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excellence, ethics, professionalism,
and leadership in dentistry

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

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Approach social media
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FROM THE EDITOR

LESSONS IN SHIFTING THE BURDEN: #3. THE CRITICAL MOMENT FOR DENTAL ETHICS

The first few years of practice are the critical moment. Beginners are most heavily influenced by what they see their senior colleagues doing and by how those they look up to define success.

To have maximal effect, ethics instruction should be applied at the right place and time. The accepted, one-shot model is that dental school is the right place because students are impressionable, all in one place, and likely to carry everything they learn in school over into practice. I suggest a two-step alternative: the leaders in the profession should model and enforce ethics among typical practitioners, who will then enculturate the new graduates. The second part of this plan is certainly in place now. It is the first step—leaders developing an ethical climate among their colleagues—that needs the attention.

Many schools have a faculty member with training in ethics presenting a combination of lectures and seminar discussion. Sometimes practitioners participate in these programs; occasionally practitioners present the entire ethics program to students in a one-day session. Typically coverage includes the five bioethics principles on which the ADA code is based and discussion of dilemmas that arise in practice. An example would be the clash between honoring a patient's request for esthetic treatment (respect for autonomy) when underlying conditions point to greater needs for basic restorative and periodontal care

(beneficence). Other cases might be the extent to which child abuse must be reported, up-coding on insurance, overtreatment, and keeping one's hands off patients. Of course the latter are not dilemmas at all; they are just matters of doing the right thing when it may be inconvenient. The question is not what to do, but why it is not being done.

Since 1997, ethics instruction has been an accreditation requirement for all dental schools. That means we have a crop of more than 60,000 young practicing dentists who are (theoretically) more ethically qualified than their seniors were at graduation. Although welcomed universally, the current approach to teaching ethics in dental schools leaves some concerns unaddressed. For students, fee-splitting or justifiable criticism or selling high-end cases are hypothetical matters. It is rare that dental school ethics programs are grounded in the challenges students face, such as cheating on exams, hoarding patients, or studying from "leaked" National Board tests.

When the College met in Philadelphia a number of years ago, one of the LeaderSkills programs was presented by a group from Harvard called the Making Good Project. This organization has worked with businesses, professions, and public organizations to understand the forces that encourage ethical behavior in professional work settings and those that present barriers. They have conducted in-depth investigations of

journalism, theater arts, and genetics research, among others.

Their findings, summarized in the book *Making Good* and on the Web site of the same name, are consistent across professions. The first few years of practice are the critical moment. Beginners are most heavily influenced by what they see their senior colleagues doing and by how those they look up to define success. Dentistry already has a ubiquitous “mentoring” program. The question is what values the “mentors” are passing along and who is minding them.

It turns out the schools have little lasting effect. Students in professional schools are the cream of the crop of those who can give the answer a faculty member wants to hear. They are equally brilliant at copying the behavior of the first colleague they associate with and patterning their habits to those who are held up as models on the CE programs or in trade magazines.

Beginning professionals in the Making Good Project consistently report they are aware of the new ground rules that apply upon entering practice. They are also aware—often painfully so—of the inapplicability of “school ethics” in the real world. Almost always, and with professed reluctance, beginners in professions feel it is necessary to “cheat to establish a practice” but not to maintain one. Here is a direct quote from a young journalist: “Cutting corners and lying... was the price we had to pay in order to advance in our profession and maintain


our personal values. We were willing to pay the price because we aspired toward a long-term goal.” Over and over, too often for comfort, researchers heard participants express their willingness to cross lines. Often this admission was closely followed by an assurance that when they finally achieved prominence, they would behave in a different and morally laudatory manner.

The project also studied established leaders in at least some of the professions to learn why so many of the beginners felt let down by them. The “successful” professionals spoke eloquently of high standards and the honor of their professions. It was easier to do so by “skipping a generation” and telling the students what to do rather than working to ensure that their colleagues were up to standard. The young professionals in the Harvard study were disappointed by the top people, who explained how they practice now but passed over the challenges of early professional life.

What students and young professionals wanted was practical help coping with problems that beginners face. It is no surprise that the recently created Student Professionalism & Ethics Association in Dentistry (SPEA) that is appearing in dental schools across the country is student run and focused on ethical issues of students and young

professionals. Check their Web site at www.speadental.org.

The American College of Dentists has traditionally supported Sections in their programs where Fellows make presentations in schools. More recently, we have begun to focus on the practitioner. Daylong training programs have been offered at annual meetings and have now reached more than 100 Fellows. We provide scholarships for master’s level ethics training for practicing dentists. Our Practice Ethics Assessment and Development program is a 50-hour, online training program in ethics designed for the entire dental office team available at www.dentalethics.org.



SOMEONE GUIDED YOUR PROFESSIONAL GROWTH: DO THE SAME

W. Scott Waugh, DDS

ACD PRESIDENT-ELECT'S ADDRESS

October 17, 2012

San Francisco, California

Good day to each of you. Or better said in my colloquial manner, "How are all you all doin'?" That's how we greet our friends and colleagues from Oklahoma! Yes, I'm from Oklahoma—"the land of waving wheat that sure smells sweet when"—Oscar Hammerstein and I agree—"the wind comes right after the rain!" It is my privilege to welcome you to our 92nd American College Annual Session and Convocation. It is indeed an honor for me to address you today as your incoming president.

