve Ralls, our Executive Director; Dr. David Chambers, the Editor of our journal; Karen Matthieson, Paul Dobson, and the rest of our staff for their guidance throughout my years on the Board. The dedication of our staff to the College and to the profession is truly inspirational. Steve, you of your own volition have advanced this College significantly over your tenure and, through it all, your actions have epitomized ethics and professionalism.

Additionally, I would be remiss if I did not mention two mentors in particular. These statesmen, Dr. Richard Bradley and Dr. John Wilbanks, have had a long-

standing, positive influence on my professional advancement.

Finally, I wish to express my sincere gratitude to the Texas Section of the College and to Regency 6 for nominating me for the position of Regent and for their continued support and encouragement over these past seven years. I am sincerely grateful for the opportunity to serve as your President. I accept this responsibility and will humbly endeavor to lead the College with the same dedication and dignity as my predecessors.

DENTISTRY IS AT A TIPPING POINT

I consider it a particular privilege to extend my congratulations to all you new Fellows of the College. Recognition by one's peers is the highest accolade a professional can receive. Today, you are receiving that recognition from the oldest and one of the most prestigious honorary organizations in dentistry.

But your honor today means even more than that. Nearly 100 years ago, a group of individuals who were then the leaders of dentistry—leaders in 1920 who had experienced the transition of dentistry from a proprietary enterprise to a health profession, leaders who had seen the importance of dental education, science, and ethics as the foundation of our profession—those leaders met



Dr. Blanton is a practicing periodontist in Dallas, Texas, and is First Vice President of the American Dental Association.

on a blustery day in Boston with the express purpose of creating a group, an organization if you will, to promote the basic tenets of our profession, e.g., ethics, excellence, leadership, and professionalism, and furthermore to ensure that dentistry remains a profession, never again to be relegated to guild status. After many hours over several meetings, it was determined that the American College of Dentists would be established, distinct from any other organization and separate from political influence, with the definitive purpose of promoting ethical leadership and identifying and recognizing those individuals, those leaders, who had served and do serve to assure the future of dentistry as a profession.

Today, you are honored as “the leaders” envisioned by “those leaders” so many years ago. You practice those principles and it is you who will be making the leadership decisions for dentistry over the next decade—decisions that will determine the future of dentistry and the fate of our profession. Yes, we are celebrating your honor today, but we are also acknowledging that your leadership is going to be very important, particularly in the coming years, as the challenges that lie before us are great.

It is generally acknowledged that, over the last century, dentistry has several times found itself at a crossroads. These are situations where challenges and opportunities must be balanced and where the choices made determine the future. But today I see the issues to be

sufficiently great to place dentistry at a so-called “tipping point,” to use the words of contemporary author Malcolm Gladwell. I think we all agree that the healthcare professions face unprecedented challenges as part of the national debate on healthcare reform; and all this is occurring at the same time that third-party and for-profit entities are applying pressure to dentistry. One might say that a crossroads is a specific decision point, whereas a tipping point carries a deeper importance. The steps we take now may not be retracable. As never before, dentistry is in need of leaders who will get it right on the first try.

Over the years, the American College of Dentists has addressed many of these issues that we must now attend to—commercialism, deceptive advertising, and proprietary dental schools, to list a few. I am proud of the fact that, historically, the American College of Dentists has had a profound influence on the outcome of those challenges on behalf of the profession. To use the words of scholar and anthropologist Margaret Mead, “A small group of thoughtful people could change the world. Indeed, it is the only thing that ever has.” To paraphrase, the 3.5% of caring and committed dentists who are ACD Fellows have, on numerous occasions, led in making choices that shaped dentistry.

We dentists must assume our responsibility as stakeholders if dentistry is to be the profession we would want for Americans in the future.

I challenge you to step outside of your practices and represent our profession in the eyes of the public.

To emphasize the significance of our unprecedented challenges, I draw on history, as it is said that “past is prologue.” Looking back at the history of our country, I believe there are certain parallels. One example, in 1803, President Thomas Jefferson knew that if the nascent democracy was to survive, America would have to take responsibility to control its destiny. He knew there would be challenges to this effort from many outside influences and with ongoing threats to our self-proclaimed autonomy as a nation. Jefferson intuitively understood that America would have to continually fight for self-control and that that responsibility would fall to all Americans. In short, Americans would be stakeholders in the future of America and, likewise, Americans would be the beneficiaries of those efforts at stewardship of the fledgling nation.

We can take lessons from Jefferson as our profession, our practices, and healthcare delivery in general face new frontiers and an uncertain future. We must accept that our autonomy is not assured. We must accept that it is dentists who will and should have the greatest impact on the future of the profession. And we dentists must assume our responsibility as stakeholders if dentistry is to be the profession we would want for Americans in the future. In short, we must accept, as noted by Alexander the Great, that “upon the conduct of each lies the fate of all.”

Now fast-forward to the twenty-first century. It has opened with all the promise of a new beginning, with advances in technology and informatics that have the potential to change all that had gone before. Just as the demand for evidence-based outcomes has replaced the empiricism of the past, the profession of dentistry continues to evolve. I was taught “extension for prevention” and now I subscribe to “restriction with conviction.” Clearly, these changes have led us into the modern era of unforeseen advantages, and yet, an era in which we find ourselves with perhaps unanticipated and certainly unprecedented challenges. Among these challenges I would note: (a) increasing disparities among the legitimate needs for patients; (b) available resources to meet those needs; (c) increasing dependence on market forces to transform healthcare systems; and (d) temptation for dentists to forsake their traditional commitment to the primacy of patient interests.

Most dentists would agree that we must craft the future we seek for the profession. They would further say that care should inherently be safe and patient-centered and that there is no real health without oral health.

But to be successful in our quest, as we promote these basic premises on behalf of the profession, we stakeholders must face and address precisely those questions that place us at a “tipping point.” I see those questions as including:

1. How will oral health care be delivered in 2025 and beyond?
2. Who will deliver it?

3. Who will pay for it?
4. How will Americans routinely access dental therapy?
5. Are mid-level providers necessary, and who will decide the outcome of that debate?
6. How will dentists be distributed geographically?
7. What will be the impact of for-profit entities buying up our dental practices?
8. How do we respond to the graduate who claims he or she must take a “job” with a large, production-oriented clinic due to high student debt and no way to establish their own practices?
9. What will be the impact of the nine new nontraditional dental schools with up to ten or more proposed—many of these characterized by high tuitions?
10. What will be the impact of the transformation of dental schools away from university-centered models?
11. Will we as a profession address the “barriers to care” or leave that to models of care conceived by others?
12. Will we continue to focus on dentistry as beautifying, repairing, and replacing teeth, or will we accept the broader responsibility for oral health care?
13. Will organized dentistry still be the collective voice of the profession?
14. Ultimately, what will dentistry be like in 2025?

The way we answer these questions—the way you contribute to shaping the answers—will lay the foundation for three broader and more far-reaching challenges:

- Will dentistry continue to be a professionally rewarding career?
- Will dentistry continue to attract committed young professionals?
- Will dentistry continue to be autonomous and patient-centered and deserving of the public's trust?

THE ROLE OF THE COLLEGE IN SHAPING THE FUTURE OF THE PROFESSION

These are large questions, and it would be rash for anyone to pretend they have all the answers. But one thing I can predict with confidence is that the American College of Dentists will have a responsible and respected voice in the discussion.

The American College of Dentists historically has been the leader in the advancement of ethics and professionalism and has always been at the forefront of our profession as we have faced choices in the past. I challenge you to continue in this tradition as we face a tipping point for dentistry. Whether you practice, teach, do research, serve industry, or all the above, or have since retired and continue to represent the profession, I challenge you to wear the mantle of the professional. Furthermore, I challenge you to be the role model, the mentor for your colleagues, for dental students, and for young dentists. I challenge you to step outside of your practices and represent our profession in

the eyes of the public. Become a leader in your community or even at the state or national level. We must have a palpable presence in politics and public service. I see you candidates as that “small group of thoughtful people that will change the world;” those who place ethics first as you steer dentistry successfully beyond this tipping point.

Again, I congratulate you. Each of you has demonstrated to the Credentials Committee that you are worthy of this recognition. You are here because of your leadership qualities alone and not because of any influence by another. This afternoon, as the College bestows on each of you the honor of Fellowship in the American College of Dentists, I encourage you to accept the challenge as well as the recognition. We need more than the preservation of the professional values you exemplify; we need you to raise our profession to heights never before envisioned.

I encourage you to embrace your opportunity to influence the direction of dentistry. To use the words of U.S. Supreme Court Justice Elena Kagan, “Be proud of what you have done but be passionate about what you will do.” And in my own words: “What you do will determine not only your future but your legacy.” ■

Optimism Is PART of the CURE

Nicole Johnson, MA, MPH

CONVOCATION Address

October 11, 2011
Las Vegas, Nevada

I am just about to realize my nineteenth anniversary of living with diabetes.

Because of that, I feel compelled to share my diabetes reality—especially considering that I am among a group of healthcare leaders. I want to encourage and challenge you today regarding an aspect of your profession that sometimes receives small attention: the skill of communicating optimism. There is incredible power there. It is necessary to build business, to put back together lives challenged by disease, and to truly make a difference in the world.

I hope that over the next few minutes you will hear themes of hope and determination. I also hope that you will hear the message that your patients are more than numbers and procedures; that all patients need TLC; and that the family and friends of those you care for are often also dealing with the effects of disease. To be healers, you must be aware of and work with the body, the mind, the spirit, and with others who are part of the lives of your patients.

In my almost 19 years of living with diabetes, I have had to intervene more than 56,000 times to save my own life. That is 45,000 finger sticks, 10,000 injections, and 1,500 insulin pump site changes.

What it means to live with diabetes has changed dramatically. Just 40 years ago, glucose testing was not a reality. Insulin pumps were not much. The pumps that were available were the size

of a big brick. In fact, that is what they were called—the Blue Brick!

Continuous glucose monitoring was not even a blip on the radar. The medical guidelines have changed to reflect better understanding of the disease and availability of new treatment options.

People with most chronic conditions today face a future of hope. A recent lecturer noted that diabetes is the number one cause of absolutely nothing—if it is well controlled. If it is not well controlled, the likely consequences include blindness, heart failure, amputation, and shortened life.

My experience did not begin with optimism or a positive perspective. It began with a massive thunk. That deadening sound was all of my dreams crashing down. I was told in the first days of living with diabetes that everything I wanted out of life was impossible because of my new condition. I was advised by my healthcare professionals to drop out of college, move home with my parents, choose a predictable and calm career, and to forgo motherhood. I was also told that I should avoid competitive environments because they were not a safe place for people with diabetes.

Unfortunately, at first I believed that advice, mainly because I did not know any better. I was given medically appro-



Nicole Johnson, Miss America 1999, has devoted her professional career to promoting diabetes awareness; www.nicolejohnson.com.

priate treatment, but the professionals left out one essential element. They had failed to communicate a realistic sense of optimism. They forgot to tell me that I could live a full and wonderful life if that is what I chose for myself.

Because I was blessed with a natural abundance of self-determination, I self-medicated on positive images for living a full life and not a diseased one. Today, I have two master's degrees and a job in television; I have flown over three million miles educating people about diabetes; and in 2006 I gave birth to a perfect child. In 2010 I secured funding for and am the Executive Director of an innovative project called "Bringing Science Home" at the University of South Florida. Oh, and there was that competition in 1999!

I want you to always keep in mind the power on others of your own visions, your words, and your reactions when you are communicating with patients and their families. So often they are searching your face and your tone of voice for hope. Beyond the medical advice you impart, there are also incredible opportunities to touch patient hearts and souls with motivation.

Are you willing to be open enough to allow that to happen? Are you willing to do absolutely everything in your treatment approach that the patient needs? From where I stand, that is what I believe all patients expect of you.

It is well documented that dentists are among the first observers of disease or disease ramifications, yet they often say little. I implore you to speak up, become engaged, and use the incredible

position you have to affect the health of the entire person. Do everything within your power to make others healthy—fully healthy in the sense of living complete lives, not just in the sense of fixing isolated problems.

Science supports this notion. A positive attitude or optimism leads to a better quality of life and that leads to better outcomes—regardless of the disease! If people believe they can, they will. My coping was accomplished with a lot of help from family, medical experts, a strong social structure, and my faith. I came to understand that diabetes does not have the power to steal life's joys. I know I have worth, regardless of any challenge or obstacle.

Getting to this understanding, however, was not easy. It took plenty of time, patience, and care. I experienced a full range of responses from many health-care professionals. And watching closely, I learned what I needed and what was incomplete care.

Let me give you two stories from my experiences as a patient and a health professional—one inspiring and one not so good.

The good experience happened during my pregnancy, when for the first time in my years with type-1 diabetes I felt welcomed by my healthcare provider. I had often heard the expression, "The doctor will see you now." But for the most part I had only been "looked at," or more accurately, my chart, my lab

I was told in the first days of living with diabetes that everything I wanted out of life was impossible because of my new condition.

I want you to always keep in mind the power on others of your own visions, your words, and your reactions when you are communicating with patients and their families.

results, or radiographs has been duly noted. It is a privilege to be recognized for who one really is. And for the first time I felt as though I was really being “seen.” I became part of my healthcare team. And I was invited to participate in research and contribute to the knowledge base. The feelings and realities in this experience did more good for my diabetes care than any single recommendation or therapy in my life with the disease.

There is value in engaging the patient and then connecting with the patient in an authentic, believable way. There is an old adage that says, “You must be believed to be heard.” When I believed that my providers cared about more than my numbers, my entire reality shifted. My confidence grew. My commitment leaped. These are common sense reactions. People, all people, have an intrinsic need to be noticed and to be heard.

The not so good experience happened as a result of a routine endocrinology visit where I asked to have a copy of my lab results faxed to me. When I received that fax, next to the A1c value were the words, “This is bad.” (In actuality, the A1c value was near the American Diabetes Association recommended level, at the time 7%; but that is beside the point.) The use of the word “bad” was an indictment on my behavior. It was a generalization made without context or knowledge. This left me, as the patient, nervous about future healthcare visits, depressed, angry, and somewhat unwilling to retest my A1c.

Again, this is to the point of compassion, understanding, and appropriate communication, not just about medical knowledge. Communication extends beyond words. So many times in my care I have only seen the top of the professionals’ heads. Their eyes never made contact, their hands never felt my nervousness and frustration, and my feelings were never acknowledged or addressed. Care is incomplete if it does not respect the whole patient.

Helen Keller said, “Character cannot be developed in ease and quiet, but only through the experience of trial and suffering can the soul be strengthened, vision cleared, ambition inspired, and success achieved.”

I have learned several things by living with my disease, and I want to share them with you. First, our limitations do not define us. It is how we respond to these challenges that matter. Second, modern medicine is wonderful, and I am grateful for what it has done in my case and for so many others. But it is incomplete and insufficient when it is nothing more than technical competence. Tell me that I am worthwhile and that I have opportunities and I will flourish despite what others may regard as limitations.

That is what I came here today to tell you: “You, you Fellows of this college, are worthwhile and you have amazing opportunities for helping others.” See, doesn’t that pick you up just a little?



2011 ACD AWARDS

ETHICS AND PROFESSIONALISM AWARD



The Ethics and Professionalism Award recognizes exceptional contributions by individuals or organizations for effectively promoting ethics and professionalism in dentistry through leadership, education, training, journalism, or research. It is the highest honor given by the College in this area. The American College of Dentists recognizes the **International Dental Ethics and Law Society** as the recipient of the 2011 Ethics and Professionalism Award.

In the final two decades of the twentieth century, interest in the disciplines of dental ethics and law began to rise rather quickly. At the inspiration of Dr. Yvo Vermylen, the first International Congress on Dental Law was held in Belgium in 1992. Subsequent international congresses were held in Copenhagen in 1995 and London in 1998 and were expanded to include the field of dental ethics. Two dental ethics summits were also held in the United States in 1998 and 2000 sponsored by the American College of Dentists. A handful of dental ethics textbooks appeared in various

languages, and the number of dental law textbooks grew larger as well. Various local societies for dental ethics or law existed, but an international organization had yet to be founded.

In late 1999, a number of experts in the field of dental ethics and law decided to explore the feasibility of a new international organization. The group was expanded to a total of ten, representing as many different countries. This planning committee defined the nature and scope of the new organization, its primary functions and structure. The statutes were completed in the fall of 2000, and the organization was formally incorporated in December of 2000 as the International Dental Ethics and Law Society (IDEALS). The founding board first met on December 29-30, 2000 in Louvain. It was founded to foster international dialogue on the values that guide oral health care. It is multidisciplinary and open to all interested in this dialogue. There are about 70 members. The Society is a definite force in advancing ethics, professionalism, and ethical principles on a global level.

Accepting the award is Dr. Klaas-Jan Bakker, president of the International Dental Ethics and Law Society. Selected activities and accomplishments of the Society are summarized below:

- Its biannual International Congress on Dental Law and Ethics draws beyond its membership and has had registrations over 200 and it sponsors other major conferences and meetings related to dental law and ethics

- Presentations and papers from its meetings are archived on its Web site and it posts selective book reviews, special invitational papers, and proceedings from other ethics meetings such as ASDE
- The interactions of both law and ethics are uniquely addressed within and between all countries, including the United States
- How variations in ethics and law influence each other, and thus influence our understandings of both law and ethics, are examined, especially the impact on professional ethics in dentistry
- The advance of academic education in ethics, professionalism, and law are fostered and it promotes research and other scholarly activities
- The development of public policies that are respectful of the rights of patients and research subjects are promoted as well as the professional character of the oral health care disciplines
- Working groups are installed that develop and distribute "white papers"
- Close contacts with other international, national, and local organizations interested in ethics and law have been developed and maintained

The Ethics and Professionalism Award is made possible through the generosity of The Jerome B. Miller Family Foundation, to which we are extremely grateful.

HONORARY Fellowship

Honorary Fellowship is a means to bestow Fellowship on deserving non-dentists. This status is awarded to individuals who would otherwise be candidates for Fellowship by virtue of demonstrated leadership and achievements in dentistry or the community except that they are not dentists. Honorary Fellows have all the rights and privileges of Fellowship except they cannot vote or hold elected office. This year there are four recipients of Honorary Fellowship.



Dr. Laura J. Bishop is the Academic Program Officer for International, Library and Outreach Initiatives of the Kennedy Institute of

Ethics and its Bioethics Research Library at Georgetown University. The Bioethics Research Library is the national reference library for ethics and the epicenter of ethics resources of all types. Dr. Bishop is an active member of the American Society for Dental Ethics Section of the College. She has been invaluable in cooperative efforts involving the Ethics Resource Clearinghouse. Highlights of her accomplishments and credentials include:

- BA, Biology with Science and Human Values minor, Wells College, Phi Beta Kappa
- MA, Philosophy, Georgetown University
- PhD, Philosophy and Bioethics, Georgetown University
- Academic Program Officer, Kennedy Institute of Ethics
- Director, High School Bioethics Curriculum Project, Kennedy Institute of Ethics
- Research Associate, Bioethics Research Library, Kennedy Institute of Ethics
- President, Graduate Student Organization, Georgetown University

- Group Leader and Special Topics Lecturer, Intensive Bioethics Course, Kennedy Institute of Ethics
- Program Director, Multi-week Course on Fetal Alcohol Syndrome, Department of Family Medicine, Georgetown University
- Ethics Consultant, Collaborations to Advance Understanding of Science and Ethics (CAUSE) Project, NWABR
- Ethics Consultant, Collaborations to Understand Research and Ethics (CURE) Project, Northwest Association for Biomedical Research (NWABR)
- Program Director and Coordinator, Dental Ethics Symposium, in association with Intensive Bioethics Course, Kennedy Institute of Ethics
- Coordinator, Dental Ethics Affinity Group, American Society for Bioethics and Humanities
- Member, Professional Ethics Initiative Committee, American College of Dentists
- Strategic Planning Committee, American Society for Dental Ethics Section
- Author or co-author, scholarly papers in well-known publications
- Henry Wells Scholar
- Recipient, Francis Tarleton Farenthold Leadership Prize
- BS., Chemistry and Mathematics, Victoria University of Wellington, New Zealand
- MSc, Physical Chemistry, University of Manchester, School of Pharmacy, England
- PhD, Chemistry, Victoria University of Wellington, New Zealand
- Dean, University of California, San Francisco, School of Dentistry
- Professor and Chair, Department of Preventive and Restorative Sciences, University of California, San Francisco, School of Dentistry
- Professor and Chair, Department of Oral Sciences, Eastman Dental Center, Rochester, NY
- Distinguished Scientist Award for research in dental caries, IADR
- T.H. Maiman Award for Excellence in Dental Laser Research, Academy of Laser Dentistry
- Lifetime Honorary Member, Academy of Laser Dentistry
- Joseph J. Krajewski Award for outstanding activities that have contributed to the advancement of the dental profession, American College of Dentists
- Zsolnai Prize for outstanding research in dental caries, European Organization for Caries Research
- Lifetime Achievement Award, World Congress on Microdentistry
- Ericsson Prize in Preventive Dentistry, Swedish Patent Fund, Karolinska Institute, Stockholm
- Excellence in Research Award, World Congress of Minimally Invasive Dentistry
- Norton Ross Award for excellence in clinical research, ADA
- Co-organizer, Caries Management by Risk Assessment Symposium
- Author or co-author of over 220 papers and book chapters



Dr. John D.B. Featherstone has served as the Dean, University of California, San Francisco, School of Dentistry since 2008. It is

unusual for a dental school to have a dean who is not a dentist. Dr. Featherstone is a scientist with a broad background of leadership and accomplishment. He is leading the effort to change the standard of care for dental practitioners. It is expected his research will markedly change the teaching and practice of caries management. Dr. Featherstone's record of accomplishments is summarized below:



Dr. Joseph M. Holtzman is a tenured professor in the Department of Community Health at the New Jersey Dental School.

With the assistance of the College he worked to establish the first multiyear program in ethics at the school, which he directed and in which he has taught for over 17 years. Significant achievements and accomplishments in the career of Dr. Holtzman include:

- BA, Sociology, State University of New York at New Paltz
- MA, Sociology, University of Connecticut
- PhD, Sociology, University of Connecticut
- Research Professor of Gerodontology, University of Colorado School of Dental Medicine
- Director, Long-Term Care Gerontology Center, Health Sciences Center, University of Oklahoma
- Director of Research and Assistant Chief of Geriatrics, Department of Family Practice, Southern Illinois University School of Medicine
- Director, Division of Behavioral Sciences, Departments of Pediatric Dentistry and Community Health and General Dentistry and Community Health, New Jersey Dental School
- Holder of numerous Clinical, Adjunct, and Visiting Academic Appointments
- Recipient of numerous research grants (variety of subjects)
- Author or co-author of 36 publications, 16 book chapters, and 35 published abstracts
- Numerous invited presentations at a wide range of venues
- Member of editorial boards of six journals, three dentally related; and reviewer for four journals

- President of the Academic Assembly, New Jersey Dental School
- President of the Council of Chapters, American Association of University Professors, University of Medicine and Dentistry of New Jersey
- President of the Board of Governors, American Association of University Professors, Newark Chapter, University of Medicine and Dentistry of New Jersey
- Established first multiyear ethics program, New Jersey Dental School



Dr. Jos V.M. Welie is a Professor, Center of Health Policy and Ethics, School of Medicine, Creighton University. He is

an expert in ethics and was a founding member of the International Dental Ethics and Law Society. His scholarship is extensive and influential, and he has a reputation for collaboration and consensus building. He has played an integral role in the online graduate-level courses in ethics at Creighton University. His major accomplishments and milestones in the area of dental ethics are:

- MMedS, Medicine, University of Maastricht (The Netherlands)
- MA, Philosophy, Radboud University (Nijmegen, The Netherlands)
- JD, University of Maastricht (The Netherlands)
- PhD, Medical Ethics, Radboud University (Nijmegen, The Netherlands)
- Recipient of a Fulbright grant in 1988 to study medical ethics at Loyola University of Chicago
- Author or editor of more than 180 publications, among them almost 60 that are specific to the field of dental ethics, including two dozen peer-reviewed articles in leading dental journals and an edited book on ethics and justice in oral health care

- Editorial board member or reviewer for several journals in the field of dentistry
- Founding Secretary, International Dental Ethics and Law Society (IDEALS)
- Congress Chair, Fifth International Congress on Dental Law and Ethics in Omaha
- Instructor of dental ethics for more than 15 years at the Radboud University (Nijmegen, The Netherlands) and Creighton University School of Dentistry
- Lecturer on dental ethics topics in a variety of international venues, including Canada, Croatia, Germany, Italy, Sweden, The Netherlands, Brazil, and Australia
- Principal Investigator, NIDCR-funded grant on the impact of dental education on oral health disparities
- Member, Editorial Committee, first edition of the Dental Ethics Manual produced by the FDI World Dental Association
- Leadership role (with other members of the IDEALS Board) in the drafting of the international guideline on the involvement of dentists in torture adopted by the FDI in Dubai
- Integral faculty member of the online Master of Science in Health Care Ethics at Creighton University
- Course designer and director of the online 3-unit graduate level course in dental ethics at Creighton University expected in late spring 2012

OUTSTANDING SERVICE AWARD

The Outstanding Service Award recognizes Fellows for specific efforts that embody the service ideal, emphasize compassion, beneficence, and unselfish behavior, and have significant impact on the profession, the community, or humanity.



The recipient of the Outstanding Service Award is **Dr. Frank C. Andolino II**. Dr. Andolino is recognized for his

exceptional service to dentistry, his community, and mankind. Dr. Andolino has been a driving force in numerous meaningful service efforts, national and international. A summary of his record of accomplishments and service includes:

- BS, Zoology, Michigan State University
- DDS, Georgetown University School of Dentistry
- Certificate of Orthodontics, Columbia University, School of Dental and Oral Surgery
- Cultural Attaché, Visiting Exchange Students, Georgetown University
- Participant, Exchange Program, Kings College Dental School, London
- Certificate of Appreciation for Services to Delta Sigma Delta Fraternity
- Fellow, New York Academy of Dentistry
- Fellow, American College of Dentists
- Fellow, International College of Dentists
- Co-Founder and Secretary, American Lingual Orthodontic Association
- Ethics Instructor, New York University dental students through New York Academy of Dentistry
- Taught English as a second language to Laotian refugees
- Volunteer, Oral Awareness Program, Golden Harvest Nursing Home
- Volunteer, Children's Identification Program, Washington, DC
- Volunteer, Health Screening at DC Dental Society meeting
- Volunteer, Oral Screening Program, New York Public High School
- Volunteer and Chair, Child Care, Covenant House, NY
- Dance Committee Member, Habitat for Humanity
- Crew Chief, U.S. Olympic Committee Drug Testing
- Health Volunteer Overseas, two weeks of lectures and clinics in Hanoi and Ho Chi Minh City, Vietnam
- Health Volunteer Overseas, site assessment, Phnom Penn, Cambodia
- Himalayan Health Care, lecture and dental clinic in Nepal
- Miracle Corners of the World Dental Outreach Program, Songea, Tanzania, and exploratory visit to Sierra Leone
- Health Volunteer Overseas, Former Director, Vietnam, and Director, Tanzania
- FDI World Dental Federation Representative to the United Nations

SECTION ACHIEVEMENT AWARD

The Section Achievement Award recognizes ACD Sections for effective projects and activities in areas such as professional education, public education, or community service. The 2011 recipient is the **New York Section**, recognized for teaching and promoting ethics at three New York dental schools: Columbia University, New York University, and State University of New York at Stony Brook.

SECTION NEWSLETTER AWARD

Effective communication is a prerequisite for a healthy Section. The Section Newsletter Award is presented to an ACD Section in recognition of outstanding achievement in the publication of a Section newsletter. The award is based on overall quality, design, content, and technical excellence of the newsletter. The **Florida Section** and the **Tennessee Section** are the 2011 co-winners.

MODEL SECTION DESIGNATION

The purpose of the Model Section program is to encourage Section improvement by recognizing Sections that meet minimum standards of performance in four areas: Membership, Section Projects, ACD Foundation Support, and Commitment and Communication. This year's Designation goes to the **British Columbia Section**.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to a Fellow who has been a member of the College for 50 years. This recognition is supported by the Dr. Samuel D. Harris Fund of the ACD Foundation. This year's recipients are:

David A. Bensinger
 Julius J. Bentman
 Charles D. Carter
 D. Walter Cohen
 Floyd E. Dewhirst
 Robert E. Doerr
 Arthur S. Gorny
 Campbell H. Graham
 J. Paul Guidry
 Frank J. Kratochvil
 Theodore E. Logan, Sr.
 Melvin R. Lund
 Ernest B. Mingleddorff
 Mary Lynn Morgan
 Claude L. Nabers
 Kenneth D. Rudd
 Leo Stern, Jr.
 Robert W. Thompson
 Robert B. Underwood
 Daniel E. Waite
 Elmer J. White

2011 Fellowship Class

The Fellows of the American College of Dentists represent the creative force of today and the promise of tomorrow. They are leaders in both their profession and their communities. Welcome to the 2011 Class of Fellows.

Michael A. Abbott
Salem, VA

Gary R. Ackerman
Carmichael, CA

Scott R. Adishian
Pasadena, CA

Chris L. Adkins
Stockbridge, GA

Alejandro M. Aguirre
Plymouth, MN

James D. Allen
Brentwood, TN

Louis J. Amendola
Orange, CA

Peter Arsenault
Dracut, MA

Ronald E. Askeland
Indian Harbor Beach, FL

Jean Edouard Asmar
Washington, DC

Noel J. Aymat
San Juan, PR

William D. Bailey
Atlanta, GA

Marshall A. Baldassarre
Bedford, NH

Cynthia A. Banker
San Antonio, TX

Jeffrey M. Barlow
Merritt Island, FL

Thomas G. Barrick
Cicero, IN

Mark T. Barsamian
Garden City, MI

F. Scott Bauer
Corinth, MS

Ronald M. Bellohusen
Elmira, NY

Jeffrey D. Bennett
Indianapolis, IN

Richard Benninger
Medina, OH

Jeffrey H. Berkowitz
South Burlington, VT

Scott C. Berman
McLean, VA

John S. Bettinger
Santa Monica, CA

Mark H. Blaisdell
Bountiful, UT

Norman B. Blaylock
Rocky Mount, NC

Bernard J. Blen
Collierville, TN

Irene G. Bober-Moken
San Antonio, TX

Mark V. Bohnert
Indianapolis, IN

Ruth Wauqua Bol
Menifee, CA

Kimberley M. Bolden
Chicago, IL

Ronald S. Bowen
Midvale, UT

Richard A. Box
Austin, TX

Brian J. Brada
Golden, CO

George M. Brock
Chattanooga, TN

James R. Brookfield
Kirkland Lake, ON

Donald F. Brown
Atlanta, GA

Michael W. Brown
Newport, AR

William E. Bruce
Simpsonville, SC

Peter A. Brymer
Toronto, ON

Thien D. Bui
San Jose, CA

Charles K. Burling
Dowaglac, MI

Tana M. Busch
Austin, TX

David W. Canfield
Blue Ridge, TX

Gerard A. Caron
Andrews AFB, MD

Frank Carotenuto
Roselle Park, NJ

John J. Carpendale
Vancouver, BC

Robert S. Carter
Fayetteville, NC

John L. Carter
Midland, MI

Angelle M. Casagrande
Tucson, AZ

Stephen M. Casagrande
Carmichael, CA

May M. Chang
Portland, OR

Peter J. Chauvin
Montreal, QC

Jake Jinkun Chen
Lexington, MA

Susan M. Chialastri <i>Flourtown, PA</i>	Diane Ede-Nichols <i>Miami Shores, FL</i>	Elizabeth K. Gesenhues <i>Jacksonville, FL</i>	Wayne S. Harrison <i>Gloversville, NY</i>
Kenneth Chow <i>Vancouver, BC</i>	Adam A. Edwards <i>Altamont, NY</i>	Micaela Gibbs <i>Gainesville, FL</i>	Mary S. Hartigan <i>Jacksonville, FL</i>
Brian L. Cilla <i>Ada, MI</i>	Richard S. Eidson <i>Chapel Hill, NC</i>	E. Jane Gillette <i>Bozeman, MT</i>	Dennis B. Hartlieb <i>Glenview, IL</i>
David V. Ciriani <i>Kamloops, BC</i>	Michael L. Ellis <i>Dallas, TX</i>	Randal M. Glenn <i>Missouri City, TX</i>	David M. Hasson <i>Mt. Airy, MD</i>
Bryan Cobb <i>Greensboro, NC</i>	Alyson D. Emery <i>Long Beach, CA</i>	Joel T. Glover <i>Reno, NV</i>	Drake A. Hawkins <i>Little Rock, AR</i>
Greg Condrey <i>Sugar Land, TX</i>	Neal H. Engel <i>Aurora, CO</i>	Michael J. Goldberg <i>New York, NY</i>	William H. Heisler <i>Loma Linda, CA</i>
McClellan B. Conover <i>Burton, MI</i>	Armond M. Enos <i>Ashland, MA</i>	Michael V. Gomez <i>Douglas, AZ</i>	John A. Hendry <i>Lafayette, LA</i>
Robert A. Corns <i>Valparaiso, IN</i>	Sheila Esfandiari <i>Rockville, MD</i>	Thomas C. Goodsell <i>Battle Creek, MI</i>	Alan S. Herford <i>Loma Linda, CA</i>
Fred W. Costello <i>Ormond Beach, FL</i>	Jeffrey C. Esterburg <i>Medina, OH</i>	Harvey P. Gordon <i>Ft. Lauderdale, FL</i>	Gary N. Herman <i>Valley Village, CA</i>
Sun Costigan <i>Novato, CA</i>	Joanne M. Falzone <i>Weymouth, MA</i>	Payam Goudarzi <i>Johnson City, NY</i>	Sally Hewett <i>Bainbridge Island, WA</i>
Steven C. Crowson <i>Chico, CA</i>	Phillip J. Fijal <i>Des Plaines, IL</i>	Paul W. Guevara <i>Honolulu, HI</i>	Michael R. Higashi <i>Seattle, WA</i>
Paul E. Cullum <i>Columbia, TN</i>	Maxwell D. Finn <i>Dallas, TX</i>	Peter H. Guevara <i>Clarksville, TN</i>	Diane I. Hines <i>Detriot, MI</i>
H. Candace DeLapp <i>Highland Ranch, CO</i>	Dan E. Fischer <i>South Jordan, UT</i>	Tony Guillen <i>Fallon, NV</i>	Joel A. Hirsch <i>New York, NY</i>
James A. DeLapp <i>Highlands Ranch, CO</i>	Ulrich Foerster <i>Gainesville, FL</i>	Hans P. Guter <i>Circleville, OH</i>	Steven C. Hollar <i>Warsaw, IN</i>
Robert L. Delarosa <i>Baton Rouge, LA</i>	Raymond J. Fong <i>Vancouver, BC</i>	Janet M. Guthmiller <i>Chapel Hill, NC</i>	Robert P. Hollowell <i>Morrisville, NC</i>
Elizabeth A. Demichelis <i>Modesto, CA</i>	Daniel W. Fridh <i>La Porte, IN</i>	James W. Hackler <i>Tulsa, OK</i>	Terry E. Hoover <i>Los Gatos, CA</i>
Christopher T. Di Turi <i>Shrewsbury, NJ</i>	Marc B. Gainor <i>New York, NY</i>	Cheryl D. Haley <i>Ozark, MO</i>	Joyce P. Huey <i>Baltimore, MD</i>
Christopher J. Douville <i>Tucson, AZ</i>	Audrey Levitt Galka <i>Fort Lauderdale, FL</i>	Howard A. Hamerink <i>Plymouth, MI</i>	Mary Jennings <i>Walla Walla, WA</i>
Brendan Dowd <i>Kenmore, NY</i>	Steven P. Geiermann <i>Chicago, IL</i>	Barry D. Hammond <i>Evans, GA</i>	Lee D. Jess <i>Grand Rapids, MN</i>
Howard J. Drew <i>Short Hills, NJ</i>	Jonathan R. Gellert <i>Lowville, NY</i>	Robert A. Handysides <i>Loma Linda, CA</i>	Gene Jines <i>Little Rock, AR</i>
John W. Drone <i>DeMotte, IN</i>	Daniel C. George <i>Holland, MI</i>	William G. Harper <i>Poquoson, VA</i>	Jay A. Johnson <i>Cocoa, FL</i>
Richard L. Dunham <i>Wilton, NY</i>	Suzanne S. Germain <i>Zionsville, IN</i>	Bradley M. Harris <i>Memphis, TN</i>	Christine M. Johnson <i>Sedro Woolley, WA</i>

Michael R. Johnson <i>Hixson, TN</i>	Thomas S. Layton <i>Charlotte, NC</i>	Kieth E. Manning <i>Edmonton, AB</i>	Jennie E. Nichols <i>Medina, OH</i>
Robert L. Jones <i>Washington, DC</i>	Irene S. Lazarchuk <i>Sterling Heights, MI</i>	George A. Maranon <i>Encino, CA</i>	Sandra L. Nicolucci <i>London, ON</i>
Bradford S. Jungels <i>Northfield, NJ</i>	Bach T. Le <i>Whittier, CA</i>	Michael J. McCartney <i>Tustin, CA</i>	Richard Niederman <i>Cambridge, MA</i>
Douglas C. Jungman <i>Bradenton, FL</i>	Huong N. Le <i>Oakland, CA</i>	Jack M. McGill <i>Tupper Lake, NY</i>	Marc G. Nuger <i>Glen Burnie, MD</i>
Bruce C. Justman <i>Iowa City, IA</i>	Jonathon E. Lee <i>Foster City, CA</i>	Samuel T. McGill <i>Charleston, SC</i>	William A. Octave <i>Greensburg, PA</i>
Nazeem S. Kanani <i>Vancouver, BC</i>	James Lemon <i>Columbia, SC</i>	John C. McLister <i>London, ON</i>	Anne E. O'Day <i>Furlong, PA</i>
Christopher Kane <i>Sacramento, CA</i>	Arlene M. Lester <i>Atlanta, GA</i>	Richard G. Meltzer <i>Aspen Hill, MD</i>	Gerald W. Ogilvie <i>Blue Springs, MO</i>
Sarit Kaplan <i>Bethesda, MD</i>	Marci H. Levine <i>New York, NY</i>	Peter G. Meyerhof <i>Sonoma, CA</i>	David M. Okuji <i>Aptos, CA</i>
Peter R. Kearney <i>West Vancouver, BC</i>	Christopher G. Liang <i>Potomac, MD</i>	Michelle S. Mirsky <i>New York, NY</i>	Eliot L. Paisner <i>Nashua, NH</i>
Paul A. Kennedy <i>Corpus Christi, TX</i>	Panagiotis Limniatis <i>Laval, QC</i>	John T. Modic <i>Mechanicsville, MD</i>	Gary M. Palsis <i>Indiana Harbour Beach, FL</i>
Mark C. Kilcollin <i>Union, WV</i>	Mitchell J. Lipp <i>New York, NY</i>	Laurie F. Moeller <i>Metairie, LA</i>	James M. Pappenfus <i>Pittsburgh, CA</i>
Allen C. Kincheloe <i>Stafford, TX</i>	John T. Lockard <i>Broken Arrow, OK</i>	Vincent E. Montgomery <i>Norman, OK</i>	Craig S. Pate <i>York, PA</i>
Scott O. Kissel <i>New York, NY</i>	Lester H. Low <i>Stockton, CA</i>	Joseph T. Morgan <i>Lake Mary, FL</i>	Mina Paul <i>Needham, MA</i>
Michael A. Kleiman <i>Edison, NJ</i>	Edward Lowe <i>Vancouver, BC</i>	Susan K. Morgan <i>Morgantown, WV</i>	Manuel F. Pavez Herrera <i>Santiago, Chile</i>
Perry R. Klokkevold <i>Rancho Palos Verdes, CA</i>	Oariona Lowe <i>Whittier, CA</i>	Michael S. Moscovitch <i>Westmount, QC</i>	Bettina A. Pels-Wetzel <i>Schenectady, NY</i>
George F. Koerber <i>Oakland, CA</i>	Christopher D. Lynch <i>Heath, United Kingdom</i>	Brett H. Mueller <i>San Antonio, TX</i>	Neil J. Peppitt <i>Hunters Hill, Australia</i>
Mitchell W. Kramer <i>Edmond, OK</i>	Richard J. Lynch <i>Williamsville, NY</i>	Esteban Mulkay <i>Pembroke Pines, FL</i>	David M. Perry <i>Alameda, CA</i>
Wayne Kye <i>Flushing, NY</i>	Robert D. Lynds <i>Paso Robles, CA</i>	Mark S. Murphy <i>Little Rock, AR</i>	Leslie L. Pitner <i>Columbia, SC</i>
John D. LaBriola <i>Annandale, VA</i>	Lucinda J. Lyon <i>San Francisco, CA</i>	Richard J. Nagy <i>Santa Barbara, CA</i>	Denise A. Polk <i>Flint, MI</i>
Edward P. Laco <i>Crown Point, IN</i>	M.A.J. MacNeil <i>Oak Park, IL</i>	Greg C. Nalchajian <i>Fresno, CA</i>	Richard W. Portune <i>Dayton, OH</i>
Ronald J. Laux <i>Elmira, NY</i>	Robert D. Madden <i>Littleton, CO</i>	Kenneth Namerow <i>Fort Lauderdale, FL</i>	Steven E. Powell <i>Norman, OK</i>
Mark A. Lawrence <i>Columbus, GA</i>	Felix T. Maher <i>Savannah, GA</i>	Dallas L. Nibert <i>Huntington, WV</i>	John E. Pratte <i>La Canada, CA</i>

Glenn C. Prezkop <i>Santa Maria, CA</i>	Ronald J. Sani <i>Fresno, CA</i>	William T. Spruill <i>Carlisle, PA</i>	A. Melissa Vargas <i>Chicago, IL</i>
Timothy J. Pruett <i>Tavares, FL</i>	Earl L. Sauget <i>Tamuning, Guam</i>	Richard C. Staller <i>Princeton, NJ</i>	James W. Vargo <i>Beckley, WV</i>
John T. Raabe <i>Denver, CO</i>	Thomas R. Schierbrock <i>Council Bluffs, IA</i>	Larry M. Stanleigh <i>Calgary, AB</i>	Curtis E. Vixie <i>Susanville, CA</i>
Allan A. Raden <i>Voorhees, NJ</i>	David C. Schirmer <i>Corning, NY</i>	Heidi J. Stark <i>Lincoln, NE</i>	Petra von Heimburg <i>Barrington, IL</i>
Michael D. Rader <i>South Bend, IN</i>	Paul E. Schneider <i>Philadelphia, PA</i>	Michael S. Stern <i>Montgomery Village, MD</i>	William F. Waggoner <i>Las Vegas, NV</i>
Raj M. Rawal <i>Merritt Island, FL</i>	Melvin Schwartz <i>Montreal, QC</i>	Roy L. Stevens <i>Oklahoma City, OK</i>	Harmeet D. Walia <i>Dhahran, Saudi Arabia</i>
Robert E. Reed <i>Bakersfield, CA</i>	Joseph P. Sciarra <i>Woodland Hills, CA</i>	Jeffrey A. Stolarz <i>Whiting, IN</i>	Kenneth G. Wallis <i>Santa Clara, CA</i>
Kevin I. Reid <i>Rochester, MN</i>	William W. Seaton <i>St. Louis, MO</i>	William E. Strohman <i>Algona, IA</i>	Cheryl Watson-Lowry <i>Chicago, IL</i>
James H. Reisman <i>Dallas, TX</i>	Charlotte L. Senseny <i>Torrance, CA</i>	Rada Sumareva <i>New York, NY</i>	Lawrence W. Weeda <i>Memphis, TN</i>
Jean-Marc Retrouvey <i>Montreal, QC</i>	Louis R. Sertich <i>Merrillville, IN</i>	Scott D. Swank <i>Bel Air, MD</i>	Gary Weisbly <i>Little Rock, AR</i>
Lorin Rice <i>Portland, OR</i>	Susan L. Settle <i>Oklahoma City, OK</i>	Edward J. Swift <i>Chapel Hill, NC</i>	Brian D. West <i>Nashville, TN</i>
Marc Robert <i>Longueuil, QC</i>	Anthony R. Silvestri <i>Plymouth, MA</i>	James F. Szarko <i>Parkersburg, WV</i>	Theresa M. White <i>Oklahoma City, OK</i>
Victor Rodriguez <i>Houston, TX</i>	Donald Sirianni <i>Happy Valley, OR</i>	George Taybos <i>Jackson, MS</i>	John B. Whitley <i>Baton Rouge, LA</i>
Diane D. Romaine <i>Frostburg, MD</i>	Jay Skolnick <i>Webster, NY</i>	George W. Taylor <i>Ann Arbor, MI</i>	Aldridge D. Wilder <i>Chapel Hill, NC</i>
Genaro Romo <i>Oak Lawn, IL</i>	Dave L. Smith <i>Las Vegas, NV</i>	Sorin T. Teich <i>Beachwood, OH</i>	Daniel J. Wilguess <i>Edmond, OK</i>
Nancy R. Rosenthal <i>Jenkintown, PA</i>	Susan E. Snyder <i>Lafayette, IN</i>	R. Bruce Templeton <i>Edina, MN</i>	Claude R. Williams <i>Dallas, TX</i>
Bruce E. Rotter <i>Glen Carbon, IL</i>	Jane A. Soxman <i>Allison Park, PA</i>	Larry J. Tenaschuk <i>Milton, ON</i>	Barry R. Wolinsky <i>Springfield, NJ</i>
Barry F. Rouch <i>Austin, TX</i>	Ronald D. Spain <i>Durham, NC</i>	Sharine V. Thenard <i>Alameda, CA</i>	David T. Wong <i>Los Angeles, CA</i>
Brett A. Roufs <i>Newton, KS</i>	James A. Sparks <i>Oklahoma City, OK</i>	Vic H. Trammell <i>Broken Arrow, OK</i>	Ralan D. Wong <i>San Francisco, CA</i>
Byron G. Rowell <i>Grand Rapids, MN</i>	Mark M. Spatzner <i>Westmount, QC</i>	Raymond J. Unland <i>Metairie, LA</i>	Debrah J. Worsham <i>Center, TX</i>
Steven J. Sadowsky <i>San Francisco, CA</i>	Craig W. Spencer <i>Lansing, MI</i>	Gary A. Uriu <i>Captain Cook, HI</i>	Cecile Yoon-Tarlie <i>Newton, MA</i>
Sima Salimi <i>San Francisco, CA</i>	Mike E. Spoon <i>Victor, NY</i>	Eric W. Van Zytveld <i>Denver, CO</i>	Paul S. Zimmerman <i>Augusta, ME</i>

PERSONAL ETHICAL DILEMMA: IS THE PATIENT COMPETENT?

Alice Nunes

Directions for Course Assignment: *Please describe an incident that happened during your training here at the University of Washington School of Dentistry that posed an ethical dilemma for you. Please disguise the identities of each person involved. Begin by describing the incident, applicable state laws and ethical principles, the options that you as the dentist had, and the best option that you as the dentist had*

Mr. E is an 88-year-old gentleman who lives on his own in a suburb of Seattle. He was assigned as my treatment-planning patient one year ago. Mr. E typically rides the bus for two hours to get to his appointments in Seattle, but occasionally he will receive a ride from a neighbor. During our early conversations Mr. E. disclosed that he has two different engineering PhDs, was the CFO for a national energy corporation, and was the president of a national engineering organization.

Mr. E has been a patient of the University of Washington School of Dentistry for a number of years. Mr. E has rampant caries on his remaining teeth, all of which have relatively new porcelain or complete ceramic crowns. Mr. E no longer has the proper dexterity to care for his remaining teeth and he admits that he no longer brushes them. Most of Mr. E's remaining teeth cause him significant pain. To alleviate tooth pain, Mr. E sucks on cough drops, swishes with gin, and takes sleeping pills.

Mr. E has very poor vision and thus has difficulty seeing the condition of his

teeth. His primary concern is tooth #8, which is the only remaining tooth in his right maxillary arch. The tooth is fractured at the gum line and carious. He says he is embarrassed because he has meetings with prominent elected officials and his teeth do not look right.