Greetings to President Blanton, Officers, Regents, candidates, Fellows of the College, Dr. Ralls, our ACD staff, and our special guests of today.

I want to especially thank my Oklahoma Section and Fellows in Regency V for their support in nominating me for their Regent and for their continued support.

Congratulations are in order for you, our newest incoming candidates, for today is a very special day. You are being recognized for your leadership and commitment to your chosen profession of dentistry. I look forward to getting to know you and welcome you to the College.

In 1989, I was sitting where you are. I was excited, I felt so honored to become a Fellow in the American College of Dentists. But like many of you, I was not fully aware of the significant role the American College plays in the promotion of ethics and professionalism within dentistry. Only three and a half percent of dentists are asked to become Fellows

in the College. This recognition is not for who you knew. It is solely based on your personal achievements. For that you should be proud.

Like many of you, I was very humbled when I received notification of my nomination and when I learned who the two individuals were that nominated me. Dr. Dean Robertson, one of those who nominated me for Fellowship, had written my letter of recommendation while I was applying to dental school at Oklahoma 25 years earlier. And Dr. Dean Johnson, Professor of Removable Prosthodontics at the University of Oklahoma, whom I had worked with on several cases, was the other nominator. They were both pillars in our dental community. In my eyes they were the pinnacle of professionalism and ethics. I shall forever be grateful for their confidence in me. I shall always cherish their mentorship and guidance.

I would like to take a moment now to introduce myself to you by telling you of my personal journey in dentistry. I had a shaky start. I was a senior in college and had applied to dental school. But as you know or may have been told, in 1968 the Vietnam War was at its highest levels of intensity. I received my draft notice 32 days prior to receiving my acceptance letter to Baylor College of Dentistry. After making a frantic plea,



Dr. Waugh is in private practice in Edmonds, Oklahoma.

it became clear that there would be no changing Uncle Sam's mind. I spent the next 20 months in the U.S. Army, 16 of them in Vietnam. I was not sure my dream of dental school would ever come true. I served as infantry point man. Then, through a series of circumstances, I became a medic. I completed my tour as a door gunner/medic. But God was with me and I returned home uninjured. That was the spring of 1970, and I entered Baylor Dental School in the fall of 1970.

Shortly after my return I was introduced to a beautiful blonde on a blind date. I'm so fortunate to say that after 42 years, Sheri is still my best friend, the wind beneath my wings, and best of all, mother to our three children. She has stood beside me throughout my dental career and leadership opportunities. I am forever grateful for a lifetime of devotion and support.

I have practiced in a general dental setting for 38 years in Edmond, Oklahoma. I have a wonderful staff that understands what is required to conduct a patient-centered practice, and I practice with two dedicated colleagues, who I'm proud to say, were inducted into the College last year.

My foundation came from two loving parents, Woody and Pal Waugh, who taught me that with hard work, a strong unwavering value based life, and a strong faith-centered foundation, anything could be accomplished. There are many, many others that have had a positive influence on me, and to all I say thank you.

Ninety-two years ago dentistry was in a difficult position. There were no

standards in dental education, commercialism was rampant, and professional journals were little more than a collection of articles by uncredentialed authors that made many unsubstantiated claims. We were mostly, in the public's eyes, nothing more than a trade. Sadly, our recognized trademark was the red-white-and-blue barber pole. Dentistry faced many serious challenges. There was an increasing threat from proprietary dental schools and deceptive advertising. Perhaps this sounds all too familiar today, doesn't it?

The American College was founded by a group of dental leaders from the American Dental Association and dental educators. Their vision was to "cultivate and encourage the development of a higher type of professional spirit and a keener sense of social responsibility throughout the profession." That vision and goal continues today, and it remains strong.

The mission statement of the College is to promote excellence, ethics, professionalism, and leadership. The American College of Dentistry has been a beacon and guiding force in helping to establish these standards through the years.

Recently through the leadership and guidance of Dr. Steve Ralls, our Executive Director, the College has developed a series of online courses in dental ethics and dental leadership. Many dental schools use these courses in their ethics classes. I will also tell you that many state boards require ethics as a continuing education requirement and rely on

Ninety-two years ago dentistry was in a difficult position. We were mostly, in the public's eyes, nothing more than a trade.

these courses as a resource. The College has become a clearinghouse for ethics resources and ethics-related materials, including a collection of ethical dilemmas written by Dr. Tom Hasegawa and originally published in the *Texas Dental Journal*. All of these courses can be easily accessed by going to our Web site. We are presently working with Creighton University by offering scholarships to practicing dentists who wish to study dental ethics.

In addition, the College has published *The Ethics Handbook for Dentists* and ethics wallet cards. These are distributed to all first-year dental students. I would also like to point out that the College has sponsored several ethics summits. Most recently, the College, through a collaborative effort with the ADA, was heavily influential with the Joint Subcommittee that addressed integrity issues in dental education. Other summits that the College has sponsored focused on commercialism and truth claims in dentistry. At this very meeting, the Executive Director and Officers met with the Corporate Dental Practice Governing Body to explore the possibility of convening a summit in the near future.