One year ago Mr. E told me that he is primarily interested in temporary fixes to his oral health problems. Mr. E has two brothers in Portland, both of whom are "on their deathbeds." Mr. E has also informed me that he frequently checks the newspaper obituaries and he has noticed that most obituaries are for those in their 80s. He told me that a temporary fix for him is most likely going to be a permanent fix since he will not be alive for much longer.

Mr. E has a son who lives a few hours away. I have inquired as to whether his son would like to come to our treatment-planning appointments so that he could offer Mr. E. some support and advice on his oral health. Each time I inquire about having Mr. E's son present at our appointments, Mr. E replies that he will think about the possibility, but then informs me that his son is a very busy man.



Alice Nunes is a fourth-year dental student at the University of Washington. This assignment is typical of those required of students for their ethics class. The paper was submitted by Dr. Trilby Coolidge, co-coordinator of the ethics course.

I feel Mr. E does not understand the gravity of his condition. Not only is Mr. E neglecting his oral health, but he has informed me that he does not regularly see a physician and seldom takes medication for any ailments. Despite his actions, I believe that Mr. E's credentials are genuine and that he is quite an intelligent man.

In the past year, Mr. E has come in for several treatment-planning sessions. As he has called to discuss his painful teeth, I have made appointments for him to have them extracted. It has been a long and frustrating process convincing Mr. E to extract his remaining teeth after he recently invested so much time and money into crowns and veneers placed by previous University of Washington dental students.

WASHINGTON STATE LAWS

RCW 74.34 describes the responsibility of dentists and others to report possible abuse of vulnerable adults. Although Mr. E lives on his own, I am concerned that he may not be completely capable of caring for himself. Mr. E's diet consists primarily of candy, ice cream, canned soups, and alcohol. Mr. E does not want to ask his son for help in matters regarding his health care. I firmly believe that Mr. E is a vulnerable adult and is currently living in a state of "self-neglect," compromising his health by masking his dental problems with sleeping medications and alcohol. Community members, regardless of age, make poor decisions regarding their health care. When is it the dentist's responsibility to alert social services when an elder falls into this category?

RCW 18.130.180, Section 4 describes incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. Mr. E's previous student dentist may have been demonstrating negligence or incompetence if he or she had performed the extensive dental work on Mr. E knowing that he is not fully capable of properly managing his oral hygiene. A dentist must be aware of a patient's ability to maintain dental restorations. Mr. E's poor oral hygiene, diet, vision, and manual dexterity should have been taken into consideration before the previous dentist placed porcelain crowns and veneers. Had these circumstances been evident during the previous treatments, Mr. E's prior dental student may be seen as creating unreasonable health risks to Mr. E, thus demonstrating negligence.

RCW 18.130.180, Section 16 describes misconduct resulting in promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service. The previous dental student would have violated this section if the treatment for Mr. E was completed in order to satisfy clinical requirements while disregarding Mr. E's need or indication for such treatment.

ADA Code of Ethics

Patient Autonomy: Mr. E's thought process is different from what I would want for myself if I were in his position. However, Mr. E seems to know what he does and does not want. I have spent many hours in treatment-planning sessions talking to him, explaining his needs and presenting him with possible treatment options. We have discussed the possible outcomes and associated costs of various treatments. The time I have spent with Mr. E has allowed him to accept that he needs a comprehensive treatment plan that addresses his whole mouth while preserving his general

health. Such a plan will avoid trying to save his remaining teeth with root canals, buildups, and new crowns while he is unable to maintain proper oral hygiene.

Mr. E's ability to provide informed consent is uncertain. We spent many appointments reviewing the hopeless prognosis for his teeth and his need for a denture. He frequently leaves appointments saying, "Well, you've surely given me a lot to think about." He calls several days later asking about crowns and the possibility for dental treatment other than what we had discussed. Being that Mr. E has had such extensive dental treatment in the past, he may simply be upset that he must extract his teeth and is trying to avoid this plan.

In order to abide by the principle of confidentiality (Section 1B) I have avoided discussing the complications of Mr. E's case with the gentleman who occasionally brings Mr. E to his appointments. This gentleman's daughter is a nurse and has called the dental school in the past to inquire about Mr. E's care. She did not get in contact with me; however, Mr. E may allow me to talk with her to coordinate the treatment presentation appointment so that he can be properly cared for while he is healing from oral surgery.

When does a dentist decide if a person is unfit to make decisions for himself or herself? Just because someone is elderly, should his or her ability to make mistakes and poor judgment calls be limited? Younger adults make poor decisions constantly; however, they are allowed autonomy to follow their own desires.

Nonmaleficence: It may be easy to assume that the student dentist responsible for the expensive dental treatment Mr. E has had in the past was being negligent and causing harm to Mr. E. Alternatively, the patient may have been more diligent about oral hygiene in the

past and the work may have been warranted at the time. Due to the principle of nonmaleficence, I must not abandon my patient despite my frustrations (Section 2F).

Beneficence: Though Mr. E is an extremely intelligent man, he seems to be making poor choices for himself. It is a dentist's obligation to make Mr. E aware that combining alcohol and sleeping medications is a deadly combination. It may be the dentist's responsibility to contact social services in this case (Section 3E). I feel it might benefit Mr. E to contact social services or a caregiver, but Mr. E may strongly oppose this decision.

Justice: It has been difficult finding the patience to work with Mr. E for the last year. The slow pace of our treatment has hindered my ability to see other patients. Should Mr. E be informed that the treatment plan implemented by previous dental students might have been ill-conceived, given his lack of dexterity and poor oral hygiene? At the time of these procedures, was Mr. E better able to care for the restorations? If there was overwhelming evidence supporting the same general conditions that I have seen with Mr. E, perhaps the concerns over treatments made by prior dental students should be brought to the attention of those heading the University of Washington School of Dentistry (Section 4C).

Veracity: My communications with Mr. E have been truthful. I have explained the possibility of having a full mouth rehabilitation or other treatment.

WHAT IS TO BE DONE?

Ethically I am obligated to provide care to Mr. E. I am also obligated to report Mr. E to the authorities if he is experiencing self-neglect. The definition of self-neglect and the definition of whether someone

is capable of providing consent for their treatment seem blurred. My patient can take the bus to Seattle and write checks and balance his checkbook to pay for his treatment. He also makes poor life choices. At what point does a practitioner intervene and attempt to put limits on a patient's freedom to live as he or she pleases?

The dentist has several options. I can present several treatment options and allow Mr. E to make the final call. Or I can provide the "ideal" possible treatment for Mr. E that incorporates overall health, function, esthetics, time, finances, and travel. Most likely the more extensive treatments that would not be appropriate for someone incapable of brushing his or her teeth should be omitted. I can call the authorities to have Mr. E cared for by a government agency. I can refuse treatment to Mr. E unless he returns with someone who can help him make better decisions.

On balance, it seems most appropriate for me to request Mr. E to bring a trusted friend or family member to help him make the best decision regarding his health care. If he continues to demonstrate self-negligent behavior, social services should be involved. It would also be useful to discuss Mr. E's condition with a friend or family member (should he allow it) and advise that person to monitor him for complaints of dental pain. Such an advocate should also become aware of the dangers of mixing drugs and alcohol and be requested to bring Mr. E to the dental clinic for tooth-related pain issues. ■

At what point does a practitioner intervene and attempt to put limits on a patient's freedom to live as he or she pleases?

PUTTING YOUR MONEY WHERE YOUR MOUTH IS

THE INFLUENCE OF AMERICAN CONSUMER CULTURE ON CONTEMPORARY DENTISTRY

Annalee Asbury

While plainly dressed in jeans and a white shirt, and without uttering a word of my horrible French, the woman blatantly exposed my American roots because “Your teeth,” she reasoned, “they’re too nice.” After months of trying to fit in Paris, my teeth blew my cover instantaneously. I might as well have stamped AMERICAN across my central incisors in red, white, and blue.

This idea of a clearly distinct American smile is much deeper than just the confines of dentistry. Health care, and within that category, dental care, is quite inseparable from the social, economic, and political climates of our country. Hundred-year-old forces have spawned an American consumer culture which has infiltrated into the healthcare arena and has turned people’s health into commodities, patients into consumers, and doctors into providers. These powerful forces have seeped into the field of dentistry and influenced modern perceptions and practices of cosmetic dentistry, but have also posed serious challenges to traditional dental ethics.

This paper examines the impact of the American consumer mentality on the current practice of American dentistry and recommends against treatment that has an exclusively esthetic purpose.

HISTORICAL PERSPECTIVE

American consumer culture, as developed at the turn of the twentieth century, created a society whereby the purchasing

of goods constituted a national identity and way of life. A consumer society is one in which discretionary consumption has become a mass phenomenon, not just the province of the rich or even the middle classes, and it started in the United States in the 1920s. The idea was first exemplified by the “line production system” for “maximum production economy” in the Ford factories in 1910. Ford was able to make cars quickly and efficiently, and someone had to buy Ford’s cars. By the 1920s “interest in and employment of the industrial potential extended far beyond the automotive industry” into forming the greater part of the American national identity (Ewen, 1976). This paradigm that launched the United States into the world’s economic forefront over 100 years ago resulted in modern-day consumer culture and can be seen in contemporary dental practices.

CONTEMPORARY IMPLICATIONS FOR DENTAL ESTHETICS

American consumer culture influences dentistry such that the smile as a cultural object has been constituted by society through a range of meanings and practice and has most definitely become an item of consumption and can be bought and sold, not so dissimilar to a Ford car in the 1910s. Not only has the United



Annalee Asbury is in her final year as a dental student at the University of the Pacific. This paper was prepared for the second-year ethics course and was recommended by the course director, Dr. Bruce Peltier.

States incorporated cultural principles into teeth and their appearance, but so have several other nations. Similarly, because American consumerism heavily influences the smile, dental esthetics focus more on social implications rather than biological function. Veblen's (2007) model of conspicuous consumption certainly applies. Patients use the appearance of their teeth to represent their success in life. A beautiful smile is proof to the self and others that they have made it and are worthy. Finally, as the American culture pushes for the culturally centered smile, it turns people into consumers who demand that dentists supply a characteristic smile. Despite the ideal view that dentistry's mission is to treat and cure diseases of the mouth, the culture in which we live inherently adds powerful additional considerations as seen in how dental esthetics is viewed and treated.

More than just tools of mastication, teeth represent the culture of their attached individual whether it is a cave-man or bushman in South Africa or a skinny model on the front of a modern fashion magazine. Essentially, teeth are artifacts of human culture. Characteristics of teeth are assigned certain cultural values, and represent something to be identified that make teeth something not just of need, but a want and demand. There are endless examples of how different cultures view the appearance of their teeth and modify them according to their given cultural climates, just as American teeth are viewed and assigned value based on the consumer culture.

In addition to dental modifications seen in American dentistry, tooth adjustments from around the world include everything from color modifications to jewel inlays, and all have been speculated to represent or symbolize values of the time and people. The actual look of teeth varies from culture to culture. For example, in Vietnam, people have deliberately stained their teeth as an indicator of social status because "any dog can have white teeth" (Johnson, 1999). In one area of Vietnam, village inhabitants broke their incisors at the gum line to indicate adulthood, marriage status, and beauty. Blackening of the teeth in the Heian and Edo areas of Japan signified, among other things, "robustness" and "dignity" of Samurais and the marital status of young women. In late classic Mayan sites, modifications ranging from crown shaping to jewel inlays have been seen. In general, many investigators believe that dental mutilation correlates with high social position.

Contemporary American dental esthetics are complicated, but not so different from many ancient civilizations. In an essay on dental anthropology, Clarke Johnson (1999) explains: "Our clinical ideals of dental beauty as straight, white, vertically positioned teeth in perfect bilateral symmetry are shaped by Hollywood, advertising, and the media. Indirectly, we associate attractive teeth with health and vigor."

With the media available for patients to educate themselves about a variety of esthetic procedures, patients turn themselves into consumers who are apt to "shop around" for a practitioner to provide what they want.

Hollywood, advertising, and the media are all key players in the conception of American consumer culture. American dentists are selling their esthetic work as a necessity, calling the smile, “the ultimate fashion accessory” (Paulus, 2010). The very word “fashion” implies a cycling of products to be bought and discarded when they are out of fashion and thus closely mirrors the throw-away society created by the mass production-consumption economy. Other values from the consumer culture such as prestige, beauty, acquisition, and self-adornment still ring true when thinking about today’s smile in its association with attractiveness, vigor, youth, health, and wealth. The American smile has become a name brand in global dentistry and the trademark label is stamped across patients’ faces.

The consumer mentality in the United States places a price tag on the smile, similar to that of a car, and thus makes it an item of social status. In 1899, Thorsten Veblen published *The Theory of the Leisure Class* in which he coined the term “conspicuous consumption,” meant to describe excessive expenditure of money and resources to outwardly display a higher social status. Since Veblen’s documentation of this phenomenon at the beginning of the twentieth century, conspicuous consumption continues unabated in America, as seen in brand-name labels on clothing, types of cars, and leisure activities. These are all items viewed socially, indicating that they are not necessarily meant for utility, but rather for expression of social status. It has been noted that the body has become a

form of physical capital—a possessor of power, status, and distinctive forms central to the accumulation of various resources meant to attain social status. The idea of Veblen-goods can also be extended to esthetic dentistry in that much of it is not driven by the utility of the procedure, but more so the vanity of the patient wishing to attain an image of health, vigor, and wealth culturally associated with teeth as described above. Cosmetic dental procedures of today are clear extensions of Veblen’s observations of the American economy.

Finally, the consumer culture machine created an increasingly self-conscious generation of people where media-created insecurities can be addressed by the consumption of esthetic dentistry. The urge to consume was actually made into a national priority in a Calvin Coolidge speech to advertisers in 1926 where he mentioned the need to induce in people the desire for better things (Ewen, 1976). American marketing of dental beauty as an unnaturally white, straight, symmetrical smile creates its own demand. Dentists, dental supply companies, and esthetic procedures provide the supply. This kind of advertising, as seen almost in all aspects of American goods, glorifies an unnatural smile as healthy and happy and suggests that anyone without it is in need of treatment.

American consumer culture as developed in the early 1900s has created a cultural push for a “piano key” smile, an interest in displaying status through cosmetic dental procedures, and a market that is based on the continual want of better things.

Ethical Implications

American consumer culture heavily influences the American smile, and with ever-increasing technologies, the means exist to carry out these procedures. The

question is then: should the dental profession go down this road of selling the latest “fashion accessory” (Paulus, 2010)? The extension of consumerism into the dental field through the esthetic smile introduces some critical economic-based commercial features into oral care. In many cases, these features are in conflict with traditional ethical principles of health care. Some of these conflicts include the increase of advertising of professional services, the stress on the doctor-patient relationship, and finally the issue of overtreatment or unnecessary treatment. The creation and increase in demand of dental esthetics has indeed complicated dental ethics.

The consumer culture is well suited for the American capitalistic economy, but dentists are caught between the worlds of health care and commerce when it comes to cosmetic treatments. One such example is the increase in advertising of dental procedures. “From the days of dentistry’s first code of ethics, the profession’s governing organizations have attempted to address this issue with the intent of restricting commercialism that was deemed to be at odds with professionalism” (Jerrold & Karkhanehchi, 2000). Overall, commercialism stresses profit as a primary goal with the exchange of money for commodities as a means for profit. On the other hand, health care properly views the health of the patient as a primary goal with money as a secondary consideration (Giusti & Peltier, 2008). When the profit motive clashes with the health of a patient, which prevails? Advertising and marketing, then, under the category of commercialism to drive profit, seem to be misplaced in the context of oral healthcare providers. In a 1979 ruling regarding professional advertising, the U.S. Supreme Court decided that: “Since advertising is ‘...the traditional mechanism in a free market economy for a supplier to inform a potential purchaser of the availability and the terms of exchange,’ a rule

restraining advertising would be at odds with the profession's ethical imperatives to help facilitate the making of legal (dental) professional services fully available to the public" (Jerrold & Karkhanehchi, 2000). The ruling alone acknowledges that the "free market economy" precedes the ethics of the dental profession and views advertising of dental care as acceptable. The modern increase in advertising and marketing activities in dentistry clearly demonstrates a growing overlap between the commercial world and dental profession, generally challenging the ethics of care.

Cosmetic dentistry changes the doctor-patient relationship by moving the practitioner away from a role of trust in making decisions in the best interest of the patient (with the goal of restoring functional oral health) to one of selling alterations that achieve culturally determined esthetics. The doctor-patient relationship plays a critical role in the ethics of health care and provides the basis of trust between participants (a fiduciary relationship). The introduction of consumerism into dental practices does not take into consideration this pivotal part of treatment and instead emphasizes a competitive buyer-seller interaction. With the media available for patients to educate themselves about a variety of esthetic procedures, patients turn themselves into consumers who are apt to "shop around" for a practitioner to provide what they want.

While in some aspects, increased public awareness is an important gain in a path toward mutual participation of the patient and doctor in treatment decisions, elective, esthetic oral procedures are found almost entirely in the commercial marketplace. As Gordon Christensen (2000) puts it: "Elective oral treatment competes with every discre-

tionary consumer expense, and patients must make a choice between spending discretionary funds on oral treatment or on other items such as a television, a vacation, or an automobile."

Different from routine fillings and crowns to replace decayed tooth structure, esthetic treatments clearly turn dentists into "sellers" and patients into "buyers," greatly shifting the care model of dentistry closer to a commercial model of business.

Finally, the issue of overtreatment must also be considered because esthetic dentistry almost always involves the removal of sound and healthy tooth structure. This behavior is at odds with dentists' primary goal of healing disease that compromises teeth. Richard Simonsen (2007) pinpoints the issue when he says, "The point is that no material we have is as good as the enamel and dentin we are born with, and to replace virgin teeth with unnecessary crowns... or veneers, is unethical, even if the expertly placed veneer or crown never fails." One of the first things preached in dental school is conservation of tooth structure, which is in direct conflict with the current cultural trend of a Hollywood smile created with veneering and fragile crowns.

However, patients are willing to pay for these procedures and at this time, cosmetic dentistry in the United States earns a pretty penny for the practitioner. This sector in dentistry incorporates commercial factors more than anything else: patients are the consumer of the culturally valued American-esthetic smile, they shop around for what they want and someone who will sell it to them. The overall goal of treatment cannot be restoring oral health because poor esthetics is not a pathology. Low self-esteem combined with a groupthink mentality is the pathology, and straight, white teeth cannot solve this psychological problem. Regardless of the external

The issue of overtreatment must also be considered because esthetic dentistry almost always involves the removal of sound and healthy tooth structure.

Low self-esteem combined with a group-think mentality is the pathology, and straight, white teeth cannot solve this psychological problem.

forces that create the desire for any type of smile—the blackening of teeth, putting jewels on teeth, whitening of teeth, straight or crooked—the profession as a whole needs to re-define its view of service to communities as “health care professionals concerned with long term health gain and not short term opportunistic and temporary beauticians who prey on the vanities and insecurities of vulnerable patients” (Burke & Kelleher, 2009).

Conclusion

People have changed the appearance of their teeth for thousands of years in order to demonstrate or obtain certain cultural values, and that urge is here to stay. My straight, white smile will always reveal my American identity. Clean, healthy teeth and gums are good for people, and dental care can result in enhanced positive feelings. But purely esthetic procedures need to be called exactly what they are and be clearly recognized as cultural extensions, not advancements in oral health care. It is our mission as dentists to treat and prevent diseases of the mouth. We as a profession need to emphasize and promote oral health and not esthetics in how we practice and promote dentistry to the public. Dentists are too highly educated and trained to consume their time with the “Hollywood Smile” when thousands in our population are without dental care and have active oral diseases. All in all, as a profession, dentists need to be clear and cognizant about their goals to improve oral health and try to keep the consumerism that drives the rest of America out of their treatments.



REFERENCES

- Burke, F. J., & Kelleher, M. G. (2009). The “Daughter Test” in elective esthetic dentistry. *Journal of Esthetic and Restorative Dentistry*, 21 (3), 143-146.
- Christensen, G. J. (2000). Elective vs. mandatory dentistry. *Journal of the American Dental Association*, 131 (10), 1496-1498.
- Ewen, S. (1976). *Captains of consciousness: Advertising and the social roots of the consumer culture*. New York, NY: McGraw-Hill.
- Guisti, L. & Peltier, B. (2008). Commerce and care: The irreconcilable tension between selling and caring. *McGeorge Law Review*, 785-800.
- Jerrold, L., & Karkhanehchi, H. (2000). Advertising, commercialism, and professionalism: A history of the ethics in advertising in dentistry. *Journal of the American College of Dentists*, 67 (4), 39-44.
- Johnson, C. (1999). *Hominid evolution, dental anthropology, and human variation*. Oral Biology and the Department of Orthodontics, UIC College of Dentistry.
- Paulus, K. (2010). Society and the smile. *Journal of the American Student Dental Association*, 30 (4), 8-11.
- Simonsen, R. J. (2007). Overtreatment? You bet it is! *Journal of Esthetic and Restorative Dentistry*, 19, 235-236.
- Veblen, T. (2007). *The theory of the leisure class*. New York, NY: Oxford University Press.

CAN WE CHANGE?

Tyler Beinlich

The seemingly abandoned wallet, stacked with a wad of cash. The time card at work, where no one notices the extra minutes added. The careless conversation between colleagues, detailing the name and selected items from the medical history. How do we learn to do what is right?

WERE ALL THE CHOICES MADE YEARS AGO?

Our lives are filled with choices; and with each opened door and choice made, we make ourselves. Although we are more than the culmination of our choices day in and day out, these tiny afterthoughts shape us with every step we take. Learning and implementing the lifestyle of honesty on a spelling test in third grade makes that choice easier to make in fourth grade...and fifth...and beyond. This continues until life becomes the stage upon which these patterns reveal what we have become.

As a dental student, the question in my mind is this: are we too late? Are our routines of morality and ethics so deeply entrenched in us at this point that any attempt at revamping or even modifying our ethical sense is the equivalent of spinning our wheels? Dental students are constantly engaged in ethically revealing situations. Whether it is the test-heavy first two years or later on in clinic, we must make choices of how we will conduct ourselves.

It seems too easy to throw our arms up and retreat, citing that those who cheat on tests and in the clinic have probably been cheating their whole lives and will continue to do so. For an

optimist like me, that philosophy is too fatalistic, too subject to the forces around us. I do not believe that the die has been cast. There are few phrases that are as empowering as "You can change." It is my assumption that this belief is shared by many in the dental education community, as evidenced by the push for ethical awareness in dental schools around the country. The push is not for enhanced policing, but ethical development. It would be an easier but arguably less productive solution for faculty to simply eagle-eye the moves of every student from test time until graduation. However, the goal of dental education is to develop young professionals who act in accordance with the profession's principles whether they are being watched or not.

NOT SO EFFECTIVE...

The next logical question is "how?" How do you take young adults, calibrate their moral compasses, and grow them into upstanding dental professionals who obey and honor the profession's code of ethics? Though this topic is well beyond the scope of this short essay, I will discuss from a student's perspective some of the methods currently being employed, what could be employed, and what I believe to be effective.



Tyler Beinlich is a third-year student at Marquette University. This class exercise was submitted by the course instructor, Dr. Toni Roucka.

The first approach is basically similar to an option we give patients when presenting a treatment plan to them: "do nothing." That is, allowing students to simply hit "rock bottom" if they should experience an ethical breach. After all, this is professional school and there should be a certain level of trust between students and faculty, right? The scenario may play out as follows. Imagine yourself in this position. The sweat is gathering on your forehead as you struggle to finish the final exam in pharmacology. The paper next to you is practically begging to be cited on your own page. Following the glance that lasted two seconds too long, you're out in the hallway being marched up to the dean's office. As a result, a very definitive decision is made to suspend you from dental school. Following this decision, it is the hope that you, the perpetrator, will realize the errors of your ways and change your behavior in the future and that this abrupt response will serve as a deterrent to other students who might be tempted to cheat. However, since past behavior is the best predictor of future behavior, will this really work or will you simply just get better at cheating?

Is this really an appropriate approach to fostering professional development? It is extremely reactionary in nature. Allowing students to flounder along without ethical guidance until they "do something stupid" and then punishing them may deter others from doing the same thing but this punitive approach is in itself unprofessional. Faculty, who should be mentors become policemen, lying in wait to catch possible cheaters. Also, the Commission on Dental Accreditation (CODA) expects dental schools to have a formal curriculum in ethics. Although there need to be repercussions for academic dishonesty, "scaring people

straight" is not an appropriate way to promote professionalism and teach self-regulation of the profession.

Another approach to teaching professional development is one that I have seen over and over again throughout my educational career. The reason for its prevalence is its simple approach and ease of implementation. I am speaking of the case-based method in which different vignettes are presented, options are given, and the correct choice is revealed to the learners. It is my opinion, however, that this is not the best way to teach ethics and professionalism at this point in our careers, for the following reasons. First of all, each ethical situation is different and has nuances that differentiate it from anything previously encountered. What works as the "right decision" in one scenario may not work in another very similar one with a small difference. In the case-based approach it is more practical to teach underlying principles rather than "situations and solutions." Even then, this model has its limitations. Many students will agree to a given conclusion just because they know it is what the instructor wants to hear. For example, it is easy to know that cheating on a test is wrong but it is a lot more difficult to actually turn in a classmate you know is cheating or to resist the temptation yourself. Students find creative ways to justify unethical behavior if it involves them or their close friends directly! The challenge is to get students to not only recognize what ought to be done in a particular situation but, when it comes down to it, to actually have the guts to "just do it."

STUDENT ETHICAL RESPONSIBILITY

I believe the most effective way to teach ethical problem solving in dental education should take a different approach. This approach involves much more peer interaction and discussion. Students listen to each other and share a common bond and consciousness through the dental school experience. On the other

hand, through a diverse student body, we all bring different things to the table. If the ethical didactic foundation is in place, students can intelligently approach an ethical dilemma with a group of peers and come to a rational conclusion with an understanding of why the answer is what it is.

Using a small-group format, dilemmas can be considered and debated within the ethical framework outlined in class. Students may have more candid discussions among their peers about issues, not having faculty listening in on the conversation. Another benefit of ethical discussion is that it gives people an opportunity to poke holes in our arguments. Other people's perspectives often bring light to our own biases and errors in thought. In seeing the errors in our own thought processes, the principles that we believe in can be applied more objectively and honestly. Students who are comfortable with their ideals yet able to see any situation more objectively will be able to navigate a dicey dilemma and come out completely honest to the convictions that guide their everyday behavior.

So the question still remains: are things already set? It is my firm belief that anyone, at any time, can start brand new. Professional development is an ongoing process throughout not only dental school, but our entire careers. New starts do not come, however, without breaking down held ideals in favor of new paradigms. If we are willing to take the time and do the hard work of listening to each other and learning from our common experiences as well as our diversity, we can ensure that the principles of autonomy, beneficence, justice, nonmaleficence, and veracity will be upheld every day and that students will gain an understanding of why these principles are intrinsically valuable to a profession well practiced. ■

COMPREHENSION AND RETENTION OF ORTHODONTIC AND ORTHOGNATHIC SURGERY TREATMENT INFORMATION

A REVIEW OF LITERATURE

Renie Ikeda, DDS

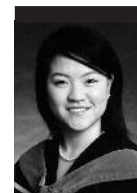
Orthodontic diagnosis and treatment planning involve detail-oriented evaluation of various aspects of oral function, dentition, and facial aesthetics. What strikes the orthodontist as obvious issues regarding a case may differ considerably from the chief concern of a patient or parents. Therefore, communication and mutual understanding regarding orthodontic treatment is crucial for a successful orthodontic outcome.

The doctrine of informed consent has become an integral part of standard of care in today's health practices, and it is now the dentist's legal and moral responsibility to communicate the risks, benefits, and alternatives of the proposed treatment (Ackerman & Proffit, 1995). Before the evolution of the informed consent doctrine, patients played a limited role in the decision-making process in health care, and it was not until the second half of the twentieth century when the doctrine of informed consent was established to respect patient's individual autonomy when making healthcare decisions. Informed consent is "a process of communication between a healthcare provider and patient that educates the patient as to the patient's needs and the potential solutions for those needs, and leads to the endorsement of a healthcare treatment plan" (Cameron, 1997), and the consent is considered legally ineffective if the patient lacks an understanding of material information that is being authorized (Salgo, 1957).

Therefore, any treatment information including the informed consent should be presented in such a way that patients and parents can understand it without difficulty. Furthermore, patient and parent understanding are especially important in orthodontics, since treatment requires much compliance from the patient as well as support and encouragement from the parent. The present study aims to review the available literature on the topic of patient and parent comprehension and retention of orthodontic and orthognathic surgery treatment information as well as any literature that examined the method of delivery of such information.

MATERIALS AND METHODS

A literature search was conducted using the PubMed electronic database employing the following keywords: orthodontic, orthognathic, informed consent, patient information. Specifically, the following combination of keywords was typed into the PubMed search field: (orthodontic OR orthognathic) AND (informed consent OR patient information). All electronic searches were conducted in



Dr. Ikeda is currently a resident in the orthodontic postgraduate program at UCSF. This paper was completed as part of the course requirements in Ethical and Behavioral Considerations in Clinical and Research Aspects of Dentistry taught by Dr. Howard Pollick at UCSF.

August 2011 and included articles published and available in print or online at that time. A cursory search was performed initially to identify potential articles pertaining to the topic of interest based on title and abstract. The initial inclusion criteria were (a) publication in English, (b) abstract available on PubMed, (c) content relevant to patients' understanding or retention of information given prior to orthodontic treatment or orthognathic surgery, and (d) full article available online using University of California, San Francisco remote access. Studies were further selected to be included in the final list of publications to be reviewed in this article based on the level of evidence. Articles were excluded from the review if they did not meet the initial inclusion criteria or if they were editorials, expert opinion, or case reports.

Results

An electronic search on PubMed using the aforementioned set of keywords identified 564 articles. Of those, 511 were written in English, and 483 articles had abstracts available. Through review of title and abstracts, 21 articles were identified to be on relevant topics, and 11 were subsequently excluded from the review due to the nature of the

publication and the level of evidence they provided. Within the final list of ten articles, four were on patients' comprehension or retention of orthodontic information, one on patients' comprehension and retention of orthognathic surgery information, and five were related specifically to efficacy of various communication modes in presenting orthodontic information to patients (Table 1).

The level of comprehension and retention of orthodontic information through the informed consent process as well as other supplemental items was evaluated in four studies, and the major findings are summarized in Table 2. Baird and Kiyak (2003), in a study with a sample of 21 children receiving Phase I orthodontic treatment and their parents, assessed understanding of informed consent through open-ended interview questions regarding reasons and risks for treatment. The child and the parent were interviewed separately. A chart review was performed to reveal information reviewed in the consent, and a vocabulary test was completed. The study revealed that, overall, parents and children knew very little about the child's diagnosis, and while the chart listed just over four reasons for treatment on average, parents could only recall

about two on average and children only one. Furthermore, regarding risks of treatment, 12 children and seven parents stated that there were no risks associated with orthodontic treatment, and another five children and five parents could not recall any risks. The study showed a correlation between education and vocabulary level, and the number of reasons and risks reported by parents and children.

In a similar study of 33 low-income children beginning their early orthodontic treatment, Mortensen and colleagues (2003) examined patient and parent comprehension of the child's Phase I orthodontic treatment with regard to the purpose of treatment, possible risks, and responsibilities of children and parents. The study showed that, on average, of the 2.34 reasons for treatment presented, patients recalled 1.10 and parents 1.66. For 2.45 items on procedural information presented, the recall rate was 1.55 and 1.59 for patient and parents, respectively. That of risks was 0.66 and 1.48, respectively, even though 4.66 items were mentioned by the orthodontist on average. As for patient's responsibility, number of average recalled items was greater: 2.21 for patients and 2.07 for parents, out of 3.38 presented. The only exception to the low recall rate was parents' reports of their responsibilities associated with their children's treatment as they listed more than what the orthodontist had mentioned. Most of these items were responsibilities for children, not parents. In all but one part of informed consent, parents recalled more than children; the exception was on what the child should do for a successful outcome. Children's recall rate was low regardless of vocabulary level, but vocabulary levels of parents were significantly correlated to their recall rate.

A study conducted by Ernst and others (2007) in the United Kingdom aimed to

TABLE 1. RESULT OF ELECTRONIC SEARCH IN PUBMED DATABASE

	<i>Satisfied initial inclusion criteria</i>	<i>Full text available</i>	<i>Selected</i>
Comprehension/Retention of orthodontic treatment information	13	6	4
Comprehension/Retention of orthognathic surgery information	3	1	1
Communication method in presenting orthodontic information	7	5	5

Table 2. SUMMARY of MAJOR FINDINGS from SELECTED ARTICLES

<i>Article</i>	<i>Year</i>	<i>Sample</i>	<i>Main Findings</i>
Patient and parents' comprehension and retention of orthodontic information			
Baird et al	2003	21 child/parent pairs	On average, of 4.1 reasons for treatment presented: 1 recalled by patient, 2.1 by parent. 17/21 patients and 12/21 parents either reported there was no risk with treatment or could not recall any risk.
Mortensen et al	2003	33 child parent pairs	On average, both children and parents recalled significantly fewer items than what the orthodontist had presented. Trend was particularly worse when recalling risks. Parents recalled more than children in most areas.
Ernst et al	2007	41 patients 8 parents	High recall rate of having covered certain aspect of informed consent. Recall rate of specific items covered as risks and retention was low.
Harwood et al	2004	26 leaflets	42.3% rated as "fairly difficult" or "difficult" to read: comprehensible by 24-40% of UK population. BOS leaflets were "standard" or "fairly easy" to read: comprehensible by 70-80% of UK population.
Patient and parents' comprehension and retention of orthognathic surgery information			
Brons et al	2009	24 patients	Average recall rate of information on risks/complication as 42%. Efficacy of various methods in presenting orthodontic information to patients.
Communication Method in Presenting Orthodontic Information			
Thomson et al	2001	28 patient/parent pairs	Though difference not great, written method was found to be more effective than verbal or visual methods. Patients responded poorly to verbal communication when compared to parents
Thickett & Newton	2006		Recall rate was better in mind map and acronym groups compared to BOS leaflet
Patel et al	2008	80 patients, 40/group	On average, patients assigned to visual group (slide show) recalled more than written group (BOS leaflets).
Kang et al	2009	90 patient/parent pairs (30/group)	AAO consent alone or modified informed consent (with improved readability) alone resulted in 40% recall rate. When modified informed consent was presented with visual information (slide show; improved processability), significant improvement in recall rate to 50% was observed.
Wright et al	2010	60 patients	Supplementing verbal information with written information in consent process increased motivation in patients.

determine the level of patient and parent recall of previous consent to orthodontic treatment at least six months previously. The sample included 41 patients and eight parents and used a questionnaire with mostly closed and multiple-choice questions. This study, unlike the aforementioned studies conducted in the United States, showed that patients and parents demonstrated a high level of recall. This study reported that 96.0% remembered being told about the reason for orthodontic treatment, 75.5% for risks, and 83.3% for length of treatment. Seventy-seven percent recalled being told about the need for extractions, and approximately 73% of the cases were actual extraction cases. However, with respect to recall of specific items from the risk and retention portion of the consultation, recall rate was much lower; 36.8% recalled being told about decay and less than 21% could recall being told about risk of root resorption. Fifty-three percent remembered they had been told about retainers, and only 35% were told how long retainers should be worn.

Harwood and Harrison (2004) conducted a study to evaluate the readability of 26 orthodontic patient information leaflets, the majority of which were from the American Association of Orthodontists (AAO) and British Orthodontic Society (BOS). They found that 42.3% were rated as "fairly difficult" or "difficult" to read, meaning IQ of 104+ would be necessary to understand these leaflets. According to the authors, this means that only 24-40% of the United Kingdom population would be able to read them. However, when comparing the AAO to BOS leaflets, all of the BOS leaflets were considered to be more reader-

friendly and were rated as "standard" or "fairly easy" to read, meaning 70-80% of the United Kingdom population would be able to comprehend them.

Only one study assessing the patients' comprehension and retention of treatment information related to orthognathic surgery met the inclusion criteria. Brons and others (2009) assessed how much information patients could recall immediately after a pretreatment consultation of orthognathic surgery using a short questionnaire consisting of three multiple-choice and two open-ended questions. This study, involving 24 patients treatment planned for mandibular advancement via sagittal split osteotomy, was conducted in the Netherlands, and revealed an overall average recall rate of 42% regarding possible risks and complications reviewed by the informed consent process (Table 2).

Five studies focused on the various methods in presenting orthodontic information to patients, and a summary of findings is given in Table 2. Thomson's (2001) research team compared written, verbal, and visual methods when communicating orthodontic information in the United Kingdom. Twenty-eight patients and their parents were included in each of the three categories, and information portrayed in each method was identical in content and in order of presentation; the visual method was slide presentation with illustration and short caption. Recall by the patient and parent was assessed twice via independently completed questionnaires: once 10-15 minutes and again eight weeks after the consultation. Although the majority of questions were answered well and the differences between the three methods were not great, the researchers found that written information performed better than other methods, and patients responded poorly to verbal communication when compared to their parents. Also, three questions relating to

importance of good oral hygiene, effects of treatment on day-to-day life, and importance of retainer wear, were answered poorly.

Thickett and Newton (2006) studied the effect of different types of written information on short-term and long-term recall of orthodontic information in the United Kingdom. Participants, aged between 12-14 years, were presented with either a leaflet published by the BOS, mind map, or acronym using the word BRACES to convey information. Questionnaires given immediately after and six weeks after the consultation showed that mind maps and acronyms have a small but significant advantage in patient recall of patient information over written information leaflets.

Patel, Moles, and Cunningham (2008) compared the efficacy of a commercial information leaflet published by the BOS and a visual computer program (slide show) showing the same information in addition to supplemental verbal information in the United Kingdom. Forty participants were randomly assigned to each group, and age range was 8 to 27 years, though most patients were between ages 11 and 13. Retention was assessed with a questionnaire immediately after and eight weeks after the presentation. The study showed that computer-based visual information was more effective and patients had better retention of information. In addition, it was noted that one question, relating to retainer wearing, was particularly poorly answered in both groups.

Kang and colleagues (2009) evaluated recall and comprehension among 90 pairs of patients and parents by using the AAO informed consent form and new forms incorporating improved readability and processability. To compare with the highly used AAO document, a modified informed consent (MIC) with

lower grade reading level and other reformatting to increase readability, was used. In addition, a narrated slide-show presentation (SS) was used in conjunction with MIC for improved processability. An interview no longer than 45 minutes after the consultation revealed correct recall and comprehension response of only 40% with the AAO consent form or MIC alone, and thus increasing readability of the form had no significant improvement in recall or comprehension. With improved processability (MIC and SS together), there was significant improvement in recall rate, which was 50%.

Wright and others (2010) looked at the effect of supplementation of verbal information with written information when obtaining consent to orthodontic treatment in the United Kingdom. Participants 12 to 16 years of age were randomly assigned to the two groups and completed questionnaires prior to meeting the clinician, four weeks after consenting to treatment, and after 12 weeks of initiating treatment. Supplementation of verbal information with written information resulted in improved motivation for orthodontic treatment but had no statistically significant effect on anxiety, apprehension, or patient compliance.

Discussion

Obtaining informed consent for treatment is the responsibility of the dentist, not the patient.

Informed consent and patient autonomy have become a part of the standard of care in the health care field, and orthodontics is no exception. Patient understanding is especially important in orthodontics as orthodontic treatment often demands long-term compliance from the patient. Furthermore, for younger patients, parents play a large role in the treatment as an enforcer. Therefore, the current state of compre-

hension and information retention by patients and their parents may be of particular interest to orthodontists.

This literature review suggests a disappointingly low level of comprehension and low recall rate of treatment information by patients and parents with regard to orthodontic and orthognathic surgery treatment. Generally, studies reported poor recall rate by both patient and parents, and it was particularly worse when recalling risks related to treatment. A study that evaluated readability of commonly used leaflets stated that comprehensibility of many of such written documents, particularly those published by AAO, would only allow 24-40% of the United Kingdom population to understand them (Harwood & Harrison, 2004). Therefore, it may be valuable to adopt more effective methods of communicating with patients and parents.

Studies on various communication methods and their effectiveness in conveying treatment information to patients and parents showed somewhat conflicting results. While one study (Thomson et al, 2001) found written information to be more effective than verbal or visual information, two studies (Kang et al, 2009; Patel et al, 2008) reported that information recall was improved when given as a visual slide show; in one of these studies, visual information was not given by itself, but as a supplement to written information (Kang et al, 2009). A different study focused on unconventional ways to convey written information to patients and looked at a mind map approach and the use of acronyms compared to leaflets, finding that information retention was improved with a mind map and an acronym (Thickett & Newton, 2006). Thomson

Obtaining informed consent for treatment is the responsibility of the dentist, not the patient.

and colleagues (2001) suggested that written information be given in conjunction with verbal information, particularly to children, as their study revealed that children respond poorly to verbal communication alone. As mentioned previously, Kang and others (2009) showed that a combination method—with written and visual information in particular, for their study—increases information processability and subsequently improved retention of information. There may be some benefit to presenting the information in more than one way, and the benefit may extend beyond comprehension and retention of information, as suggested by a study by Wright and colleagues (2010) that showed increased motivation in orthodontic patients who received both verbal and written information in the consent process.

Evidence is still lacking and findings are not consistent, particularly when it comes to effective information presentation methods. Existing studies point to the low level of comprehension and recall of treatment information by orthodontic patients and parents, and future studies are needed to assess how this communication gap between patients and orthodontists can be diminished through more effective consultation methods. In particular, studies with a sufficiently large sample size allowing several intervention groups with different combination of methods may be of value.

Conclusions

Current evidence does not support the claim that orthodontists are meeting their ethical obligation to base treatment on informed consent by patients or their parents.

Information recall by orthodontic and orthognathic patients and parents was low, particularly regarding information on risks associated with treatment. In general, children recalled less than parents.

Several studies investigated the effectiveness of different modalities in presenting treatment information to patients and parents, but results are inconsistent.

Due to inconsistencies in the available studies, no definitive conclusion can be drawn regarding which method is most effective when communicating with patients, and further study is needed.



REFERENCES

- Ackerman, J. L. & Proffit, W. R. (1995). Communication in orthodontic treatment planning: Bioethical and informed consent issues. *Angle Orthodontist*, 65 (4), 253-262.
- Baird, J. F., & Kiyak, H. A. (2003). The uninformed orthodontic patient and parent: Treatment outcomes. *American Journal of Orthodontics and Dentofacial Orthopedics*, 124, 212-215.
- Brons, S., Becking, A. G., & Tuinzing, D. B. (2009). Value of informed consent in surgical orthodontics. *Journal of Oral and Maxillofacial Surgery*, 67, 1021-1025.
- Cameron, C. A. (1997). Informed consent in orthodontics. *Seminars in Orthodontics*, 3 (2), 77-93.
- Ernst, S., Elliot, T., Patel, A., Sigalas, D., Llandro, H., Sandy, J. R., et al (2007). Consent to orthodontic treatment—Is it working? *British Dental Journal*, 202, E25.
- Harwood, A., & Harrison, J. E. (2004). How readable are orthodontic patient information leaflets? *Journal of Orthodontics*, 31, 210-219.
- Kang, E. Y., Fields, H. W., Kiyak, A., Beck, F. M., Firestone, A. R. (2009). Informed consent recall and comprehension in orthodontics—Traditional vs improved readability and processability methods. *American Journal of Orthodontics and Dentofacial Orthopedics*, 136, 488.e1-448. e13.
- Mortensen, M. G., Kiyak, H. A., & Omnell, L. (2003). Patient and parent understanding of informed consent in orthodontics. *American Journal of Orthodontics and Dentofacial Orthopedics*, 124, 541-550.
- Patel, J. H., Moles, D. R., & Cunningham, S. J. (2008). Factors affecting information retention in orthodontic patients. *American Journal of Orthodontics and Dentofacial Orthopedics*, 133, S61-S67.
- Salgo (1957). *Salgo v Leland Stanford Jr. Board of Trustees*, 317 P.2d 170 (Cal Ct App 1957).
- Thickett, E., & Newton, J. T. (2006). Using written material to support recall of orthodontic information: A comparison of three methods. *Angle Orthodontist*, 76, 243-250.
- Thomson, A. M., Cunningham, S. J., & Hunt, N. P. (2001). A comparison of information retention at an initial orthodontic consultation. *European Journal of Orthodontics*, 23, 169-178.
- Wright, N. A., Fleming, P. S., Sharma, P. K., & Battagel, J. (2010). Influence of supplemental written information on adolescent anxiety, motivation and compliance in early orthodontic treatment. *Angle Orthodontist*, 80, 329-335.

THE ETHICS OF ROUTINE USE OF ADVANCED DIAGNOSTIC TECHNOLOGY

Renata Khelemsky, DMD

The advent of new technology often holds the promise of improving on imperfect, previously used devices. Specifically, the dental setting has seen numerous cases of technological advances, such as the high-speed dental drill, adding a distinct and real benefit to practice. Within the last decade, the advent of digital radiography in dentistry has led to increased attention from practitioners for its many apparent benefits such as ease of use, immediate observation of images, and the ability to enhance image quality without retakes (Christensen, 2004).

A recent issue in the realm of digital image acquisition relates to the safety of radiation exposure and the practice of using advanced imaging techniques such as the cone beam computer tomography (CBCT) scan in various clinical situations, especially those affecting children and adolescents. According to a recent article in the *New York Times* entitled "Radiation Worries for Children in Dentists' Chairs," (Bogdanich & McGinty, 2010), the dental office has emerged as the site of faulty and unnecessary radiography practice where specialists employ high-radiation CBCT scans for routine use on the susceptible population of younger patients.

The facts that underlie the situation are important to the discussion of ethical issues. For example, it is well-known that CBCT scans have allowed dentists to investigate maxillofacial structures in all three dimensions during challenging situations of implant placement, surgery, and orthodontics (Hatcher, 2010). The

use of such scans has coupled each imaging session to "specific clinical questions." To much surprise, Bogdanich and McGinty (2010) showcase plenty of examples of how dentists are generally unaware of the CBCT radiation dose compared to conventional two-dimensional techniques. The scholarly literature is also inconsistent but tends to agree that, regardless of the variables an operator can control, CBCT scans generally expose patients to significantly more radiation than panoramic and cephalometric radiographs (Hatcher, 2010). Still, the risks of morbidity and treatment failure from poor diagnostic imaging also need to be evaluated. The present situation most certainly confronts dentists with an inherent ethical question: should the CBCT be used for clinical decision making given the risk associated with additional radiation exposure?

Ethical Principles

A primary survey may suggest that dentists are using new digital technology to enhance the accurate diagnosis and

This essay was written as a class assignment in the ethics sequence at the Columbia University College of Dental Medicine when Dr. Khelemsky was a third-year student. She is currently a resident in the Oral and Maxillofacial Surgery Program at Beth Israel Hospital. The paper was submitted by Dr. Robert Miner, who teaches in the ethics program at Columbia.

Failing to tell parents and patients about the risks and alternatives of CBCT scans is an example of misrepresentation because it fails to achieve truthful communication and intellectual integrity.

successful treatment of patients. In this respect, the professional is fulfilling the principle of beneficence, or the ethical duty to promote the patient's welfare. However, the practice of doing good becomes much overrepresented with respect to the current trends of using the CBCT in practice. Consider the simple fact that some specialists admit to using CBCT scans to screen all patients for treatment. This gives heavy consideration to the ethical principle of nonmaleficence, which holds the duty to refrain from harming the patient. To do so, the dentist is obligated to keep his or her knowledge and skills current, presumably to avoid the introduction of harmful practice. Prescribing a CBCT scan for all patients, regardless of whether the patient has indications for three-dimensional imaging or if other methods producing less radiation can be used to achieve the same clinical outcome is thus an example of unethical behavior. Furthermore, a breach of nonmaleficence occurs when dentists justify the use of such scans for their appeal to children who see the 3D images as a "fun" part of treatment, as was reported by Bogdanich and McGinty (2010). Again, in the absence of specific clinical objectives for attaining such images, a discussion that weighs the benefits of using CBCT against the risks cannot even be approached, and the dentist appears to be engaging solely in the harmful practice of exposing radiosensitive organs to radiation.