As you can see, the College has many ongoing activities. It has been referred to as the “conscience of dentistry,” and as such we have an obligation to continue to hold up ethics as a cornerstone of our profession.

I am an eternal optimist and I believe our profession will endure the external influences that challenge our core values. We have only to look in the Yellow Pages filled with promises, false or misleading credentials behind a name, and cheating scandals in our dental schools. Dentists refer to other dentists as competitors, not colleagues. Excessive overtreatment is creeping in—all for greed. This tarnishes our image.

We cannot rely on the College to stand up against lack of professionalism entirely on its own. But you can count on our being in the front line. I really believe that our efforts to stem the tide must come from the grassroots activities of our Sections. That is where the rubber meets the road. The College can have a direct influence through the membership and Section activities. Each Section is encouraged to be involved in one or more activities. We are not a “gold watch” organization. It is our responsibility to help our colleagues understand that dentistry is a calling, not just another job, and that patients are not a commodity to be coaxed into treatment but to be treated in a fair, respectful manner.

Many of our Sections sponsor White Coat ceremonies. What a tremendous time it is to have a positive influence on our very newest colleagues. Other Sections provide one-on-one guidance through ethical dilemma programs at dental schools. Students enjoy the opportunity to have an open dialog with practicing dentists, hearing their perspective on various dilemmas that challenge our ethics. Other Sections support dental students by granting

scholarships and some are involved with mentoring. Not only do they mentor dental students, but they also coach new colleagues who locate their practice in the same community.

One of the newest opportunities for Sections is to become involved with a SPEA chapter. SPEA stands for Student Professionalism & Ethics Association in Dentistry. This movement was started at the University of Southern California by students who recognized an opportunity for students to improve the ethical climate in schools. Although only in its infancy, many chapters have been started. In Oklahoma, our SPEA chapter had its first meeting in September. To show you how important this is to students, there were over 80 students present at the inaugural meeting. This is student organized and student driven. The Oklahoma Section of the American College of Dentists voted to support this club by providing financial aid for their meetings. (As a side note, we had a member at our meeting who immediately stepped up and made a pledge of matching funds.)

The College has endorsed this new organization and helps by sponsoring space and providing speakers for their national meeting which is held in conjunction with our own meeting. The members of the Oklahoma Section will only be used as resource advisors.

Let me touch on a subject that is near and dear to me: that is mentoring. There is no greater way to have direct influence on a desired outcome than

mentoring. Even Socrates pondered the question: Can ethics be taught? His conclusion was that the greatest influence is that which is shown by example. I know that each one of you, as you listen to me, is thinking of an individual or several individuals that have had a direct influence on you, your chosen profession, or your chosen lifestyle. Is it your parents, a pastor, a teacher, a professor, or colleague that helped you formulate the values that guide you today?

I strongly urge you to get involved, ask young practitioners to lunch, offer to help them diagnose and sequence a case, invite them to a study club, or invite them to your local dental society meeting. Taking the first step and opening the door may be all it takes to establish a meaningful friendship. Your influence may be all that is required to help steer a struggling colleague in the right direction.

A couple of years ago, I received a letter from a new graduate. He started his letter like this:

“I’m writing you this letter because I’m really troubled by stories some of my classmates have told me about the dentistry they have encountered since graduating. I know you sit on the ADA ethics board, and I thought I would let you know about this information and ask what if anything I can do to correct this situation that jeopardizes the integrity of our profession.”

WOW! That is a plea from one of our young colleagues who is worried about the future of his new profession. He related stories of Medicaid fraud, over-

treatment, fraudulent up-coding of insurance claims, and unnecessary procedures being done—all in the name of greed.

He went on to say, “I think these things need to be talked about in dental school and call them what they are: fraud. I remembered that you and some of your ACD colleagues came to our school and talked to us about ethics. More of those talks need to take place.”

You see, you never know how valuable your time can be when mentoring a young, bright star in our profession.

I’m proud to say the apple does not fall far from the tree; this young man’s father is being inducted into Fellowship this year. I am sure it will not be long and his son too will be inducted.

In conclusion, I again want to congratulate you, our newest inductees. But as you can tell from my remarks, much will be expected from you. This indeed is a critical time for our profession, and your influence is needed more than ever. And to you, our more mature, seasoned Fellows, thank you for taking time to nominate deserving candidates and thank you for your involvement in ACD activities.

I am grateful for this opportunity to serve as your President. I promise to do my best. I can assure you that your Board of Regents and our ACD staff are here to assist, encourage, and motivate. Thank you and enjoy this wonderful day!



I know that each one of you, as you listen to me, is thinking of an individual or several individuals that have had a direct influence on you, your chosen profession, or your chosen lifestyle.

You Will Look Good TREATING OTHERS WITH RESPECT — I GUARANTEE IT

George Zimmer, A B

CONVOCATION ADDRESS

October 17, 2012
San Francisco, California

George Zimmer opened the first Men's Wearhouse clothing store in 1973 in Houston, Texas. Since then Mr. Zimmer has led the company through every phase of its growth. He attributes much of the company's success to integrating his servant leadership values in the corporate culture. These core corporate values of collective trust, honesty, respect, integrity, authenticity, celebration, good will, and caring for each other stand side by side with other essential principles like hard work, accountability, loyalty, and commitment to customer service. His humanity developed simultaneously with the growth of his business acumen which, together, created a Fortune 1000 company with a corporate culture that has been recognized, with eleven appearances, in *Fortune's 100 Best companies to Work For*.

I appreciate the opportunity to speak to a group of dentists without lying down. Today I want to share some of my thoughts about the key to organizational success—specifically Men's Wearhouse—and close with some general comments about business ethics.

We started Men's Wearhouse in 1973 and had the usual start-up challenges during our first years. But we learned quickly and refined our business practices over the first decade as we grew to 20 stores located in Texas and the Bay Area. In the early 1980s—during the Texas-centered oil crisis—our bank loan was called, and even though we had been profitable for ten years, we had to scramble to save our business.

And we would not have been able to do that if employee morale and confidence had not remained strong. But we trusted each other and that trust continues to be the key ingredient to our success today. When employees trust the company, they naturally choose to work toward company goals.

And here is how to make that happen. Trust is, of course, built over time. We strive to be authentic and transparent when communicating to employees. To be trusted, it requires that you display both competence and character. Our management training program emphasizes developing both these traits. We train our managers to strive to become “servant leaders” who focus on helping their team reach their goals and treat them with respect, fairness, and compassion. We do not tolerate selfish managers

who push their teammates to make themselves look good. Servant managers are trusted.

We start building trust with our employees by trusting employees from the moment we hire them. And they appreciate that we do not believe in polygraphs, drug tests, or secret shoppers. If you do not demonstrate trust with your employees, how can you expect them to trust you?

We invest an unusually large amount in training our employees. We fly all our 3,000-plus store managers to California for annual training meetings, and non-management employees are trained in our stores throughout the year. Our employees recognize that we believe in them and trust them enough to make that investment.

Also, we promote from within whenever we can, instead of looking outside the company when opportunities arise. Employees appreciate that their growth does not go unnoticed and that the company is loyal to them.

There are tangible results from trust within our organization. This includes lower turnover, fewer lawsuits and Workers' Compensation claims than normal, and our shrinkage is only about 10%. [Editor's note: Shrinkage is undesired reduction in inventory caused by theft, spoilage, loss, and mishandling, all of which must of course be passed on to



George Zimmer is founder and CEO of Men's Wearhouse.

customers in higher prices. Recent data from the state of California place average shrinkage at 30%.]

It is also important that our customers trust the company. We train our store managers to act as though the customer is always right—even when they are wrong. And our return policy—which is printed on our receipts and very well known—really is: “I guarantee it.”

Because we trust our employees, it creates a trust feedback loop where our employees go the extra mile for their customers. Here is an example. We supply the tuxedos for one-quarter million weddings and twice that number of proms each year. These are special events in people’s lives. When a tux rental mistake is made, our employees extend themselves to correct it. We have had employees personally deliver a tux to the groom so close to the ceremony that they made the wedding pictures and stayed for the wedding itself.

And our shareholders trust us because we focus on long-term profits. We do not chase short-term results.

Our vendors trust us because we strive to build loyal, long-lasting relationships with them. We do not squeeze them for the last nickel in negotiations, despite our leverage in the industry.

I am often asked what I think about business ethics. In business, doing the right thing, the ethical thing, is not free, but it is not that expensive either. In fact, in the long run it is less costly than surrendering to illusive little tricks.

Our ethics start with how we treat our employees. It is not a cost, it is an

investment, and one that can pay huge dividends. From the bottom-line perspective, the positive human energy and collaboration that is created at Men’s Wearhouse offsets the possible lost profit opportunity from being too harsh, too tough, or too focused on maximizing profits down to the last dollar.

In today’s world, businesses must be defined and evaluated by more than just maximizing shareholder value. And CEOs will not do it by themselves. It is also up to shareholders and board of directors to make this happen. And for me, dealing with tough decisions is compounded by my being the spokesperson for our company.

Business today is frequently attacked about its lack of ethical business practices. There are many buzzwords used nowadays when people talk about doing business the right way. For example, you hear terms like: “socially responsible business,” my favorite “conscious capitalism,” and “the triple bottom line,” which includes business impact on the environment as well as profit-and-loss statements and balance sheets.

These are all great, but let’s not forget a simple rule that has guided human relations for thousands of years: “Do unto others as you would have others do unto you.”

In my business journey, as well as my life, following the Golden Rule has served me well. Try it. You’re going to like the way you feel. I guarantee it!



In business, doing the right thing, the ethical thing, is not free, but it is not that expensive either. In fact, in the long run it is less costly than surrendering to illusive little tricks.

2012 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 **Student Professionalism & Ethics Association** as the recipient of the 2012 Ethics and Professionalism Award.

In March 2007, a group of students at the Herman Ostrow School of Dentistry of the University of Southern California met with Dr. Alvin Rosenblum, Professor of Dental Ethics, to discuss how they could become more proactive in promoting ethics at their school. What ensued was the first of several brainstorming sessions that led eventually to the creation of the Student Professionalism and Ethics Club (SPEC). The first SPEC event open to students, faculty, and staff was held in October of 2007, with an attendance of over 100.