Still, perhaps no greater ethical issue can be extracted from this situation than the one regarding the principle of veracity or the duty to communicate truthfully. The *American Dental Association Principles of Ethics and Code of Professional Conduct* explicitly maintains that "dentists shall not represent the care being rendered to their patients in a false or misleading manner," citing misrepresentation of fact or even omission of fact that would otherwise make a statement not materi-

ally misleading as examples of false and misleading behavior. For example, if parents were honestly informed that their child faces a 1-in-10,000 risk of developing cancer from a single CBCT scan, it is unlikely that parents would hinge their decision-making process on the same factors as they would have before this information was presented. Instead, parents would rightfully seek more information regarding the need for such a scan in their child's specific case, which seems wrongly insignificant when these scans are "routine" practice. Therefore, failing to tell parents and patients about the risks and alternatives of CBCT scans is an example of misrepresentation because it fails to achieve truthful communication and intellectual integrity. Also, since informed consent ultimately asks the patient to weigh the treatment benefits against the risks, the omission of information regarding the amount of radiation in CT scans disregards the ethical principles of veracity and autonomy.

The *ADA Principles of Ethics and Code of Professional Conduct* also makes reference to potential financial incentives hidden in recommendations made to patients, holding that dentists "must take care not to exploit the trust inherent in the dentist-patient relationship for their own financial gain." From the article by Bogdanich and McGinty (2010), it is clear that there is widespread violation of such ethical practice. Dentists are open to the economics of the CBCT because it appears to be a quick and easy solution, with "more profit per unit chair time," to treating common dental problems. Some scenarios allow orthodontists to use a digital camera to acquire clinical images instead of the CBCT, which would require about 30 extra chairside

minutes. When orthodontists explicitly admit to choosing the CBCT in almost every case because it saves time and hence large dollar amounts for each minute saved, they are clearly acting unethically by ADA standards. The incentives to shorten treatment time and increase revenue are financial incentives that would not be evident to the patient without disclosure, and, therefore, the practice of promoting these incentives defies the moral principle of veracity and is thus entirely unethical.

The moral obligation of dentists to act on behalf of their patients is also strained when the frequent practice of using CBCT scans in private practice suggests the apparent safety of such a practice. If specialists really do require a 3D scan for every implant or every orthodontic case, then the skilled clinical judgment required of a professional appears deficient in this situation. Since it is a well-accepted fact that no two cases are identical given the individual patient factors, then it seems prudent to prescribe imaging on a case-by-case basis. Because the patient cannot make such decisions without professional assistance, the dentist is obligated to use expertise in a manner that protects the patient from unnecessary harm. By making acquisition of CBCT images a routine practice, dentists depart from their role as trusted professionals within society and falsely portray a risky service as safe. Furthermore, relying on positive claims that are made by the manufacturers of these machines, or simply resolving that such machines are the "best" from personal experience leaves out any consideration for the validity of such findings as would be given by sound scientific research. The ADA in fact holds dentists responsible for inquiring about the accuracy of any claims. When manufacturers are allowed to underwrite articles in popular dental journals or when expert panels consist

of paid speakers intimately tied to imaging companies, the need to review valid research findings within published literature before making recommendations to patients becomes even more apparent.

One can also view the ethical dilemma from the standpoint of justice, or giving each individual his or her due. This principle relates to fairness and giving patients the care they deserve to alleviate pain and prevent disease (Hebert, 2009). But once patients are presented enough information to make a decision about whether or not they want a CBCT scan, can they be trusted to make the right decision every time? Dentists will often face conflicts between two opposing principles, such as respecting a patient's autonomy and acting beneficently. A patient may blatantly dismiss the CBCT scan without apparent consideration of the sound clinical indications. In that case, neither justice nor beneficence can be maintained due to the moral duty to respect the patient's personal beliefs.

ALTERNATIVES, CHOICES, AND OUTCOMES

The ethical dilemma of using CBCT scans for the diagnosis and treatment of patients is a complex one. Possible courses of action must take into account the fact that CBCT scans are often used to gain distinct clinical advantages, such as avoidance of critical structures during surgical procedures. The problem of overuse as previously described also needs to be considered, as well as the potential of underuse. If dentists strive to achieve the best treatment outcome for patients, then one possible solution is to present patients with the information necessary to make an informed decision each time. To do so, the dentist needs to have a clear indication for the type and

quality of image needed to produce a satisfactory outcome. Any obvious advantages of a CBCT scan to the case, like identifying difficult anatomical defects made evident by clinical examination that may compromise treatment, must be clearly stated for the patient and at the same time weighed against the disadvantages of an added lifetime risk for developing radiation-induced cancers. Of course, this may reveal a conflict between patient and dentist as to the best course of treatment.

As a moral agent of the healthcare profession, it is most important to identify that such conflicts exist within the clinical setting in order to seek appropriate resolutions. The patient may regard the dentist as uncaring, and the dentist may believe the patient is difficult, and neither lends itself to giving patients their due, proper care (Hebert, 2009). If patients are to be treated fairly, then communication between patient and dentist is the most important aspect of this process. Dentists can express concern over possible negative outcomes in a way that is empathetic and constructive, perhaps offering the patient additional time to seek another opinion. Ozar and Sokol's Interactive Model of professional relationships speaks to this belief, where both dentist and patient seek one another's respect, share an equal moral standing, and maintain separately their personal values regarding the situation (Ozar & Sokol, 2002). Only through proper open collaboration, rather than competition, can both parties arrive at a "right" decision.

Determining what is the right thing for the patient presumes that there are several alternatives to one ideal course of action. Therefore, clear alternatives should be considered in this ethical dilemma. Given that CBCT scans were only added to United States market in 2001 (Hatcher, 2010), it is reasonable to

believe that dental problems were readily treated with conventional imaging to a successful degree. For example, simple alternatives to the CBCT include a panoramic x-ray and lateral cephalograms taken at various stages of treatment. The only other possible alternative is refraining from all x-ray imaging and treatment altogether. Obviously each option has different ethical implications with respect to autonomy, beneficence, and maleficence. The patient receives no benefits from no treatment, but may receive partial benefit from older x-ray devices. It is also imperative to ask whether the dentist is confident in his or her ability to render treatment given the compromises the patient makes. A dentist can determine moral responsibility by weighing solely the consequences of actions, as the theory of consequentialism suggests, deeming actions as morally right only if the consequences are more favorable than they are unfavorable. Then, it is possible that certain alternatives, such as using a panoramic x-ray to place an implant into a severe lingual bony undercut, are too grave in prognosis to still provide service to patients because of the greater negative consequences of that action. The right choice in this situation, unlike the one in the superlative respect for autonomy, is indeed no treatment.

Deciding what to do in a difficult clinical situation depends on the key players in the situation. If the dentist abides by an interactive relationship, then he or she would place the value of autonomy above all other ethical considerations (Ozar & Sokol, 2002). If the patient is unable or unwilling to make a

decision, then the dentist can act on the patient's behalf and require a CBCT, or even refuse treatment without it, because such intervention can be justified on the basis of preventing harm to someone who is unaware of it, a practice otherwise known as paternalism. Still, ethical principles cannot provide solutions to every clinical dilemma, since emotional and real life factors may weigh heavier than the ethical constructs. Patients may have cultural or religious factors that deter their ability to act on moral considerations. Therefore, the discussion of all pertinent ethical issues cannot always lead to distinct right or wrong decisions, but rather is limited to the moral implications of making such decisions (Hebert, 2009).

Unlike the consequentialist theory that determines moral responsibility on the sole basis of consequences, duty theories view ethical behavior as an extension of certain obligations irrespective of the consequences that may follow. According to the seventeenth century German philosopher Pufendorf, the scope of duties can be classified as those to God, to oneself, and to others. Concerning those duties towards others, he claimed that absolute duties are those that avoid wronging others and promoting the good of others, no matter the ends of such actions. Then, if applied to the dilemma of routine CBCT scans in dental practice, we can argue that any dentist who is aware of the harmful effects of radiation is wrong in giving all patients a CBCT scan, even if such scans produce good consequences in some cases. In pure duty theory, one should not harm a patient to justify any positive outcomes of that harm.

Another framework for this discussion comes from virtue theories popularized by philosophers such as Aristotle, who believed that developing good character traits early on determines ethical actions in the future. Rather than following rules of ethics, an individual who learns

from moral education will act on moral principles when confronted with an ethical dilemma. A dentist, then, could rely on virtues like justice and honesty in the decision-making process regarding the CBCT scan, which may lead to different conclusions about the need for CBCT scans in the face of adequate and safer technology. For example, rather than setting rules for which patients and which cases necessitate additional scanning, the dentist can act benevolently in every situation to promote the virtue of honesty. This means that truth-telling takes precedence over the need to produce better treatment outcomes. Similar to this principle is the belief of the eighteenth-century philosopher Immanuel Kant that lying is always wrong no matter the benefit it produces (Hebert, 2009). In modern clinical practice, this has not always been an easy task, especially when truth-telling to patients is rarely black and white. When diagnosis, prognosis, and potential effects of treatments are uncertain, clinicians may opt for the therapeutic "white lie" in order to fulfill wishes of patients such as maintaining hope. In this specific case, however, truth-telling applies to the full disclosure of risk rather than the omission of irreversible harm. Patients do have the power to change the fate of such accumulated risks, and thus, should be provided the means to do so. It is a weak argument 20 years from now to say that a correctly aligned implant (positive outcome) was worth a consequent cancer of some form (negative outcome). Kant's proponents therefore dismiss consequences of behavior altogether and instead place emphasis on acting according to universal law.

Whether an emphasis on duty or consequences gives the best account of morality remains to be established, but

the multitiered ethical decision-making process can give way to one absolute commitment in healthcare: “respect for humans is required in everything that we, as healthcare providers, do.”

THE RIGHT THING TO DO

According to the *ADA Principles of Ethics and Code of Professional Conduct*, the dental profession holds a special position of trust within society, affording dentists certain privileges that are not available to members of the public at large. It remains important to maintain this trusting relationship not only to conform to a written standard, but to first and foremost protect humans from faulty treatment no matter the circumstances. It seems clear in this situation that routine use of the CBCT scan for diagnosis and treatment is a faulty practice, misguided, and lacking valid scientific support. Some patients may indeed benefit from the chance discovery that an impacted tooth lies in the line of treatment, but such discoveries are not precluded from simpler imaging modalities. When three-dimensional treatment planning is essential to the outcome of the case or to the wishes of the patient to avert a possible risk such as permanent numbness to the jaw, chin, and lips due to involvement of the nerve canal, the CBCT can offer a solution to clinical problems. This practice implies that the right thing to do is to disclose to patients the risks, benefits, and alternatives of the CBCT prior to treatment, specifically explaining the amount of radiation exposure in comparison to other imaging devices, which seems to be missing from current practice standards. On a societal level, objective guidelines and regulations for the use of CBCT scans ought to be created as well, with the patient's best interest in mind. Dentists need not appear negligent in challenging cases if they recognize the need for CBCT-generated information; but as with

any proposed treatment, respecting the patient's wishes is paramount to the moral behavior of any professional.

Philip Hebert, in his book *Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians*, discusses what to do when faced with truly difficult clinical situations. He writes, “Conscience and emotional reaction to a case can provide reasonable brakes on an action,” and when an ethical decision-making tree falls short of one, clear, unobjectionable course of action, the entrusted professionals of society must learn that “doing the right thing is sometimes the hard thing, but [they] learn by attempting it and by the perseverance it requires (page 22).” After all, when one happy patient, at the conclusion of treatment reported in the Bogdanich and McGinty (2010) newspaper article, states “Trust the doctor—that’s what you have to do,” he is offering proof that doctors must not betray the exceptional trust that they have been granted. ■

REFERENCES

- Bogdanich, W., & McGinty, C. J. (2010). Radiation worries for children in dentist's chair. *The New York Times*. 22 November.
- Christensen, G. J. (2004). Why switch to digital radiography? *Journal of the American Dental Association*, 135, 1437.
- Hatcher, D. C. (2010). Operational principles for cone-beam computer tomography. *Journal of the American Dental Association*, 141, 3S.
- Hebert, P. (2009). *Doing right: A practical guide to ethics for medical trainees and physicians*. Ontario: Oxford.
- Ozar, D. & Sokol, D (2002). *Dental ethics at chairside: Professional principles and practical applications*. Washington, DC: Georgetown University Press.

The multi-tiered ethical decision-making process can give way to one absolute commitment in healthcare: “respect for humans is required in everything that we, as healthcare providers, do.”

RETENTION OF UNDERREPRESENTED MINORITY STUDENTS IN DENTAL SCHOOL

ONE DENTAL SCHOOL'S STORY

Ernestine S. Lacy, DDS
Barbara H. Miller, DDS
Sheryl A. Hornback, MA
Ann L. McCann, PhD
Jayne S. Reuben, PhD

ABSTRACT

There is a large disparity between the proportions of African-Americans, Hispanics, and Native Americans in the general population and in the dental profession. While these underrepresented minorities (URMs) as a group make up almost 30% of the United States population, they constitute only about 6% of the nation's dentists. Eliminating this disparity is important in addressing access to care for underrepresented groups. Texas A&M Health Science Center Baylor College of Dentistry (TAMHSC-BCD) enrolled greater numbers and proportions of URM students than any other non-minority school from 2006-2010. Strategies used to achieve this level of diversity include a Whole File Review process; career awareness activities for elementary, junior high and high school students; and academic enrichment programs for college students and college graduates. Retaining and graduating URM students is just as important as enrolling them. TAMHSC-BCD's retention rate over the last five years is 95.7% for all students and 92.5% for URM students. A wide range of services aids in the retention process. These services are available to all students and include monitoring of students' academic performance followed up with academic advisement as appropriate, peer tutoring, an alternative five-year curriculum, professional psychological counseling, professional learning assessments, social support; and mentoring through student organizations. The retention program at TAMHSC-BCD can serve as a model for other dental and other health professions schools seeking ways to ensure the academic success of their URM students. The more of these students we enroll and graduate, the more the problem of access to dental care is addressed.

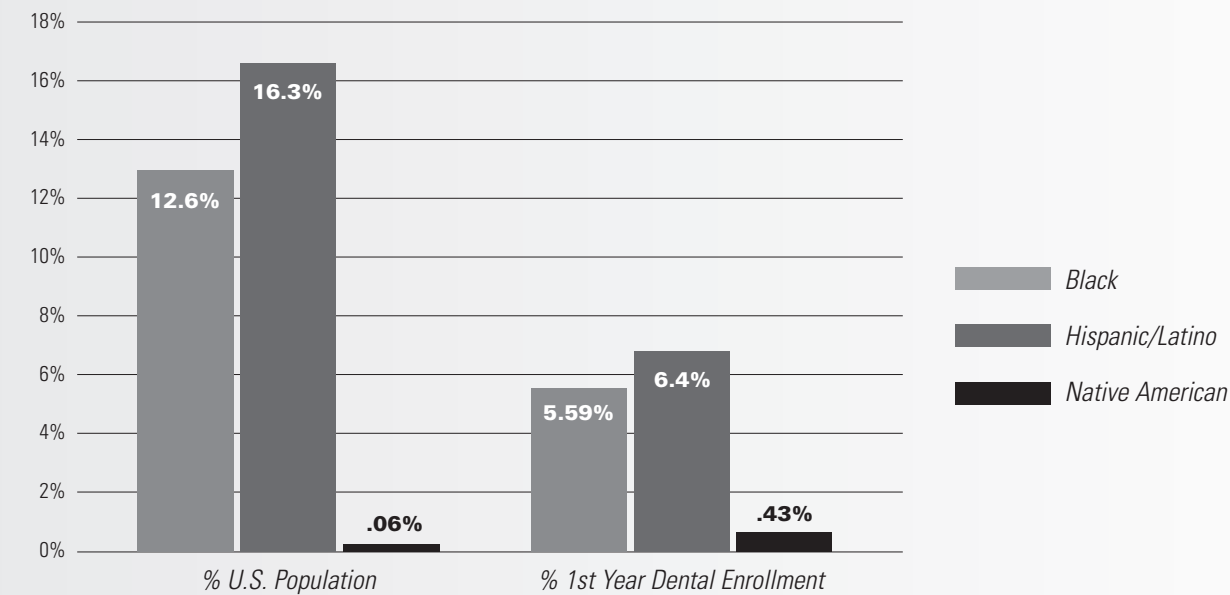
There is a large disparity between the percentages African-Americans, Hispanics, and Native Americans in the general population and the percentages of those groups in the dental profession. While these underrepresented minorities (URMs) as a group make up almost 30% of the United States population, they constitute only about 6% of the nation's dentists (American Dental Association, 2004; U.S. Census Bureau, 2010). For years, the American Dental Education Association has been diligently working with United States dental schools to reduce and, ultimately, eliminate this disparity by increasing the diversity of the students that are admitted. However, the percentage of URMs entering dental school continues to remain significantly below that of the general population. Figure 1 shows the enrollment of first-year URM dental students in the United States dental schools for the 2010-2011 academic year compared to the URMs in the general United States population.

Why is it important to increase the racial and ethnic diversity of dental students and, ultimately, the dental workforce? First, training racially and ethnically diverse healthcare providers is one of the keys to addressing the problems of barriers to dental care. The Surgeon General's Report on Oral Health points out that racial and ethnic minorities experience a higher level of dental problems than others (Sinkford et al, 2001). In a study conducted in California, communities with high percentages of

African-American and Hispanic residents were far more likely to have a shortage of physicians than were other communities. In addition, Hispanic physicians were more likely to care for Hispanic patients and African-American physicians for African-American patients. Hispanic physicians treated the greatest proportion of uninsured patients, while African-American physicians served more Medicaid patients (Komaromy et al, 1996). This finding was corroborated from two large national surveys of physicians that suggested that minority-group and female physicians were more likely than others to serve minority, poor, and Medicaid patients (Cantor et al, 1996). A 2001 study of practice areas of African-American dentists in Texas showed that these dentists commonly serve African-American patients (Solomon et al, 2001). Furthermore, "not only are minority practitioners more likely than their White counterparts to practice in underserved minority communities, but minority practitioners, educators, and researchers can influence other health professionals to be more culturally sensi-

Dr. Lacy is the Director of Student Development at TAMHSC-BCD; eslacy@bcd.tamhsc.edu. Drs. Miller and McCann and Ms. Hornback are also at TAMHSC-BCD in the capacities of Executive Director of Recruitment and Admissions, Director of Planning and Assessment, and Educational Specialist, respectively; Dr. Reuben is a clinical associate professor at the University of South Carolina School of Medicine.

FIGURE 1. URM^s IN U.S. POPULATION* AND U.S. DENTAL SCHOOLS ENROLLMENT OF URM^s IN FIRST-YEAR CLASS**



*US Census Bureau, 2010

**Based on data from the American Dental Association, Division of Education

tive in both communication and care for minority and other patients” (DeVore, 1995, p 631). Therefore, racial and ethnic diversity is critical in helping solve the access to dental care problem.

Second, diversity provides better educational experiences for all students (American Dental Association, 2010; Gurin et al, 2002; Hurtado et al, 2003; Whitla et al, 2003). Collections of people with diverse preferences and perspectives often prove better at problem solving than collections of people who agree or have more narrow experiences. Furthermore, those educated in diverse settings are far more likely to work and live in racially and ethnically diverse environments after graduation. Students who study and discuss issues related to race and ethnicity in academic courses and who interact with a diverse set of peers are better prepared for life in a complex and multicultural society (Hurtado et al, 2003).

PROGRAM DESCRIPTION

In response to the need to diversify dental students and the dental workforce, many schools have strengthened existing initiatives and implemented

new ones to recruit and enroll more underrepresented minority students. TAMHSC-Baylor College Dentistry (TamHSC-BCD) is one of these schools. The admissions policy of the college includes recruitment of students from underserved geographic locations and demographic groups which aligns with the TAMHSC-BCD’s mission relative to its student body, which is to “...increase the enrollment of students from disadvantaged backgrounds and underserved areas through enrichment and career development programs...” The school’s strategy for increasing the enrollment of students from underrepresented minority groups was to develop a multi-faceted approach for admissions and student development. One facet is the Whole File Review process used in admissions decisions. This process allows Admissions Committee members to consider other important factors, in addition to DAT scores and GPAs, that can impact a student’s academic record. Second, a series of initiatives was developed which

Training racially and ethnically diverse healthcare providers is one of the keys to addressing the barriers to dental care problem.

together form a successful comprehensive program addressing dental career awareness, attraction, academic enrichment, admissions and, ultimately, graduation of students. These initiatives, "Bridge to Dentistry: Awareness through Graduation," target students at all educational levels via dental presentations at elementary schools, field trips to the college by 7th–12th graders, Future Dentists Clubs for 4th–12th graders, summer enrichment programs for college students, and a post-baccalaureate program for college graduates. Bridge to Dentistry culminates in mentoring and support for accepted dental students. In addition, students are recruited during trips to colleges and universities and receive pre-application counseling as well as post-application advocacy.

Since 2006, these initiatives have enabled TAMHSC-BCD to consistently enroll diverse dental classes and increase the URM numbers. Once admitted, however, dental students must successfully navigate the curriculum in order to graduate and ultimately help address the access to dental care problem existing among America's underserved groups and communities. In order to better understand which factors play the greatest role in retention, a survey was conducted of students who participated in the Pipeline, Profession, and Practice: Community-Based Dental Education Program. Underrepresented minority students who participated in the survey identified support of faculty members, classmates, family and friends, post-baccalaureate programs, general school environment, student organizations and self-motivation as being very important (Anderson et al, 2009). What is TAMHSC-BCD doing to retain its URM students and how well is it retaining them? This

article will describe the programs to aid retention of dental students at TAMHSC-BCD. This article will also provide the outcomes of this effort that demonstrate that the College is retaining the overwhelming majority of all of its students, including URMs. The services offered are not specific to URM students but are available to all of the college's students.

ACADEMIC ADVISEMENT

TAMHSC-Baylor College of Dentistry has an extensive process for academic advising which includes an Education Specialist and Student Success Team who work with course directors to intervene as soon as a student begins to struggle.

The Education Specialist tracks the progress of first- and second-year dental students and dental hygiene students to assist them in successfully completing academic requirements for graduation. Throughout the year and based on test scores and feedback from course directors, she identifies students having academic difficulties and contacts them to offer counseling and other available services. This counseling includes learning styles assessment as well as exercises to enhance study practices and strategies to enhance the students' test-taking skills. In addition, students receive suggestions to improve their time-management skills and to help them cope with stress. Individual assessments can lead to group help sessions, peer tutoring, review with professors, and referral to counselors or educational diagnosticians when appropriate. The Education Specialist also communicates the academic status for each student to the appropriate administrative offices and the Student Success Team.

The Student Success Team is composed of the associate dean for academic affairs, the associate dean for student affairs, the director of student affairs, the director of student development, and the director of the dental hygiene program, the executive director of recruitment and

admissions, and the education specialist. This team monitors the academic performance of all students in order to implement preventive and intervention measures as needed. If a student's performance does not improve, the Student Success Team determines the next level of intervention.

Academic advising is also provided by course directors and lecturers for help in any given phase of the curriculum. The course directors work closely with the Education Specialist to assure that students who need academic counseling or tutoring are identified as quickly as possible. When appropriate, members of the Student Success Team may provide academic counseling as well. Third- and fourth-year dental students, who are primarily in the clinic, receive formative feedback from their Comprehensive Care Group Leaders.

PEER TUTORING PROGRAM

The Education Specialist also manages and supervises the Peer Tutoring Program. Tutoring services are available to all first- and second-year dental and dental hygiene students. The academic progress of these students is continually updated to determine the effectiveness of peer tutoring. Student tutors are nominated by their course directors and trained by the Education Specialist. The student tutors are paid by the college to provide free tutoring to all academically "at-risk" students who request their services, either one-on-one or in groups.

FIVE-YEAR CURRICULUM

In 1994, TAMHSC-BCD instituted the Five-Year Program. This program divides the traditional first-year curriculum into two years, thus spreading the academic load of the first year, which is traditionally heavy in biological sciences, into a more manageable course load. Students who are eligible to participate in this

program may require additional time for study for a variety of reasons, such as personal or family health issues or nontraditional circumstances (i.e., older with families, seeking a second or third career that did not require a science background). Any student may be accepted into this alternative curriculum after approval by the associate dean of academic affairs, the associate dean of student affairs, the executive director of recruitment and admissions, and the chair of the student promotions committee.