Shortly thereafter, SPEC began work on a start-up kit, with the goal of aiding

other schools in establishing local SPEC chapters. The group was recognized nationally and has received support from the American Student Dental Association (ASDA), the American College of Dentists, and the American Society for Dental Ethics. ASDA passed a resolution encouraging the establishment of organizations like SPEC at every dental school.

A steering committee of ten dental students from across the country—with the guidance of faculty—met in May 2010 at the Herman Ostrow School of Dentistry to lay out the strategic plan for forming a new national organization. SPEC was renamed the Student Professionalism & Ethics Association in Dentistry (SPEA).

With the support of the American College of Dentists, SPEA embarked on expanding its reach and invited student representatives from dental schools across the nation to meet at the ACD Annual Meeting. In October 2011, representatives from various dental schools collaborated and discussed the future path of the organization. The bylaws were ratified and SPEA became a new national organization. Steps have been taken to codify this new status. A second national meeting will occur October 18-19, 2012 in San Francisco.

Currently, more than half of U.S. dental schools have SPEA chapters. Many ACD Sections are helping these fledgling chapters with financial and personnel support. SPEA is a national, student driven association that was established to promote and support

students' lifelong commitment to ethical behavior in order to benefit the patients they serve and to further the dental profession. The objectives of the association are: "Act as a support system for students in strengthening their personal and professional ethics values by providing a resource for ethics education and development, fostering a nonpunitive, open-forum environment for ethics communication, and promoting awareness of ethics standards and related issues within dentistry and collaborating with leadership of the dental profession to effectively advocate for our members."

Accepting the award is Mr. Sean D. Gardner, Executive Chair of the Student Professionalism & Ethics Association.

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

WILLIAM JOHN GIES AWARD

The highest honor the College can bestow upon a Fellow is the William John Gies Award. This award recognizes Fellows who have made broad, exceptional, and distinguished contributions to the profession and society while upholding a level of leadership and professionalism that exemplifies Fellowship. The impact and magnitude of such contributions must be extraordinary.



The recipient of the 2012 William John Gies Award is **Dr. Marcia A. Boyd**. Dr. Boyd is widely recognized for her highly significant

contributions to organized dentistry, dental education, oral health care, and her community. Her record is replete with a variety of outstanding accomplishments in a multitude of venues. Dr. Boyd is held in the very highest regard by her peers. Her achievements and contributions include:

- Recipient of four honorary degrees, LHD, University of Detroit Mercy; DSc, McGill University; DSc, University of Montreal; and DSc, Dalhousie University
- Honorary Member, Canadian Dental Association (first woman)
- Honorary Member, American Dental Association (first Canadian woman)
- Distinguished Service Award, Canadian Dental Association (highest honor)
- Distinguished Service Award, College of Dental Surgeons of British Columbia (first woman, highest honor)
- Distinguished Service Award, American Dental Education Association (first woman, highest honor)
- First Canadian Regent, American College of Dentists
- First woman Canadian President, American College of Dentists Foundation
- Dean, Faculty of Dentistry, University of British Columbia
- First woman President, Association of Canadian Faculties of Dentistry
- Founding President, IADR/AADR Educational Research Group
- Inaugural Award for Lifetime Achievement in Dental Education, ADEA Gies Foundation
- Founding Board Member, Pacific Oral Health Society (nonprofit dental clinic for the disadvantaged)
- Co-chair, Best Ethical Practices Task Force, British Columbia Task Force
- First Award for Teaching Excellence, University of British Columbia (dentistry)
- First woman Dental Board Member, National Institute of Nutrition, Canada
- First woman Assistant Dean, Associate Dean, Dean Pro Tem in Canada
- First woman to chair a site visit, chair an Undergraduate Review Committee, and chair the Documentation Committee, Canadian Dental Accreditation Commission
- First woman Clinical Examiner and Chief Written Examiner, National Dental Examining Board of Canada
- First woman recipient of the Gies Award, International Federation of Dental Education Associations

From Dr. Boyd's acceptance remarks: President Blanton is a colleague whom I admire greatly for her many talents and her leadership skill. In addition, she is a lady that I am proud to call my friend.

First let me congratulate the new Fellows and welcome you to the American College of Dentists. Well deserved! But let me also congratulate the "old" Fellows, as we all recall how very special this convention day is and was for each of us, and how we continue to live up to the expectations of our nominators and the Mission of the College. Well done everyone!

My thanks to everyone: To the nominators and supporters; the College Awards Committee; my marvelously amazing, hard-working, and always supportive friend in the BC Section; indeed all Fellows of the college that I have had the pleasure to meet and get to know over the years, and of course my family.

I am truly grateful for your trust and the opportunities I have been given. So in truth, I really share this honor with each of you.

In closing, let me add that being the first woman to receive the William J. Gies Award is particularly special and I am so very humbled, honored, and proud to be able to say that I am now—after all these year—truly “one of the Gies!”

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 two recipients of Honorary Fellowship.