PROFESSIONAL PSYCHOLOGICAL COUNSELING

Counseling for minor adjustment issues is provided through the Office of Student Affairs and by various faculty, administrators, and staff on an as-needed basis. Any faculty or staff member or student can refer a student to the Office of Student Affairs for follow-up activities. Personal, confidential, off-campus counseling services are available to all students. The college pays for a limited number sessions with a licensed psychologist or psychiatrist when the student is referred through the Office of Student Affairs for adjustment counseling, brief psychotherapy, and triage. Additional sessions, if needed, are paid for by the student.

PROFESSIONAL LEARNING ASSESSMENT

Some dental students continue to struggle academically even after participation in the Peer Tutoring Program and taking advantage of other academic support services. These students may have undiagnosed learning disabilities but were able to compensate for the disabilities in pre-professional education. However, with the increased loads and more rigorous biomedical science courses in the dental school curriculum, learning disabilities frequently become more evident and students are less able to accommodate. Therefore, students who continue to have sustained academic difficulty, after preventive and interven-

tion measures have been taken, can be screened by an educational diagnostician for learning disabilities, attention deficits and other disabilities as defined by the federal Americans with Disabilities Act. Students whose learning disabilities can be documented are eligible for special accommodations, especially when taking examinations, as specified by law.

STUDENT ORGANIZATIONS

Students are encouraged to participate in a variety of organizations within the college, two of which are the Student National Dental Association and the Hispanic Dental Association, whose members are primarily African-American and Hispanic, respectively. These groups help to foster a sense of community and dental professional identity. Members tutor each other, share experiences, socialize together, and generally provide support for each other.

GREAT EXPECTATIONS

A collaborative effort between the International College of Dentists and TAMHSC-BCD, via a mentoring professionalism program, provides mentoring to incoming dental students. Each of twelve mentoring groups is composed of one mentor from the International College of Dentists, one TAMHSC-BCD faculty member, at least two third-year dental students, at least two fourth-year dental students, and up to nine nine-year dental students. This opportunity allows senior dental students and seasoned professionals—"those who have been there"—to guide new dental students in areas such as studying for tests and National Board exams and preparing for clinic. Great Expectations also provides a forum for networking and gaining ethical perspectives.

With the increased loads and more rigorous biomedical science courses in the dental school curriculum, learning disabilities frequently become more evident and students are less able to accommodate.

Table 1. URM REPRESENTATION IN U.S. POPULATION, AMONG U.S. DENTISTS, IN U.S. DENTAL SCHOOLS, AND AT TAMHSC-BCD

<i>Race</i>	<i>Population in U.S.¹</i>	<i>Dentist in U.S.²</i>	<i>Students in U.S. Dental Schools³ 2010-2011</i>	<i>Students at TAMHSC-BCD 2010-2011</i>
Black	12.6%	2.1%	5.6%	14.4%
Hispanic	16.3%	3.4%	6.3%	23.0%
Native American	0.9%	0.2%	.6%	1.0%

¹ U.S. Census Bureau, 2010

² ADA Survey Center, Distribution of Dentists in the U.S. by Region, 2004

³ Data from ADA's Survey of Predoctoral Dental Education Institutions

Office of Student Development

There are multiple offices and departments at TAMHSC-BCD that provide support services to students. However, the Office of Student Development serves as a “one-stop shop” where pre-dental and dental students can secure information and services. The director of the office oversees multiple programs in the Bridge to Dentistry initiative, serves on the college's Admissions Committee, advises the Student Promotion Committee, and serves as one of the advisors for the Student National Dental Association. The staff of the office includes the Education Specialist whose primary responsibilities are to personally counsel students who are having academic difficulty, administer and monitor peer tutoring services, monitor students' academic performance and provide information to the Student Success Team, and teach a Learning Strategies course for the college's Summer Enrichment and Post-Baccalaureate Programs. An Educational Programs Coordinator directs all pre-college enrichment programs. A Program

Assistant serves as the primary support for all college level enrichment programs and assists with pre-college activities. An Administrative Assistant serves as the primary source of support for the Post-Baccalaureate Program. Since personnel in this office work with a continuum of students, they are able to build rapport with the students and form a strong relationship with them. This establishes a “family” type environment which serves as a powerful tool in enhancing students' success.

PROGRAM OUTCOMES

Since 2006, TAMHSC-BCD has consistently enrolled very diverse dental classes, which has led to a very diverse student body. Table 1 provides a comparison of the percentage of URMs among TAMHSC-BCD's students and all United States dental students to the percentage of URMs in the United States general population and among United States dentists.

Further evidence of accomplishments in diversifying its student body can be seen in TAMHSC-BCD's URM rankings. Between 2006 and 2010, TAMHSC-BCD enrolled greater numbers and proportions of African-American and Hispanic students in its first-year classes than any other non-minority United States dental school, and the college had the greatest total URM enrollment among non-

minority dental schools from 2007 through 2010.

All students entering TAMHSC-BCD have access to resources and faculty and staff work hard to ensure that these students successfully complete the requirements for the DDS degree. Otherwise, enrolling a diverse class would be self-defeating. Over the last five years, the college has not only been successful in increasing diversity, but it has also retained the vast majority of its students. TAMHSC-BCD's retention rate over these years is 95.7% for all students and 92.5% for URM students. Table 2 provides enrollment and retention data on TAMHSC-BCD's students for the last ten years. Students classified as “dismissed” were dismissed if their departure was the consequence of poor academic performance. Voluntary withdrawal from the College was usually the result of non-academic reasons such as transferring to another dental school, deciding on a different career, or attending to health (personal or family) and other personal issues. The retention rate for Hispanic students appears to be significantly lower than that of other students. This lower retention rate can be attributed to the number of students who voluntarily

withdrew from the college. However, TAMHSC-BCD's retention rate still exceeds 90% among all of its students.

Discussion

Lack of adequate access to dental care is an ongoing problem for many Americans, but especially for the financially disadvantaged and for many of those who are from underrepresented minority groups. The solution to this problem is complex. However, dental schools can play a major role in being a part of the solution by enrolling, retaining and graduating

more dentists who are more than likely to practice in underserved communities and/or among underrepresented populations. Dental schools around the country are working hard to increase their enrollment, retention, and graduation of URM students. In light of the new CODA standard on diversity, many of these schools are doubling their efforts to enroll more diverse classes. Successful recruitment and enrollment models currently exist at several dental schools, including TAMHSC-BCD (Alexander & Mitchell, 2010; Formicola et al, 2010;

Pendelton & Graham, 2010; Price & Grant-Mills, 2010). Therefore, schools searching for effective strategies can use these models without having to "reinvent the wheel."

One of the most effective strategies for increasing the enrollment of URM students has proven to be the Whole File Review process which uses multiple factors in admissions decisions. This process is accompanied by rigorous summer enrichment programs for college students and post-baccalaureate programs, which provide opportunities

Table 2. RETENTION INFORMATION FOR TAMHSC-BCD STUDENTS, 2001–2010

	No. Total Students	% Students	No. Retained	% Retained	No. Dismissed	% Dismissed	No. Withdrew	% Withdrew	Number NB II*/Leave of Absence	% NB II*	No. Graduated	% Graduated	No. Enrolled	% Enrolled	Total No. Retained (Graduated & Enrolled)	Total % Retained (Graduated & Enrolled)
Asian	192	20.4	185	96.4	6	3.1	1	0.5	1	0.5	122	63.5	62	32.3	184	95.8
Native American	7	0.7	7	100.0	0	0.0	0	0.0	0	0.0	3	42.9	4	57.1	7	100.0
Black	88	9.4	83	94.3	3	3.4	2	2.3	1	1.1	25	28.4	57	64.8	82	93.2
Hispanic	160	17.0	148	92.5	5	3.1	7	4.4	1	0.6	52	32.5	95	59.4	147	91.9
White	494	52.5	483	97.8	2	0.4	9	1.8	1/1*	0.4	300	60.1	181	36.6	481	96.7
Totals	941	100.0	906	96.3	16	1.7	19	2.0	5	0.5	502	53.3	399	42.4	901	95.7

Retention Information for TAMHSC-BCD Students, 2001-2010.

*NB II represents students who have not passed Part II of the National Board examinations

for students to increase their competitiveness by building stronger foundations in the biological sciences which prepares them for the challenging dental school curriculum.

Retaining and graduating URM students is just as important as enrolling them. At the local, regional, and national levels, discussions about increasing the diversity of dental schools inevitably include the questions: "How well do URM students perform once admitted?" "Are they retained?" and "Do they graduate?" The American Dental Association collects national data on the numbers of dental school graduates, including URM graduates. However, there is no national data on retention rates of URM students. Although it is only one school's story, the data presented in this paper show that, once admitted, the retention rate of URM students can be very high and comparable to that of all dental students. The URM students enrolled in TAMHSC-BCD's DDS program perform across the same range of performance as the general population of the class. There are URM students in the top quartile, middle range, and bottom quartile, just like the other demographic groups. Since TAMHSC-BCD is enrolling more students who come from disadvantaged backgrounds and URM students are more likely to be from these backgrounds, slightly more URM students need additional help than the non-minority students. But this is reasonable, since being disadvantaged by definition means the student may require more support to catch up to those who have had many advantages all along their academic

careers. URM does not equate to "a retention problem."

The structure of TAMHSC-BCD's retention program is unique due to the wide array of services provided and the number of faculty, administrators, and staff involved in the retention process.

The Student Success Team represents multiple offices including those of Student Affairs, Academic Affairs, Recruitment & Admissions, and Student Development. This "team" approach facilitates a collaborative effort by key personnel who are intimately involved with students for different reasons and prevents any student from "falling through the cracks."

Peer tutors are trained by the Educational Specialist to develop and enhance their teaching skills. Tutors are also paid by the college in order to hold them to a high standard of accountability. In addition, they receive credit for a selective course for tutoring. All students are required to take at least two selective courses.

TAMHSC-BCD pays for a prescribed number of professional psychological counseling sessions for students. Therefore, students do not have to neglect receiving this service due to financial constraints.

The five-year curriculum is an alternative for students who need additional time to successfully negotiate the first-year dental curriculum. Students can choose the five-year program before matriculating into the college or they can enter it once they have are enrolled. This allows students the flexibility to make decision about the program at the appropriate time. For the last several years, the retention rate of students in the five-year program has closely approximated 100%.

The structure that the of Office of Student Development has developed into one that has a long-standing

relationship with many of the college's dental students. Many of the URM students participated in one or more of TAMHSC-BCD's pre-dental programs. These students, therefore, have developed a sense of "belonging" at the college. The office serves as a place where students can get help from those that they know and trust.

How can TAMHSC-BCD's retention program be enhanced? Table 2 shows that minimal students still need to pass Part II of the National Board exams. It is the college's goal that all students pass this exam while still in dental school. Therefore, strengthening preparation for this exam is an area in which we can improve.

So, URM students are being enrolled in TAMHSC-BCD and they are graduating. Where are they practicing? Are they practicing in areas which increase access to care for underserved communities and populations? A study by Solomon and others in 2001 indicated that URM students do generally practice in a way that increased access to care. However, the college is currently identifying practice areas of URM dentists that it graduated over the last 15 years to determine where they are practicing. When available, the results of this study will be shared with the dental community.

The retention strategies outlined in this paper can serve as a model for dental schools, other health professions schools and professional schools in general that are looking not only to increase enrollment of URM students but also seeking additional ways of providing support for students. ■

REFERENCES

- Alexander, D. C., & Mitchell, D. A. (2010). The role of enrichment programs in strengthening the academic pipeline to dental education. *Journal of Dental Education*, 74(10), S110-S120.
- American Dental Association, Commission on Dental Education (2010). *Accreditation standards for dental education programs*. Adopted August 6. To be implemented July 1, 2013.
- American Dental Association, Survey Center (2004). *Distribution of dentists in the U.S. by region and state*. Chicago, IL: The Association.
- Anderson, R., Friedman, J., Carreon, D., Jia Bai, B., Nakazono, M., Abdelmonem, A., et al (2009). Recruitment and retention of underrepresented minority and low-income dental students: Effects of the pipeline program. *Journal of Dental Education*, 73(2), 238-258.
- Beck, P., Githens, J., Clinkscales, D., Yamamoto, D., Riley, C., & Ward, P. (1978). Recruitment and retention program for minority and disadvantaged students. *Journal of Medical Education*, 53, 651-657.
- Cantor, J. C., Miles, E. L., Baker, L. C., & Barker, D. C. (1996). Physician service to the underserved: Implication for affirmative action in medical education. *Inquiry*, 33(2), 167-180.
- Chalkley, Y. (1995). A survey of minority student recruitment and retention efforts in dental school. *Journal of Dental Education*, 59(6), 645-648.
- DeVore, L. R. (1995). Participation of minorities in U.S. dental education. *Journal of Dental Education*, 59(6), 631-639.
- Formicola, A.J., D'Abreu, K.C., & Tedesco, L.A. (2010). Underrepresented minority dental student recruitment and enrollment program: An overview from the dental pipeline program. *Journal of Dental Education*, 74(10), S67-S73.
- Gurin, P., Dey, E. L., Dey, E., Hurtado, S., & Gurin, G. (2002). Diversity and higher education: Theory and impact on educational outcomes. *Harvard Educational Review*, 72(3), 330-366.
- Hurtado, S., Engberg, M. E., & Ponjuan, L. (2003). *The impact of the college experience on students' learning for a diverse democracy*. Paper presented at the annual meeting of the Association for the Study of Higher Education, November 12-15, Portland, Oregon.
- Komaromy, M., Grumbach, K., Drake, M., Vranizan, K., Lurie, N., Keane, D., et al (1996). The role of African-American and Hispanic physicians in providing health care for underserved populations. *New England Journal of Medicine*, 334(209), 1305-1310.
- Pendelton, D. D., & Graham, B. S. (2010). The role of the dental school environment in promoting greater student diversity. *Journal of Dental Education*, 74(10), S98-S109.
- Price, S. S., & Grant-Mills, D. (2010). Effective admissions practices to achieve greater student diversity in dental schools. *Journal of Dental Education*, 74(10), S87-S97.
- Sinkford, J. C. (1998). Dental education issues and trends. *Journal of American College of Dentists*, 65(4), 39-42.
- Sinkford, J.C. (1999). Losing ground: Enrollment shifts among underrepresented minority dental students. *National Dental Association Journal*, 19, 18-19.
- Sinkford, J. C., Harrison, S., & Valachovic, R. W. (2001). Underrepresented minority enrollment in U.S. dental schools—The challenge. *Journal of Dental Education*, 65(6), 564-570.
- Solomon, E. S., Williams, C. R., Sinkford, J. C. (2001). Practice location characteristics of African-American dentists in Texas. *Journal of Dental Education*, 65, 571-574.
- Thurmond, V. B., & Gregler, L. L. (1999). Why students drop out of the pipeline to health professions careers: A follow-up of gifted minority high school students. *Academic Medicine*, 74(4), 448-451.
- Whitla, D. K., Orfield, G., Silen, W., Teperow, C., Howard, C., & Reede, J. (2003). Educational benefits of diversity in medical school: A survey of students. *Academic Medicine*, 78(5), 460-466.
- Wiggs, J., & Elam, C. (2009). Recruitment and Retention: The development of an action plan for African-American health professions students. *Journal of the National Medical Association*, 92(3), 125-130.

Although it is only one school's story, the data presented in this paper show that once admitted the retention rate of URM students can be very high and comparable to that of all dental students.

ISSUES IN DENTAL ETHICS

American Society
for Dental Ethics

ASSOCIATE EDITORS

James T. Rule, DDS, MS
Bruce N. Peltier, PhD, MBA

EDITORIAL BOARD

Muriel J. Bebeau, PhD
Phyllis L. Beemsterboer, RDH, EdD
Larry Jenson, DDS
Anne Koerber, DDS, PhD
David T. Ozar, PhD (editor emeritus)
Donald E. Patthoff, Jr., DDS
Jos V. M. Welie, MMedS, JD, PhD
Gary H. Westerman, DDS, MS
Gerald R. Winslow, PhD
Pamela Zarkowski, RDH, JD

Correspondence relating to the
Issues in Dental Ethics section of the
*Journal of the American College of
Dentists* should be addressed to:
James Rule
8842 High Banks Drive
Easton, MD 21601
jrul0870@verizon.net

THE CASE OF THE PREGNANT ADOLESCENT

Bruce N. Peltier, PhD, MBA, FADC
Terry Hoover, DDS, FADC
Pamela Zarkowski, MPH, JD
Terry Patterson, EdD

ABSTRACT

In this case an adolescent, minor female presents herself for routine dental care, but is pregnant without parental knowledge. She asks the dentist not to reveal the pregnancy to her parents. Three experts including one attorney, one dental educator with 25 years of private practice experience, and one member of a state psychological association's ethics committee comment on the difficult ethical and legal issues found in this actual case.



Dr. Peltier is Professor of Psychology and Ethics at the School of Dentistry, University of the Pacific in San Francisco, bpeltier@pacific.edu;



Dr. Hoover is an Assistant Professor at the University of the Pacific;



Professor Zarkowski is Vice President for Academic Affairs at the University of Detroit, Mercy;



Dr. Patterson is Professor of Counseling Psychology at the University of San Francisco.

CASE: DR. PELTIER

This case was originally offered by a pediatric dentist in Michigan for publication in *Ethical Questions in Dentistry*, a text written by James Rule and Robert Veatch in 1993. It was modified and republished by Dr. Tom Hasegawa in the Texas Dental Journal (Hasegawa & Matthews, 1994). The American College of Dentists maintains the Hasegawa series on its Web site (www.dentaethics.org/_ethicaldilemmas/ED-5.pdf) and the discussion can be found there. Here's the case:

Mary, a 15-year-old female, came to a dental clinic for a recall appointment. She had been a patient of Dr. Virginia Jones for many years. While waiting in the clinic's radiology area, she saw a sign instructing women to inform their dentist if they were pregnant. Mary became upset and asked Dr. Jones why the sign was there. Eventually she divulged that she was pregnant and asked Dr. Jones not to tell her mother.

Dr. Jones felt she had an obligation to inform the parents of Mary's condition. Mary was not legally independent, and parents had to give consent for any dental treatment that Dr. Jones would perform. Because Dr. Jones knew Mary's parents, Dr. Jones was convinced that it would be beneficial to Mary if her parents knew and could provide care and support during this difficult period of her life.

This is an extremely complicated case with many hidden ethical curves and corners. It is one that most clinicians hope will never present itself. The matters

at stake range from legal challenges to ethical problems to hurt or hard feelings. The case wanders into one of the most contentious political arenas in the current American culture wars, and to make matters worse, involves the messy problem of dual relationships in dental practice. To make the situation even more complex, applicable laws differ significantly from state to state and the laws are in flux.

RESPONSE: DR. HOOVER

The primary concern of the dentist or any healthcare provider must be the patient's oral and overall health. Continuing a patient's dental recall appointments and routine prophylaxis is actually recommended during pregnancy (American Dental Association, 2011), and studies confirm the safety and effectiveness of such oral care during pregnancy (Kumar & Samelson, 2009). Initial information in the scientific literature suggested a relationship between a mother's periodontal health and increased risk for adverse pregnancy outcomes such as preterm birth or low birth weight (Offenbacher et al, 2006). Although recent findings have not eliminated long-standing controversy (Macones et al, 2010), attending to Mary's oral health during her pregnancy is Dr. Jones' professional responsibility. Given that Mary has been treated by Dr. Jones for many years, Mary's dental recall appointments are an essential compo-

nent of her dental care. Mary and her parents expect this treatment and have consented to it in the past.

Mary's disclosure of her pregnancy to Dr. Jones should be treated no differently than any other medical condition a patient might report to her dentist. Using her professional judgment, Dr. Jones will consider how Mary's medical condition (pregnancy in this case) affects the scheduled recall treatment appointment. For example, should dental radiographs be taken at this appointment? Is Mary feeling well and able to sit for the planned length of the appointment? Are there medical complications from the pregnancy about which Dr. Jones should be informed? After weighing these issues and making appropriate adjustments, Dr. Jones should be able to proceed with Mary's recall dental appointment. Mary's pregnancy itself is not an issue for the provision of dental care in this scenario.

The case is complicated for Dr. Jones, however, in two ways: The first is the obligation Dr. Jones feels to inform Mary's mother of Mary's pregnancy even though Mary has asked Dr. Jones not to do so. The second concern is the issue that arises should Dr. Jones discover during the recall exam that Mary has a dental problem needing treatment beyond routine recall care. Let's address each of these concerns separately.

Dr. Jones' feelings of obligation to inform Mary's mother of the pregnancy are well-intentioned. Dr. Jones knows Mary's parents and feels Mary would benefit from the "care and support that

The most favorable outcome in such a situation would be for Mary herself to disclose the pregnancy to her parents, opening the door for Dr. Jones to discuss the proposed dental treatment.

parents could provide during this difficult period of her [Mary's] life." This feeling may be shared by others, not just health professionals, as well—the desire for minors to involve parents so they may help the minor seek proper medical and emotional care during the pregnancy. However, Mary has specifically asked Dr. Jones not to tell her parents of the pregnancy.

To deliver this scheduled recall care, it is not clear that Dr. Jones has a legal obligation to Mary's parents to either disclose or withhold the pregnancy information. Dr. Jones must weigh her personal feelings of obligation to inform Mary's parents against the potential damage to the dentist-patient relationship or to Mary herself that such a disclosure may cause. Perhaps Dr. Jones would be wise to encourage Mary to make her own parental disclosure. Dr. Jones should not underestimate the positive influence that the advice of a caring, open-minded health professional can have on a young person. It is even possible that Mary has not yet spoken or reached out to any adult about her pregnancy at this point.

The decision as to whether to disclose Mary's pregnancy enters the legal arena, however, should Dr. Jones diagnose a dental problem requiring treatment beyond routine recall care. Examples would be the need for a filling, crown, root canal, or extraction that should not be delayed. Such treatment would require informed consent and in most, if not all states, dental procedures for a minor child require parental consent. Since a proper informed consent discussion with parents would involve a discussion of risks, benefits, alternatives, costs, and other implications, Mary's pregnancy would, of necessity, be mentioned in that process. The most favorable outcome in such a situation

would be for Mary herself to disclose the pregnancy to her parents, opening the door for Dr. Jones to discuss the proposed dental treatment. A more difficult conundrum ensues should Mary need invasive dental treatment but insists that her parents not be told of the pregnancy. Since Dr. Jones is obligated to disclose her dental findings and treatment recommendations to both Mary and her parents, she would likely find it difficult, if not impossible to conduct a proper informed consent discussion with Mary's parents without disclosure of the pregnancy. This case illustrates how a dentist's professional responsibilities to a patient and his or her personal values sometimes collide.

RESPONSE: PROFESSOR ZARKOWSKI

This case provides an opportunity to examine a variety of perspectives that can be supported by ethical principles and law. What follows is a description of several of the important issues found in this difficult situation. I have chosen not to weigh in with a preference for any of the options.

Regarding the request to maintain confidentiality based on the operator-patient relationship, a significant obligation has potentially been thrust on the unsuspecting dentist. Although the patient may not have legal standing in some jurisdictions, one approach is that the request to maintain confidentiality must be upheld. If the dentist chooses to maintain the confidentiality requested by Mary, the ethical principle of veracity with regard to the dentist's relationship with Mary's parents is compromised. If the parents are obligated to provide consent for treatment, they must have access to all of the relevant facts.

It is often said that a minor has limited rights. As is noted in this particular scenario, Mary is not an emancipated minor. Thus, one could argue that her parents must be informed of the situation because they have a legal right to know.

The decision to inform the parents so that they are knowledgeable about the situation and so that they can provide support for Mary honors the normative principle of beneficence and satisfies the principle of veracity as well.

The young woman, although a minor, has been involved in an "adult" activity which resulted in a pregnancy. Thus, while not "emancipated" within the legal definition, being pregnant changes the rules, and therefore the decision is not driven by the "age" but the actual condition of the young woman. Perhaps an option for Dr. Jones is to counsel the patient about her options (honoring justice). Her options include: disclosing her pregnancy to her parents; independently seeking medical care; and consulting with a high school counselor or trusted mentor. Explaining options in light of what is best for the young woman and her baby satisfies beneficence.