Ms. Valerie J. Fridley is the Executive Director of the Southern Maryland Dental Society and in this capacity has directed its

day-to-day operations for nearly 30 years. In that time she has become widely recognized for her leadership and accomplishments for the society and for her community. Ms. Fridley has been invaluable in the furtherance of dentistry in Maryland. Highlights of her accomplishments and credentials include:

- Registered Medical Radiological Technologist, Paul Himmelfarb School of Radiologic Technology, Cafritz Memorial Hospital
- Executive Director, Southern Maryland Dental Society (almost 30 years)
- Established the first component-based dental assisting school in the state of Maryland; this program

served as the benchmark for all other components and the Maryland State Dental Association in developing their dental assisting schools

- Helped to design and was instrumental in setting the guidelines and policies for ethics hearing and peer review within the Southern Maryland Dental Society
- President, Association of Component Society of Executives of the American Dental Association
- Member, Executive Directors Advisory Council of the American Dental Association (EDAC)
- Started the first Maryland component-based training program for the dental assistants with on-site facility in 1990; the SMDS Educational Facility has trained over 7,500 dental assistants in radiology expanded functions, general and orthodontics, infection control, basic dental chairside assisting, dental assisting (front desk), and understanding dental insurance and coding for the assistant
- Oversees the operations of the largest component of the Maryland State Dental Association
- Treasurer and Vice President, Auxiliary of the Knights of Columbus
- Charitable interest work, Our Lady of Sorrows Catholic Church
- Concessions Stand Manager, Women's Athletics, Elizabeth Seton High School
- Event Planner, Women's Basketball Boosters, University of Maryland Women's Basketball Team
- Event Planner, Women's Lacrosse Boosters, Virginia Polytechnic Institute and State University



Ms. Beth Truett has served as the Executive Director of Oral Health America since 2008. In this capacity she has

implemented numerous important changes that positively impact dentistry and oral health care. Ms. Truett has served in numerous high-level leadership positions and brings a wide range of experience to Oral Health America. Ms. Truett's record of accomplishments is summarized below:

- BS, Food and nutrition, Valparaiso University
- Master's degree, divinity, McCormick Seminary, Chicago
- Master's course work, Hospitality management, Florida International University
- Certificate, Nonprofit management, Indiana University School of Philanthropy
- Executive Director, Oral Health America; developed strategic plans, in concert with the board, to re-envision and re-energize a 55-year-old organization; renewed and strengthened relationships with dental organizations and corporations, establishing OHA as a preferred collaborative partner; envisioned a five-point strategy for improving access—to education and care—for older adults, through creation of the Wisdom Tooth Project; established the "Fall for Smiles" campaign, with cooperation from associations, government agencies, corporations and like-minded nonprofits, to emphasize the importance of professional and personal dental care, coupled with healthy foods and tobacco avoidance
- Executive Director, Chicago Lights (a nonprofit organization serving the needs of 7,000 Chicagoans living in poverty; established a new nonprofit organization from a group of existing

programs and doubled the organization's revenue in five years; established a program for teens, giving them training in seeking and keeping a job, with opportunities for four years of summer internships to provide a head start in going to college or obtaining employment

- Senior Vice President, McGettigan Partners (a \$35 million marketing services company serving the pharmaceutical, financial, and technology sectors); re-branded company and helped establish a Global Business Solutions unit, assisting pharmaceutical companies to consolidate meeting and marketing expenses in the United States and Western Europe
- Senior Vice President, IVI (a \$900 million for-profit serving the travel and meeting needs of Fortune 500 companies; purchased by World Travel Partners in 1993)
- Worked on team at Kraft Foods that created and implemented the company's first multicultural advertising and PR campaign
- Inducted into Leadership America, an international organization recognizing women for career and volunteer leadership
- Established a youth tennis program that grew from serving nine to one hundred low-income Chicago children
- Mentors young women through the Association of Fundraising Professionals
- Created a national tour program for the Frank Lloyd Wright Preservation Trust to educate people about the work of America's most famous architect
- Member, Board of Directors for Voices for Illinois Children
- Member, ADA's Give Kids a Smile National Advisory Council
- Trustee, Fourth Presbyterian Church of Chicago

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. Allan J. Formicola**. Dr. Formicola has served dentistry in

numerous high-level capacities for many years. He served for many years as the dean, College of Dental Medicine, Columbia University. His impact on dentistry, his community, and mankind are noteworthy. Dr. Formicola has epitomized service through numerous meaningful activities and programs, local, national, and international. His record of accomplishments and service is summarized as follows:

- BS, Zoology, Michigan State University
- DDS and MS in Periodontics, Georgetown University, School of Dentistry
- Lieutenant, Dental Corps, U.S. Naval Reserve
- Assistant Professor, Georgetown University, School of Dentistry
- Private practice, Silver Spring, Maryland
- Assistant Professor, University of Alabama, School of Dentistry and Dental Research Institute
- Chair, Department of Periodontics, University of Medicine and Dentistry of New Jersey
- Associate Dean for Academic Affairs, University of Medicine and Dentistry of New Jersey

- Acting Dean, University of Medicine and Dentistry of New Jersey
- Dean (23 years), College of Dental Medicine, Columbia University; established the Center for Community Health Partnerships, the latter merging with the Center for Family Medicine; now Dean Emeritus and Professor Emeritus
- Established the Community DentCare Network in Northern Manhattan; provides oral health care to low-income residents of Harlem and Washington Heights; care is provided in eight public schools, a mobile van and in neighborhood clinics; developed the Thelma Adair Medical and Dental Center in central Harlem
- Established the Northern Manhattan Community Voices Collaborative: A collaboration of the dental, medical and public health schools; educated 1,000 community health workers
- Co-directed the Pipeline, Profession & Practice: Community-Based Dental Education Program, the largest foundation demonstration grant ever provided to dentistry, which funded 23 dental schools to add cultural competence training and service learning in community based sites; also funded dental schools to improve recruitment and enrollment of underrepresented minority students
- Co-directed the Macy Study: New Models of Dental Education, which made recommendations on financing of dental education and the manner in which school dental clinics are operated
- Vice Chair, Commission on Dental Education

Congratulations to
all 2012 ACD Award
winners!

- Member, Joint Commission on National Dental Examinations
- Chair, Publication Review Committee, American Academy of Periodontics
- President, William Gies Foundation for the Advancement of Dentistry
- President, American Association of Dental Schools (now ADEA)
- Published 75 journal articles, two books, and several chapters and special reports
- Doctor of Humane Letters, Honoris Causa, University of Detroit Mercy
- Distinguished Alumni Award, Georgetown University
- Harlem Hospital Second Century Award
- Distinguished Service Award, American Dental Education Association
- Presidential Citation, American Dental Association

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 2012 recipient of the Section Achievement Award is the **Northern California Section**. The Northern California Section is recognized for developing and implementing its program entitled, "Professionalism—Your Responsibility to Your Patients, Your Community, and Your Profession." The program introduced the concept of professionalism to senior dental students at the six California dental schools.

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 **Mississippi Section** is the winner of the Section Newsletter Award for 2012.

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 the **Mississippi Section, New York Section, Northern California Section, Quebec Section, and Tennessee Section** earned the Model Section designation.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to Fellows who have 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 recipient's are:

Hector Bethart
Paul W. Evans
William L. Glenn, Jr.
Jess Hayden, Jr.
Walter N. Johnson
Charles A. McCallum
Frederick Pflughoeft
Edwin W. Roberts
Daniel J. Rossi
William E. Schiefer
John P. Scullin
James H. Sherard, Jr.
Charles G. Sleichter
James H. Sommers
Ray E. Stevens, Jr.
Lawrence A. Weinberg

2012 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 2012 Class of Fellows.