It is entirely possible that informing the parents would put Mary and the fetus at risk. Thus, if the patient were from a family that found this pregnancy unacceptable or even repellent, they may actually harm Mary and potentially her fetus, perhaps beating the young woman to physically punish her and the unborn child. Even worse, it is even possible that Mary could be killed because she has violated family honor, deep religious beliefs, or family reputation. Thus, informing the parents may cause serious consequences, even though this action would satisfy the "legal" obligation.

Disclosing but not disclosing is a possible "solution." This response involves telling the parents that radiographs cannot be taken or treatment not provided because the dentist has identified a situation that requires medical evaluation. When asked what the condition is, the dentist may respond that they should consult with their

daughter, thus forcing a response, or indicate that the dentist needs medical confirmation and the daughter needs to be evaluated by a physician. This moves the information-sharing burden to the physician.

The dentist might also consider delaying the entire appointment by not disclosing to the parents and creating an excuse to avoid provision of treatment on this particular occasion. Following the cancellation of the appointment, the doctor might contact an appropriate mental health professional to work with the young woman to determine how to proceed so that she is not at risk while at the same time providing the help that she needs.

In discussions of this case with dental students and licensed dental professionals, often the well-being of the young woman and the fetus rank as a high priority. Thus, if the dentist suspects that informing the parents would put the child at risk, they are likely to seek some of the alternatives mentioned above. In most cases, dental professionals talk about weighing the benefits and risks on a case-by-case basis depending on knowledge about the family situation, cultural dynamics, and the possible consequences—good and bad.

RESPONSE: DR. PATTERSON

It is appropriate for a clinic to incorporate information about pregnancy into the patient's diagnostic and treatment plan, but this is a case where clinical judgment, personal values, legal and ethical guidelines, and perhaps culture and ethnicity potentially collide.

While laws vary from state to state, in California minors of any age have the right to consent to treatment and a right to complete confidentiality in certain limited circumstances. Such situations include the right to hold the legal privilege in cases involving pregnancy, abortion, and birth control (Duplessis et al, 2010). A number of practical issues immediately

come to mind for the clinician: How can a minor carry a pregnancy without the parents' knowledge? Who will pay for the clinic visits? Am I liable, as a dentist, if the parents are upset about my failure to tell them? Will I violate the family's cultural values? How can I live with myself, knowing a 15-year-old is handling her own pregnancy?

While these are relevant and important questions, a comprehensive standard of care must include all of the applicable ethical and legal principles in order to maintain clinician objectivity and to facilitate the best possible outcome for the minor.

In light of the minor's right to complete confidentiality, let us first consider the clinical aspects of the case. A competent mental health professional, trained in both adolescent and family therapy can help such a patient consider all of the consequences as well as the resources she will need during her pregnancy, and if not contraindicated, arrange a meeting in which positive familial communication is fostered. The parents' (or other responsible adults') help could be enlisted. Second, a skilled pregnancy counselor familiar with all of the options can review various alternatives, and along with the therapist help this young patient decide on a plan that is best. Either of these two professionals or a clinical social worker can provide outreach and case management services so that the adolescent has all of the community assistance needed for a successful outcome.

Third, many healthcare providers have personal, moral, or religious concerns about both the confidentiality mandate and the various options available to the adolescent, and these concerns should be considered carefully. Do clinicians have the right to provide care or to limit options based on their

In most cases, dental professionals talk about weighing the benefits and risks on a case-by-case basis depending on knowledge about the family situation, cultural dynamics, and the possible consequences—good and bad.

Obviously, a dentist confronted with the case of the pregnant adolescent should seek an immediate and accurate consultation about current laws in his or her state.

personal mores or preferences? Most professional codes and legal standards indicate not, and despite strong opinions or statistical evidence that might convince us to the contrary, it is impossible to determine a single life course of action that fits every patient. Whether we are opposed to abortion or birth control, are pro-choice or abstinence advocates, our role as healthcare professionals and healers is to “first, do no harm,” and above all, to serve the best interests of patients.

Fourth, there are complex ethical issues for Dr. Jones to consider. Multiple types of relationships with patients may impair objectivity, and at first glance, it may seem advantageous that the doctor knows Mary’s family personally. However, the dentist’s prior knowledge may further bias her in favor of the parents’ values and preferences, thus impairing her clinical objectivity regarding the option of allowing Mary to explore the available options independently. Should Dr. Jones place herself in the role of the family’s mediator or counselor, she may actually preclude or impair the involvement of a professional family therapist who is trained and experienced in this area. Perhaps a bias toward provision of mental health treatment would contribute to this dentist’s desire to become involved in a dual role as counselor and family confidante (American Psychological Association, 2002).

In a similar vein, although we do not have information on Mary’s cultural background, there may be strong traditions in that family requiring that parents make all major decisions about their daughter. In such a case the essential conflict between laws, ethics, culture, and clinical judgment needs to be overtly addressed. Consultation with experts in these areas and willingness to document decisionmaking in the clinical record

will enable the clinician to achieve an outcome that will serve the best interests of this client.

SUMMARY AND CONCLUSIONS: DR. PELTIER

Three accomplished educators have presented thoughtful commentary on this difficult case, one from the point of view of a practicing general dentist, a second from the perspective of a dental educator who is also an attorney, and a third from a psychologist with a specialty in family practice.

In the first published discussion of this case, Rule and Veatch (1993) pointed out that the traditional view of the dentist-patient relationship was highly paternalistic, and in that view Dr. Jones would have been completely justified, if not required, to disclose to Mary’s parents if the doctor felt that disclosure was in the patient’s best interest. They also wondered about Mary’s perception about confidentiality in the relationship. Did Mary and Dr. Jones have an overt or covert agreement about information that Mary might share during treatment meetings? Did Mary reveal her pregnancy under the assumption that the news would be kept confidential or did she figure that sharing it with Dr. Jones meant that she was also sharing it with her parents (unlikely!)? Rule and Veatch (1993) viewed Dr. Jones’s confidentiality duty as derivative of a promise or covenant with Mary. They wrote that “The key is what is promised (or implied) to the patient at the time when the relation is established.... Whatever a dentist promises or implies as part of the commitment that establishes the relation, that is what is owed to patients.” (p. 144). That said, it is hard to know what a 15-year-old patient might assume about the limits of confidentiality in the dentist-patient relationship, especially if nothing overt was said to them about the matter early on. Perhaps it would be wise to have a talk with all patients,

especially the minor ones, about the nature and limits of confidentiality at the beginning of treatment.

The 1994 *Texas Dental Journal* commentary began with an informal survey of readers about the case. Respondents strove to solve the problem without telling the parents. In fact, Hasegawa and Mathews reported that “No one selected the option that Dr. Jones should contact Mary’s mother and inform her that Mary is pregnant.” (p. 23). The authors stressed the importance of trust and confidentiality in the dentist-patient relationship and noted that according to codes of ethics, the primary goal of dentistry is “benefit of the patient.” In the end, Hasegawa and Mathews deferred, citing the ambiguity in the case itself—not enough information about the family, Mary’s intentions, or the state of Mary’s dentition.

Dr. Hoover, the general dentist with 25 years of experience, and the psychologist, Dr. Patterson, both agree with Hasegawa and ethics codes that overall care of patients is the most important thing. But, what does “overall care” actually mean in the context of a pregnant adolescent? Maybe it would be in the best interest of the overall care of the patient to grab the phone and inform the parents! This would probably be the case if Mary’s level of maturity were quite low, if her judgment were suspect or poor, if her logic were incoherent, or her thinking were magical and childlike. Adolescents vary wildly along these dimensions. Some are quite mature at age 15 while others immature at 17. This implies that it might be in the best interest of the patient to violate her trust and break confidentiality. So, an essential element of the discussion of this case is the question of what is really in Mary’s best interest?

Many bioethicists consider confidentiality to be one of the (core) normative

principles. Informing Mary’s parents against her explicit request not to do so would certainly violate Mary’s confidentiality. That said, a case could also be made that Dr. Jones has an overt or covert covenant with Mary’s parents. They have placed trust in the dentist to take care of their daughter, and in their view, such care would likely include informing them of important information concerning their minor daughter’s physical condition. A decision to keep the pregnancy from them would certainly violate the normative principle of fidelity, unless the adults viewed Dr. Jones’s duty in the broadest sense, meaning that a decision not to inform the parents was the best thing that the doctor could do for Mary and her health. This implies that if the parents hypothetically knew everything about this situation, they would agree that it would be best if they were not informed. That seems like a stretch.

Relevant laws vary significantly from state to state and are in flux. A quick check of the Wikipedia site on the Internet (http://en.wikipedia.org/wiki/Minors_and_abortion) reveals a map of the United States with states shown in seven colors, each a different category of mandated parental involvement including:

- No parental notification or consent laws
- One parent must be informed beforehand
- Both parents must be informed beforehand
- One parent must consent beforehand
- Both parents must consent beforehand
- Parental notification law currently enjoined
- Parental consent law currently enjoined

Obviously, a dentist confronted with the case of the pregnant adolescent should seek an immediate and accurate consultation about current laws in his or her state.

On a practical level, it is important that dentists remain up to date and clear

about the current standard of care regarding radiology and pregnancy. As is true of the standard of care in general, standards in radiology evolve over time, especially as technology improves. Current standards, of course, generally discourage x-rays of a pregnant woman in the absence of a true dental emergency.

It must be noted that many people in their teens carefully assess adults for trustworthiness. It is certainly possible that if Dr. Jones immediately adopts an authoritarian stance, Mary might just decide that it is not safe to consult with any adults about her problem. That said, research indicates that most pregnant adolescents actually do talk with their parents. In one large national study, 61% of young pregnant women discussed the situation with at least one parent, and the percentage went up as the age of the young woman went down. Ninety percent of women under the age of 15 in the study discussed decision making with a parent, and a majority of teens who did not involve a parent did talk with another trusted adult (Henshaw & Kost, 1992).

Professor Zarkowski reviews several of the prevalent legal arguments and makes a very important point, one that is often overlooked or minimized in dental ethics discussions. Although the case states that Dr. Jones has a positive impression of the parents, one really never knows what goes on in families behind closed doors. The finest looking families can sometimes be the most toxic. We do not know what will happen to Mary if her parents are told. She seems to think that it’s not a good idea. Why? For one thing, we do not know the father of the fetus. What if the father is someone totally problematic, say an uncle—or worse, Mary’s own father? What if Mary has been raped by a

Dentists should line up professionals who are expert in eating disorders, substance abuse, pregnancy counseling, HIV consultation, and domestic violence of all sorts, including elder abuse.

stranger or coerced by a bully? These are not abstract questions, as sexual pathology is widespread in American families. The Henshaw & Kost (1992) study indicated that 30% of those pregnant teens who did not tell their parents had previously experienced violence in their family and were further afraid of being forced to leave home if the pregnancy were to be discovered.

Dr. Patterson asks this important question: How much weight do we give to the dentist's personal biases in this situation? Should they be allowed to drive the dentist's behavior? Is this ethical? Is it even possible to adequately contain them so that they do not influence the doctor's professional decision?

Dr. Hoover notes that if Mary only needs an exam and routine cleaning, the dental treatment should proceed. But, that leaves the door open to the question: Should Mary's parents be told even though there is no immediate or compelling dental reason for Dr. Jones's involvement with the pregnancy situation? Dr. Patterson notes that in California it is likely to be illegal for the dentist to reveal this information to the parents, given that adolescents have a right to confidential pregnancy care and that caregivers are actually prohibited from informing parents. California law states that "The healthcare provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with parents with a signed authorization from the minor." (Cal. Health & Safety Code Sections 123110(a), 23115 (a)(1); Cal. Civ. Code Sections 56.10, 56.11).

One pressing challenge the case poses is this: If Dr. Jones decides not to x-ray or treat Mary, what does she say to the parents? Why did she not treat Mary at the appointment? Obviously, the

dentist cannot tell the parents a lie. Can she simply pass the hot potato to Mary by telling the parents to check with their daughter about the situation? Is not this pretty close to telling the parents herself? Does she "make a deal" with Mary, telling her that she will give Mary a prescribed time period to inform her parents before the dentist calls them to check in on the situation?

Dr. Jones has another potentially serious problem. She surely must document Mary's appointment and the clinical situation accurately and completely. She simply cannot leave the pregnancy out of the record, especially if it is the reason for any clinical decision Dr. Jones might have made, such as a decision to put off treatment or radiographs. The prudent practitioner would note Mary's pregnancy even if that medical fact did not influence treatment decisions that day. It would be very difficult to make a case for leaving a patient's pregnancy out of the dental record. It is obviously relevant to Mary's healthcare status and should be cited. (What if pregnant Mary returns to the office with a toothache on a day when Dr. Jones is away from the practice?). Since Mary is a minor, her parents have an absolute right to see what is in those records, and the doctor cannot practically or legally shield parts of the record from the parents. While this is admittedly an unlikely event, should not Dr. Jones warn Mary that the fact of the pregnancy is now in her dental records...forever? It is reasonable to assume that once Mary turns 18 her parents will no longer have access to that difficult bit of medical information, but it only seems fair to discuss this matter with Mary on the spot. It may, in fact, influence her decision to reveal her situation to them. The fact that the pregnancy is noted in the dental record might even force her hand.

There is another problem for Dr. Jones: If she chooses not to inform Mary's parents, how does she cope with the situation if and when the parents

subsequently discover that the dentist knew of their daughter's pregnancy but did not tell them? This possibility is awkward enough without the specter of the complexity that dual relationships add to the situation, as Dr. Patterson noted earlier. While this question is certainly not central to the discussion, most dentists would have serious concerns if these parents are social friends in the community. On an even lesser but still relevant note, Dr. Jones's relationship to Mary's parents is changed forever, especially if she chooses not to disclose. It is unlikely that she can ever again have a social conversation with them without remembering this unfortunate situation and feeling uncomfortable, perhaps wondering whatever happened to Mary and her pregnancy.

Dr. Patterson writes from the perspective of a family therapist and his advice is sage. Dentists would be wise to cultivate a wide variety of referral sources in the local community ahead of this kind of crisis. Dentists should line up professionals who are expert in eating disorders, substance abuse, pregnancy counseling, HIV consultation, and domestic violence of all sorts, including elder abuse. Such experts are out there in every community, and they can take a heavy load off of the back of a busy dentist whose expertise is in other arenas. It is not practical for most dentists to take extensive time to counsel patients about issues not directly related to oral health, and such interventions may even lie outside of a dentist's scope of practice. It is a great idea to train interested staff members to handle situations like this one in a private consultation room, and sometimes it is helpful for a female team member to take charge of the consultation. Dentists are ill-advised to "go it alone" or to put blinders on and hope that such cases and situations will never come their way. They most certainly will.

REFERENCES

- American Dental Association, Division of Science (2011). Oral health during pregnancy: What to expect when expecting. *Journal of the American Dental Association*, 142 (5), 574.
- American Psychological Association (2002). Ethical principles and code of conduct. *American Psychologist*, 44 (4), 12-32.
- Duplessis, V., Goldstein, S., & Newlan, S. (2010). *Understanding confidentiality and minor consent in California: A module of adolescent provider toolkit*. Adolescent Health Working Group, California Adolescent Health Collaborative.
- Hasegawa, T. K., & Matthews, M. (1994). Confidentiality for a pregnant adolescent? *Texas Dental Journal*, 111 (2), 23-25.
- Henshaw, S. K., & Kost, K. (1992). Parental involvement in minors' abortion decisions. *Family Planning Perspectives*, 24 (5), 196-207, 213.
- Kumar, J., & Samelson, R. (2009). Oral health care during pregnancy recommendations for oral health professionals. *New York State Dental Journal*, 75 (6), 29-33.
- Macones, G. A., Parry S., Nelson D. B., Strauss J. F., Ludmir J., Cohen A. W., et al (2010). Treatment of localized periodontal disease in pregnancy does not reduce the occurrence of preterm birth: Results from the periodontal infections and prematurity study (PIPS). *American Journal of Obstetrics & Gynecology*, 202 (2), 147.
- Offenbacher S., Boggess K. A., Murtha A. P., Jared. H. L., Lieff S., McKraig R. G., Mauriello S. M. et al (2006). Progressive periodontal disease and risk of very preterm delivery. *Obstetrics & Gynecology*, 107 (1), 29-36.
- Rule, J. T., & Veatch, R. M. (1993). *Ethical questions in dentistry*. Carol Stream, IL: Quintessence.

It would be very difficult to make a case for leaving a patient's pregnancy out of the dental record.

HOW TO MAKE MORAL CHOICES

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

ABSTRACT

Moral choice is committing to act for what one believes is right and good. It is less about what we know than about defining who we are. Three cases typical of those used in the principles or dilemmas approach to teaching ethics are presented. But they are analyzed using an alternative approach based on seven moral choice heuristics—approaches proven to increase the likelihood of locating the best course of action. The approaches suggested for analyzing moral choice situations include: (a) identify the outcomes of available alternative courses of action; (b) rule out strategies that involve deception, coercion, renege on promises, collusion, and contempt for others; (c) be authentic (do not deceive yourself); (d) relate to others on a human basis; (e) downplay rational justifications; (f) match the solution to the problem, not the other way around; (g) execute on the best solution, do not hold out for the perfect one; and (h) take action to improve the choice after it has been made.

This essay is the second of two papers that provide the backbone for the CORE Project of the College—an online, multiplatform, interactive “textbook” of ethics for the profession.

Ponzi scheme operator Bernie Madoff did not avoid prison time by claiming that he realized he was engaging in risky investments. The several dentists who routinely overdosed patients with anesthetics, causing deaths in some cases, did not dodge penalties by appealing to a private cost-benefit analysis. In morality, as in law, we look to the actual behavior to determine how we should judge others because we have no direct feed on their intentions. In special circumstances, a reasoned ethical analysis is a valuable first step in making the right choice. Sometimes it is an after-the-fact rationalization. But usually there is no relationship between moral behavior and ethical reasoning. Many of the paragons of the profession express surprise when examples of their virtue are singled out for attention. They have no well-developed theoretical systems of ethics; they just make it a habit of doing the right thing.

1 MORAL CHOICE

A moral life requires consistent actions intended to bring about what is good and right; ethical reasoning about theories of the good and the right may or may not be part of that habit.

Morality is about the choices we make in life—or, more often, about the default positions we assume. It is about offering all reasonable treatment options to patients, taking steps to ensure one’s competency, and hiring the right office

staff and training them well. No one can guarantee that everything he or she does will make a net positive contribution to the world. But each of us can decide how to live at each opportunity in a way that we feel will bring about that end. We can guarantee 100% that we choose to live a life we intend to be positive.

Choices are actions. They are commitments of resources, under conditions of risk, with a view toward maximizing positive outcomes. Standing up in the House of Delegates to speak to an issue on access is a choice (it might bring ridicule from some colleagues or even block a promising political career). Telling a patient that for personal and professional reasons you will not perform the treatment in the order they want (cosmetic before health needs) may result in the loss of a patient. Writing triplicate prescriptions for a patient who is your current amorous interest puts you all the way into the game.

Notice in each of the examples above the question was not whether a principle such as social justice, respect for anatomy, or dual relationships is right or wrong. No one will quibble over rightness of the principle—but they might ignore it. The issue is what an individual dentist in a particular situation will do. We can have debates among people, many of whom are not dentists and will never find themselves in such situations, and these discussions can last for years, as they often do in academic journals, about the theoretical ethical foundation for these decisions. Morality is about the decisions we actually make.

2 GETTING DOWN TO BRASS TACKS

In a long-ago era when cloth was sold by the yard at retail for folks to sew their own clothes or draperies, merchants had long tables where the selected merchandise was measured off according to the amount to be purchased. Rather than determine length with a ruler, the cutting board was marked off in lengths by brass tacks. After all the comments about quality, applications, prices, and alternatives had taken place, actual commitment to purchase was signaled by “getting down to brass tacks.”

Three cases will be used to make the discussion of moral decision making more concrete. Each case is intentionally “underdetermined.” Each is a brief outline, so it will be easy to add plausible details that will tip the action chosen in one direction or another. Those who use the case method for teaching in business schools and for teaching communication skills and ethics to dentists and dental students have observed that most differences of opinion are not about principles; they are about alternative assumptions regarding the details on the ground. It really is not possible to force everyone to have the same view of the world. Most of the time there is substantial overlap. But often, different actions can both be right depending on how the case is interpreted.

2.1 WAIVER OF COPAYMENT

Most insurance contracts specify which treatments are covered and require both that the dentist charge the full and

regular fee for that procedure and that the patient add some fractional amount of that fee or a fixed amount as a copayment. Waiving the copayment is equivalent to charging the insured patient less for the same procedure than uninsured patients would pay.

It is sometimes argued that it is appropriate to selectively waive copayments, especially in cases of economic hardship. After all, waiving copayment may just be the difference between a patient receiving needed care and going without, or being directed to another dentist who can be counted on to waive copayments. This is a case where principles of veracity (honoring a contract) and beneficence and justice seem to collide. It is also a situation moral philosophers call “double effect”: the dentist who waives copayments helps the patient at the same time he or she helps the bottom line. Usually, only one of these motives will be given as the public justification. Such cases are known in the literature as “Robin Hood” cases. The dentist has an opportunity to do real social good—with somebody else’s money.

2.2 HOSTILE WORKPLACE ENVIRONMENT

What is a dentist to do when the hygienist demands that a patient, perhaps even a personal friend of the dentist, be discharged from the practice for allegedly

Doing the right thing and giving an acceptable story about it are different matters. The latter cannot substitute for the former.

making inappropriate personal remarks, including some that are sexually suggestive? There are issues here of “he said/she said,” conflicting loyalties, bent reputations and lost referrals, and potential exposure to lawsuits. There are also matters of staff morale, a chance of losing a good employee, and basic fairness involved.

Everybody knows that sexual harassment is wrong. But pronouncing the principle does very little to solve the problem. There is still the tricky business of defining just what constitutes “inappropriate behavior.” Different people legitimately draw the line in different places. It is also problematic to decide who is responsible: perhaps this is something the hygienist should learn to manage. And what authority and what practical options does the dentist have?

2.3 PATERNALISM

Imagine a situation where radiographs reveal a suggestive case of recurrent caries on the margin of a medium-sized amalgam on #3. The dentist explains that the situation is fortunate because the original preparation was conservative and the filling can be removed and replaced with a nice, natural-looking composite that very afternoon. Appropriate instructions are given to the chairside assistant to begin that procedure.

Some patients and most dentists and attorneys would regard this as a failure of informed consent. The patient was

not told about all feasible options, especially the alternative of replacement with amalgam. Ethicists call such behavior “paternalism.” The dentist substitutes his or her values for those of the patient. Some bioethicists make wide room for paternalism, noting that the professional knows better than do patients what is in their true best interests. After all, the patient came to the dentist to get something done; anyone can see that the situation needs correcting. Additionally, the dentist may believe firmly that dental amalgam poses a health risk to patients in its own right. It is also a matter of professional judgment just how “suggestive” a radiolucency must be to activate a handpiece.

In these cases of contractual agreements, workplace environment, and patient participation in their treatment decisions, it is possible to choose more than one course of action and to add circumstances not already in the case to strength the chosen behavior. In that sense, the “right thing to do” cannot be read off a list of ethical principles. As it happens, all three cases involve illegal actions. Waving copayments is a breach of contract. Employers are liable for hostile workplace environments (defined as interference with a person’s ability to perform the duties for which they were hired) whether the harassment comes from the boss, another employee, or a visitor to the place of work. Failure to obtain informed consent is an easy win for attorneys in malpractice cases if any harm to the patient can be connected with the action. All cases are common and minor infractions, usually overlooked

unless notorious or repetitive and unless there are other, larger related problems.

All are moral choices.

3 Help for Making Moral Choices

There are eight heuristics for making sound moral choices. A heuristic is a general approach or strategy that has a high success rate. There are no methods that always produce an answer that is immune from regret and criticism. If such a cocksure system for ethics had been discovered, those who know about it have been unethical in hiding it from the rest of us. The criterion used here is that we can do no better than live a life using the best methods for picking the actions we wish to pursue to make the world better, all things considered.

3.1 Focus on Actions

The first task in moral choice is to determine what actions are possible. One action for a dentist who suspects incipient marginal failure would be to make a note in the chart to watch the radiolucency. If it is indeed uncertain and the patient is an adult and a regular attender, the most probable outcome from that action is no harm or cost to the patient and a peer-appropriate behavior on the dentist’s part. Another course of action is to disclose the findings and offer the patient a choice of monitoring, replacement with composite, or replacement with amalgam. Most dentists would feel comfortable with this action because the patient will likely ask

for professional guidance in reaching a decision. Proceeding with the composite without involving the patient saves time and earns money, but has attendant risk if something goes wrong or the patient talks to others who question the wisdom of posterior composites. The dentist who pursues a policy of replacing sound restorations to free the patient of “toxic” amalgam will have some explaining to do if confronted by colleagues who understand the ADA’s position on the matter.

Moral choice is about committing to the right course of action, given realistic expectations about the outcomes of those actions. The tried and true method of placing alternative action headings on a piece of paper and listing the pros and cons under each is still an excellent place to start. Seeking guidance, discussion with advisors, and reflection are valuable for filling out complete and accurate lists of actions and outcomes. Although everyone has a favorite story about the rare cases where moral sense and professional experience produced a surprise, they are an important part of the process.

3.2 DO NOT CHEAT

It is wrong to follow a course of action based on deception, coercion, or reneging on one’s commitments—period. It is also plain wrong to hold others in contempt by denying their legitimate interests in shared activities and to collude with some to defraud others. If any of the potential actions on the list have these characteristics, they should be ruled out of court peremptorily because they are

immoral. If dentists charge patients something other than what is agreed in the insurance contract, they are probably engaged in deception. Coercion could be involved if dentists artificially limit patients’ treatment choices. Hiring an employee with the promise of a healthy work environment but failing to follow through on this obligation seems like reneging. Patients and dentists who agree to share the spoils of defrauding the insurance company are engaged in collusion. Contempt could be demonstrated in any of the examples. It just means that one does not care what others feel about potential actions. Contempt means acting as both judge and jury—usually without gathering all the evidence. Cross contempt, deception, coercion, reneging, and collusion off your list of possible moral actions.

3.3 BE AUTHENTIC

It is human nature to idealize ourselves. When we do this in moral choice situations we end by imagining a solution for a problem that is not really the same as the one we are facing. The imperative for disclosure to others in making moral choices is limited (as long as deception is avoided), but there is a rigid requirement for full self-disclosure.

An authentic moral choice means that we are not hiding inconvenient truths from ourselves. Dentists who play Robin Hood help patients and help

A moral life requires consistent actions intended to bring about what is good and right; ethical reasoning about theories of the good and the right may or may not be part of that habit.

An authentic moral choice means that we are not hiding inconvenient truths from ourselves.

themselves economically. Dentists who plump for amalgam-free mouths may have perfectly justifiable health concerns and perfectly justifiable needs for increased business. Dentists avoid hassle if staff manage their own interpersonal relations. A good list of moral choice alternatives lays out all of the consequences of each alternative, including those that are fresh and bright and those that may have a faint odor. Consider the case of making a contribution to a charitable cause and finding that your name has been left off the published list of donors. If the reaction is to make a call to point out the oversight, the original philanthropic motivation may not have been weighty enough to have carried the decision. We are looking for the right thing to do, all things considered.

3.4 RELATE AS A PERSON, NOT A POSITION

Dentists enjoy relationships with their colleagues, spouses, friends, professional advisors, patients, and baggers at the supermarket. Each of the relationships is different. Yet there is some part of the relationship that is common and essential in all of these cases. Moral choice has to do with the essential part of our relationship with others.

Imagine that a dentist is meeting with the insurance carrier's attorney to discuss a frivolous malpractice suit. This is certainly an asymmetrical rela-

tionship. The attorney knows more about the law, is on his or her turf, and is less nervous. These are circumstantial factors; they would switch entirely if the attorney were in the dental chair with an inflamed pulp. Circumstantial relationships figure in moral choice, but essentially as background. They are the context for decision making. There is nothing inherently moral or immoral in dentists charging a fair fee for their services, choosing to emphasize one aspect or another of their practices (such as posterior composites), choosing or not choosing to accept insurance, or hiring a male hygienist. Dishonesty in a poker game does not come from being dealt a good hand or playing it well. It comes from cheating: trying to play the game by a private set of rules that are not disclosed to others.

The dentist and the attorney in this case both have inherent dignity regardless of how talented they may be or whether the situation places either at a temporary advantage. There is something essential about the way we treat others that has nothing to do with circumstances. We expect a certain level of honesty and respect, an assumption that we are intelligent, that we are not manipulative, that we are competent, that we have feelings, that we care about the relationship, etc. We expect to be treated like a human being instead of an object or a means to others fulfilling their ends. There is always an "essential" part of every relationship that would not be altered if the positions were reversed. That is the moral core; everything else is circumstantial. We should play the hand

we have been dealt or which we have earned through hard work for all it is worth; but we should not behave in any way we would find offensive if the roles were reversed.

3.5 Downplay Justifications

Doing the right thing and giving an acceptable story about it are different matters. The latter cannot substitute for the former; when that is done, it is called hypocrisy or rationalization.

Sometimes the moral choice is distorted so as to make justification easier. Dentists who help patients get care through an unacknowledged subsidy from the insurance carrier emphasize the good being done for the patient. Practitioners who seek to avoid confrontation over workplace standards emphasize professionalism and harmony. That is fine—but only as long as the moral choice is made based on all motives and the dentist is willing to acknowledge all motives when asked.

Being able to offer a publicly acceptable justification for one's action is not necessarily a mark of having made the right moral choice. Politicians accused of corruption or companies charged with gouging the public typically say the charges are “politically motivated” or are “anticompetitive.” Whether that is true or not, the more important question is whether the politicians are corrupt or the companies are gouging. The stage of American politics is now so large that

individuals of integrity are no longer noticed: it has become the theater of competing half-truths.

The standard approach to teaching ethics in dental schools, and all of the health sciences for that matter, is based on the use of principles such as respect for autonomy, nonmaleficence, beneficence, justice, and sometimes veracity. Cases are discussed so as to bring out these principles. As useful as this method is for revealing how the profession tends to think about common problems, it should not be mistaken for moral choice. Most ethical issues involve actions that could be justified by several principles and contrary actions that could also be justified by various principles. That is why they are called ethical dilemmas. There are two or more correct ways of looking at the matter. Naming one or more principles involved in these cases is not the same as making a choice. Picking a course of action for whatever grounds, including self-interested ones, and attaching the name of a principle to it is a poor excuse for moral choice.

It is possible to distinguish between moral choice and ethical justification using a simple rule: in moral choice, only one course of action can be taken at a time, but it is possible to give multiple ethical justifications. There is a large difference between commenting on various ethical dimensions of a dilemma and committing to act morally. The former often ends with several alternatives, each of which could be right, with declining to take a position, or by arguing for the rightness of a principle in the abstract.

Protection against these “empty ethical calories” can be found in role-playing or writing out a script detailing exactly the words one would use in taking an action (not a description of the action).

3.6 Work with the Issue

It is not necessary to accept moral challenges as they first appear or as others define them. Taking a position on auxiliaries that extend the dentists' practice reach is worth reflecting on deeply enough so that all facets come into view. So is office policy on insurance, staff relations, and procedure and material offered to patients. It is often the case that a good answer pops into mind once the question is asked the right way.

Some of the most useful aids to moral decision making are asking colleagues and experts (probably in that order) and gathering information about the facts of the matter. Knowing what to do about posterior composites has a lot to do with understanding the science about the properties of materials. Applicable law and customs of the community are important contexts for framing decisions about waiving copayments and hostile work environments. Frequently, the most help in clarifying moral decisions comes from conversations with those people who are affected

by the decision. That would certainly be the case with regard to a claimed hostile workplace environment.

Here are some useful questions:

- Do I really know all the consequences that will follow from my choice?
- Is there any other way of looking at this issue—how would the patient describe it, or my colleagues, or a good friend?
- How have others, especially those I admire, addressed this sort of problem?
- (To those involved) How will this affect you, what do you need?

There is a very simple stopping rule for working the issue. Keep adjusting until it is unlikely that any further adjustments will change the decision you intend to make. That is different from the academic rule of stopping analysis when a principle is connected with an action one favors.

3.7 BEST, NOT PERFECT

The big difference between theoretical ethical issues and practical moral choice is that the first project is never finished and the latter always is. It is possible to read a book about philosophy or participate in a discussion of dilemmas without reaching agreement in principle or committing to a course of action. As enjoyable as this is for some, it is perpetual frustration for anyone who needs to react to daily moral challenges. Morality has sometimes gotten a bad name because it was incorrectly assumed that the goal is reaching consensus on what is right or good.

By contrast, once a choice has been recognized, some action must follow and there is always a best alternative. The patient whose radiograph hints at recurrent caries has a choice: do nothing, composite, amalgam, or possibly even a crown or an implant. Only one of these options is possible at the moment and it is unavoidable that one will be selected. It is hoped that the best option is chosen, even if it is not possible to say in some objective sense what the “right” choice should be. If the six heuristics mentioned above are followed, there is a very strong possibility that the best moral choice will emerge, even when the action truncates the inquiry and continues as before (do nothing).

In 1972 Kenneth Arrow received the Nobel Prize in economics. The award was made for proving that it is never possible to guarantee a solution to problems such as finding complete agreement on ethical principles. Twenty-two years later, in 1994, John Nash received the Nobel Prize in economics. He proved that it is always possible to find a best solution to moral choice problems when framed in practical terms.

3.8 AUGMENT THE DECISION

Moral regret is the term used to describe the bad feelings we have when making a choice that cannot be known to be perfect. Composites look better than amalgams, but they do not last as long. Some patients will be attracted to a dentist who honors contracts, others will seek those who are more expedient. Every commitment of resources under conditions of uncertainty has opportunity costs equal to the value of the best alternative that was foregone. Regret can be minimized by choosing the best course of action, but it cannot be eliminated that way.

Augmentation refers to action taken after the choice has been made

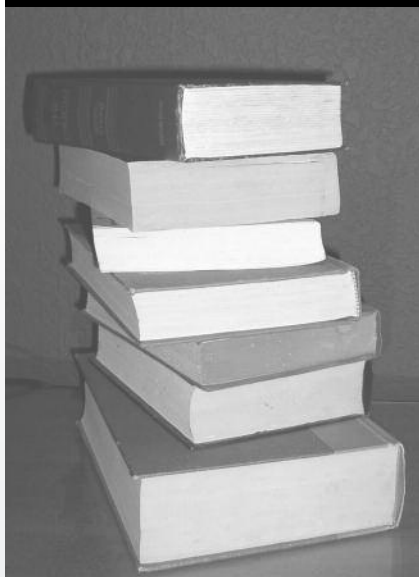
to improve the favorability of outcomes. We often take an unnecessarily narrow view of morality by assuming that it is a one-shot activity. Much can be done to make the choice right after the decision is taken. For example, a good explanation—one that lays out the reasoning behind the best alternatives and demonstrates awareness of and sensitivity to others’ concerns—can enhance the moral choice. There is abundant evidence in psychological research that the very nature of decisions is likely to change following a commitment. New information should continue to be sought. Sometimes patients or others will reveal new information after they know where the dentist stands. Sometimes supplemental safety precautions can be added. In the example of claimed hostile workplace environment, dentists, regardless of what is done about the charge, might want to call a general office staff meeting.

4 THE MORAL LIFE

We choose the life we want to live, almost never as a single theoretical analysis, always as the accumulation of a succession of moral choices. We become the consequences of the decisions we make, including deciding how we want to respond to the range of circumstances life throws at us.

In this sense, it is misleading to talk about moral choice as though it only happened on rare occasions or in special contexts such as classrooms or as a consequence of abstract reflection. It is more accurate to speak in terms of the pattern of moral choice making. For this reason alone it is worthwhile to acquire and refine the habits of moral choice presented above.

RECOMMENDED READING



The selections below have in common that they focus on living the moral life rather than talking about it. Each reference marked with an asterisk is about five pages long and uses extensive quotations to convey the tone and content of the original source. 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 moral choice; a donation of \$50 will bring you summaries for all the 2011 leadership topics.

Robert Audi (2004)

The Good in the Right: A Theory of Intuition and Intrinsic Value
Princeton, NJ: Princeton University Press

An example of a contemporary philosopher who argues for the primacy of intuitions of the good and the right as against a theoretical approach where normative action is read from principles by a process of theoretical analysis.

Jürgen Habermas (1990)
Moral Consciousness and Communicative Action*

(C. Lenhardt & S. W. Nicholsen, trans).
Cambridge, MA: MIT Press. ISBN 0-262-58118-3; 225 pages; about \$25.

Habermas moves the traditional ethical question of “how should I live” into the community context, specifically modern pluralism with regard to values. Kant’s categorical imperative (which makes the individual the arbiter of what is right) is replaced by the discursive ethic of reasoned agreement among those involved. This position requires mutual perspective taking (empathy). Becoming fully human requires being part of a group. Thus, the discussion of moral issues with a view toward reaching agreement is behavior—communicative action.

Jonathan Haidt (2010)

The Emotional Dog and Its Rational Tail: A Social Intuitionist Approach to Moral Judgment.

Psychological Review, 108 (4), 814-834.

This is a classic paper in the psychology of how people actually made moral decisions (not about how they ought to make them). It is tough reading, but in the end one may be prepared to believe that our common approach is to settle on our values quickly and intuitively and, if necessary, to patch together theories of justification.

David Hume (1738/1888)

A Treatise of Human Nature. Book III: Of Morals*

(L. A. Selby-Bigge, Ed.).
Oxford, UK: Oxford University Press,
1738/1888. No ISBN; cost unknown.

Hume, who died in the year of the American Revolution, was a great Scottish philosophy. He divided the claims one could make into two categories: (a) logically true or false based on the meaning of the words involved (married

men have spouses) and (b) empirically true or false based on observation (married men are happy). Empirical claims can never, Hume argued, be known with absolute certainty, although they can be given high and actionable probability. Ethics (Hume uses the more correct term morality) belongs to neither group. We are motivated to right or wrong behavior based on passions (a better translation today is values) and these cannot be derived from reason or principles. Hume influenced his friend Adam Smith in what is now known as the Scottish school of moral sentiment—we feel toward others; we do not rationalize toward them. This section of the very large *Treatise of Human Nature* contains the famous passage where Hume complains that philosophers make a mistake when they start out talking about what is the case and imperceptibly end up claiming what ought to be the case. There is also the famous example of two men working together in rowing a boat because human nature is naturally better achieved by common effort, not by planning. Justice is a social convention. In Book II of the *Treatise*, Hume develops his famous idea that “Reason is, and ought only to be the slave of the passions.”

Lai Tzu (attributed)

Tao Te Ching*

(Several editions and translations are combined and a short introduction is provided to set the context)

Opening with the famous challenge, “The way that can be told is not the true way,” the Taoist belief system is laid out in 81 poems. This is a beautiful statement of the difference between talking about the right way to live and living the right way. A brief concordance is provided harmonizing the Tao Te Ching and the Sermon on the Mount.

2011 MANUSCRIPT REVIEW PROCESS

Four unsolicited manuscripts were received for possible publication in the *Journal of the American College of Dentists* during 2011. One manuscript was accepted for publication following extensive modifications suggested by peer review; three were declined. Nineteen reviews were received for these manuscripts, and average of 4.75 per manuscript. Journal reviewers are encouraged to use a sequential set of standards in evaluating manuscripts. The first concern is that the manuscript presents a topic of significant interest to our readers. Those that meet this criterion are evaluated for absence of bias in the presentation. The third standard is clarity of presentation. Consistency of reviews was determined using the phi coefficient, a measure of association between review recommendations and the ultimate publication decision. The phi was .640, where 0.00 represents chance agreement and 1.00 represents perfect agreement. The College feels that authors are entitled to know the consistency of the review process. The Editor also follows the practice of sharing all reviews among the reviewers as a means of improving calibration.

The Editor is aware of three requests to republish articles appearing in the journal and nine requests to copy articles for educational use received and granted during the year. There were no requests for summaries of recommended reading associated with Leadership Essays.

In collaboration with the American Association of Dental Editors, the College sponsors a prize for a publication in any

format presented in an AADE journal that promotes ethics, excellence, professionalism, and leadership in dentistry. Thirteen manuscripts were nominated for consideration. The winner was Eric K. Curtis's "Is General Dentistry Dead? How Mid-level Dental Providers Will Affect the Profession," which appeared in the August 2010 issues of *AGD Impact*. Fourteen judges participated in the review process. Their names are listed among the *Journal* reviewers below. The Cronbach alpha for consistency among the judges was .877.

The College thanks the following professionals for their contributions, sometimes multiple efforts, to the dental literature as reviewers for the *Journal of the American College of Dentists* during 2011.

Evelyn Donate-Bartfield, PhD
Milwaukee, WI

Susan Bishop, DMD, FACD
Peoria, IL

Marcia Boyd, DDS, FACD
Vancouver, BC

Fred Bremner, DMD, FACD
Portland, OR

Alan Budenz, MS, DDS, MBA, FACD
San Francisco, CA

Thomas J. Connolly, DDS, FACD
New York NY

Caswell Evans, DDS, MPH, FACD
Chicago, IL

Marc Giesberger, DDS, MBA, FACD
Greenbrea, CA

Gary R. Goldstein, DDS, FACD
New York, NY

Theresa S. Gonzales, DMD, MS, MSS, FACD
Fort Hood, TX

N. Karl Haden, PhD
Atlanta, GA

William G. Leffler, DDS, JD, FACD
Massillon, OH

William Lundergan, DDS, FACD
San Francisco, CA

Peter Meyerhof, PhD, DDS, FACD
Sonoma, CA

Michael Meru, DDS
Los Angeles, CA

Jerome B. Miller, DDS, FACD
Oklahoma City, OK

Kirk Norbo, DDS, FACD
Purcellville, VA

Daniel L. Orr II, DDS, MS, PhD, MD, JD
Las Vegas, NV

Martha Phillips
Atlanta, GA

Marsha Pyle, DDS, FACD
Kansas City, MO

Steve Ralls, DDS, FACD
Gaithersburg, MD

Barry Schwartz, DDS, MHSc
London, ON

Robert Shekitka, DDS, FACD
Clark, NJ

Philip E. Smith, DMD, FACD
Lexington, SC

James Willey, DDS, FACD
Chicago, IL

Craig Yarborough, DDS, MA, MBA, FACD
San Francisco, CA

2011 Article Index

JOURNAL of THE AMERICAN COLLEGE of DENTISTS, 2011, VOLUME 78

Editorials

- Authority and Responsibility.....Number 3, page 2
David W. Chambers
- Great Readers.....Number 1, page 2
David W. Chambers
- Lessons in Shifting the Burden, #2: Competence to PracticeNumber 4, page 2
David W. Chambers
- The Need for Bigger Bowls.....Number 2, page 2
David W. Chambers

LETTERS TO THE Editor

- Michael P. Rethman.....Number 2, page 4
- Robert Rosen.....Number 3, page 4
- Toni M. Roucka.....Number 3, page 5

College MATTERS

- Dentistry Is at a Tipping Point—We Need Your Hand [President-Elect's Address].....Number 4, page 4
Patricia L. Blanton
- Optimism Is Part of the Cure [Convocation Address].....Number 4, page 8
Nicole Johnson, MA, MPH
- 2011 ACD Awards.....Number 4, page 11
- 2011 Fellowship Class.....Number 4, page 15
- 2011 Manuscript Review Process.....Number 4, page 64

THEME PAPERS

- The Academy of Dentistry International.....Number 1, page 16
Robert L. Ramus
- American College of Dentists: An Overview.....Number 1, page 4
Stephen A. Ralls
- Can We Change?.....Number 4, page 27
Tyler Beinlich
- The Central Florida District Dental Association Collaborates to Serve Dental Professionals.....Number 2, page 13
Jim Antoon
- Combining Practice with Ethics.....Number 3, page 29
Kevin I. Reed

Comprehension and Retention of Orthodontic and Orthognathic Surgery Treatment Information: A Review of Literature	Number 4, page 29
<i>Renie Ikeda</i>	
Dallas County Dental Society	Number 2, page 9
<i>Marissa Gutierrez and Linda C. Niessen</i>	
Dentistry and Ethics by the Road Less Traveled	Number 3, page 11
<i>Chrissy Tiller</i>	
The Dynamism of Professional and Business Identities	Number 3, page 24
Martin R. Gillis	
Ethics and the “Seasons of My Life” as a Dental Educator	Number 3, page 18
<i>David A. Nash</i>	
Ethics Is How You Respond to Life	Number 3, page 14
<i>Joseph Graskemper</i>	
The Ethics of Routine Use of Advanced Diagnostic Technology	Number 4, page 35
<i>Renata Khelemsky</i>	
International College of Dentists—USA Section: A Brief History, 1934-2011	Number 1, page 12
<i>Richard G. Shaffer and Richard J. Galeone</i>	
My Journey in Dental Ethics	Number 3, page 7
<i>Larry J. Cook</i>	
My Life as a Dentist and Ethicist: An Experiment in Creative Nonfiction	Number 3, page 31
<i>K. K. Quick</i>	
New York County Dental Society: Leaders Creating Change through Leadership	Number 2, page 15
<i>Patricia Sukmonowski</i>	
Northwestern District of the Georgia Dental Association	Number 2, page 22
<i>Wilkie Stadeker</i>	
Omicron Kappa Upsilon: A History and Current Perspective	Number 1, page 19
<i>Jon B. Suzuki</i>	
Optimism Is Part of the Cure	Number 4, page 8
<i>Nicole Johnson</i>	
Personal Ethical Dilemma: Is the Patient Competent?	Number 4, page 19
<i>Alice Nunes</i>	
The Pierre Fauchard Academy Celebrates Seventy-five Years of Service to Dentistry	Number 2, page 6
<i>Terry Brewick</i>	
Putting Your Money Where Your Mouth Is: The Influence of American Consumer Culture on Contemporary Dentistry	Number 4, page 22
<i>Annalee Asbury</i>	
The San Antonio District Dental Society: History and Vision	Number 2, page 18
<i>John P. Schmitz and Linda Shafer</i>	

MANUSCRIPTS

- Dental Students Choosing Licensure Path Give More Consideration to
Career Flexibility Rather than Ethical Dilemmas.....Number 1, page 24
Heather J. Conrad and Eric A. Mills
- Retention of Underrepresented Minority Students in Dental School—One Dental School's Story.....Number 4, page 40
*Ernestine S. Lacy, Barbara H. Miller, Sheryl A. Hornback, Ann L. McCann, and
Jayne S. Reuben*

ISSUES IN DENTAL ETHICS

- A Case of Collegial Communication and a Patient Who Does Not PayNumber 1, page 33
Bruce Peltier, Alvin Rosenblum, Muriel J. Bebeau, and Anne Koerber
- The Case of the Pregnant AdolescentNumber 4, page 48
Bruce Peltier, Terry Hoover, Pamela Zarkowski, and Terry Patterson
- The Challenges of Oral-based Diagnostics in Extending the Role of Dentistry as a
Healthcare Profession: Property Rights, Privacy, and Informed Consent.....Number 3, page 33
Anthony Vernillo, Jos V. M. Welie, Sudeshni Naidoo, and Daniel Malamud
- Writing off the CopaymentNumber 2, page 26
Barry Schwartz, Larry E. Jenson, Toni M. Roucka, and Donald E. Patthoff

LEADERSHIP ESSAY

- Decision Making.....Number 1, page 44
David W. Chambers
- Ethics Fundamentals.....Number 3, page 41
David W. Chambers
- How to Make Moral Choices.....Number 4, page 56
David W. Chambers
- Swarm IntelligenceNumber 2, page 34
David W. Chambers



Journal *of the* American College *of* Dentists

2011 STATEMENT OF OWNERSHIP AND CIRCULATION

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

The American College of Dentists is a nonprofit organization with no capital stock and no known bondholders, mortgages, or other security holders. The average number of readers of each issue produced during the past twelve months was 5,152, none sold through dealers or carriers, street venders, or counter sales; 5,246 copies distributed through mail subscriptions; 5,074 total paid circulation; 172 distributed as complimentary copies. Statements filed with the U.S. Postal Service, September 27, 2011.



American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

Periodicals Postage
PAID
at Gaithersburg, MD