Stephen H. Abrams
Scarborough, ON

Syed Tamijul Ahsan Ratan
Dhaka, Bangladesh

Charles E. Albee
Suncook, NH

Jacqueline S. Allen
Phoenix, AZ

Jorge A. Alvarez
Van Nuys, CA

Arthur N. Anderson III
Nashville, TN

K. David Anderson
Tuscaloosa, AL

Sebastiano Andreana
Buffalo, NY

Lisa R. Antonoff
New York, NY

Kolman P. Apt
Herndon, VA

Patricia E. Arola
Washington, DC

Yakir A. Arteaga
New York, NY

Michael G. Arvystas
New York, NY

David C. Ash
Canton, OH

Michelle B. Asselin
Fresno, CA

George H. Bailey
Dixon, MO

Terry L. Barnfield
Salem, IL

Ingrid V. Beard-Howell
APO, AE

William D. Beck
Flint, MI

Avram S. Berger
Torrington, CT

Daniel C. Berman
Chicago, IL

Morris E. Bernstein
Eads, TN

Marc J. Beshar
New York, NY

Janine J. Bethea
Marietta, GA

John L. Blake
Long Beach, CA

John E. Boland
Corte Madera, CA

Scotty L. Bolding
Springdale, AR

James S. Bone
Kerrville, TX

Jennifer J. Bone
Kerrville, TX

Nicholas J. Bournias
Grosse Point Shores, MI

Grace Bradley
Toronto, ON

Daniel M. Briskie
Grand Blanc, MI

Joel F. Brodsky
Lakewood, CA

Mark J. Bronsky
New York, NY

Andrew B. Brown
Orange Park, FL

Carolyn W. Brown
Columbia, SC

Kevin P. Bryant
Chattanooga, TN

William D. Brymer
Vancouver, BC

Fred L. Bunch
Stockton, CA

Jay A. Burleson
Jonesborough, TN

Mark A. Byron
Parkersburg, WV

Eduardo Calderon
Santiago, Chile

Richard S. Callan
Evans, GA

Jean J. Carlson
Cambridge, MD

William B. Carroll
Draper, UT

Rupali Chadha
New Delhi, India

Bonnie Chandler
Toronto, ON

Eros S. Chaves
Morgantown, WV

Chris Chondrogiannis
New York, NY

James L. Chrisman <i>Tupelo, MS</i>	Eric L. Dellinger <i>Fort Wayne, IN</i>	Isabel Garcia <i>Bethesda, MD</i>	Gary M. Heir <i>Bayonne, NJ</i>
Alma J. Clark <i>Martinez, CA</i>	Neal A. Demby <i>Brooklyn, NY</i>	Raul I. Garcia <i>Wellesley Hills, MA</i>	Donna Hellwinkel <i>Reno, NV</i>
George H. Clayton <i>Brentwood, TN</i>	Mark S. Denny <i>Richardson, TX</i>	Jerome M. Gibson <i>San Antonio, TX</i>	Kathryn G. Henry <i>Tulsa, OK</i>
David L. Clemens <i>Wisconsin Dells, WI</i>	Harinder Dhanju <i>Surrey, BC</i>	Martin R. Gillis <i>Liverpool, NS</i>	Robert J. Herman <i>Tulsa, OK</i>
Michael Cohen <i>Medina, WA</i>	Michael A. Dill <i>Scotch Plains, NJ</i>	James D. Gossett <i>New Braunfels, TX</i>	Craig W. Herre <i>Leawood, KS</i>
Robert D. Coles <i>Surrey, BC</i>	Michael Diorio <i>Denver, CO</i>	Edward T. Graham <i>Stockton, CA</i>	Kenneth C. Ho <i>La Canada, CA</i>
Gregory J. Conte <i>San Francisco, CA</i>	Michael E. Dix <i>Overland Park, KS</i>	Peter M. Greco <i>Bryn Mawr, PA</i>	Annie C. Hornett <i>St. Anthony, NF</i>
Noble P. Cooper, Jr. <i>Columbia, SC</i>	John C. Dixon <i>Charleston, WV</i>	John L. Greenwood <i>Fremont, CA</i>	Peter J. Hornett <i>St. Anthony, NF</i>
David S. Cornell <i>Mississauga, ON</i>	Louis Drouin <i>Pointe-Claire, QC</i>	Scott I. Gritz <i>North Potomac, MD</i>	Lee A. Hovious <i>Knoxville, TN</i>
Jennifer J. Cornell <i>Clarksville, TN</i>	Walter R. Easter <i>Pleasanton, CA</i>	Thomas A. Gromling <i>Stephens City, VA</i>	Philip M. Howard <i>Hamilton, OH</i>
Gary L. Crawford <i>Provo, UT</i>	Greggory N. Elefterin <i>Canton, OH</i>	Jane Grover <i>Jackson, MI</i>	George J. Hucal <i>Springfield, VA</i>
Jean L. Creasey <i>Nevada City, CA</i>	Andrea P.Z. Esteves <i>Vancouver, BC</i>	Steven P. Hackmyer <i>San Antonio, TX</i>	Robert T. Huff <i>Calgary, AB</i>
William G. Crews <i>Huntington, WV</i>	Glen J. Fallo <i>APO, AE</i>	Hal E. Hale <i>Wichita, KS</i>	Ryan J. Hughes <i>Lake Oswego, OR</i>
Theodore P. Croll <i>Doylestown, PA</i>	Nava Fathi <i>Gilroy, CA</i>	Kevin J. Hale <i>Grand Blanc, MI</i>	Jeffrey P. Huston <i>Lodi, CA</i>
Kenneth O. Crosby <i>Fresno, CA</i>	David A. Felton <i>Morgantown, WV</i>	Pamela R. Hanson <i>Waukesha, WI</i>	Susan Hyde <i>San Francisco, CA</i>
Yasmi O. Crystal <i>Bound Brook, NJ</i>	Elie M. Ferneini <i>Waterbury, CT</i>	Felicity K. Hardwick <i>Nanaimo, BC</i>	Terence A. Imbery <i>Yorktown, VA</i>
Frank T. Dalton <i>Corinth, MS</i>	Howard A. Fetner <i>Jacksonville, FL</i>	Lisa A. Harpenau <i>San Francisco, CA</i>	Thomas G. Ison <i>Louisville, KY</i>
Michael D. Danner <i>Pekin, IL</i>	Charles M. Fischer <i>Mission Viejo, CA</i>	James E. Haubenreich <i>Lexington, KY</i>	Leticia G. Jeffords <i>San Antonio, TX</i>
Christopher C. Delecki <i>Seattle, WA</i>	Peter C. Fritz <i>Fonthill, ON</i>	Jianing He <i>Plano, TX</i>	Harold S. Jeter <i>South Point, OH</i>
Aron E. Dellinger <i>Leo, IN</i>	Staci N. Gaffos <i>Columbia, SC</i>	Gregory P. Heintschel <i>Petoskey, MI</i>	Jason L. Jeter <i>Visalia, CA</i>
	Christopher W. Gall <i>Griffith, IN</i>		Vanchit John <i>Indianapolis, IN</i>

Mark Johnston <i>Lansing, MI</i>	Rory S. Levitan <i>Crown Point, IN</i>	Theresa G. Mayfield <i>Louisville, KY</i>	Craig L. Oldham <i>Brandon, FL</i>
Gregory B. Jones <i>Hermiston, OR</i>	Robert H. Levy <i>Dallas, TX</i>	Chester V. Mayo <i>Virginia Beach, VA</i>	Barney T. Olsen <i>Sandy, UT</i>
Randolph P. Jones <i>Oklahoma City, OK</i>	Elizabeth T. Lewis <i>Canton, GA</i>	Delwin K. McCarthy <i>Cerritos, CA</i>	R. Pierce Osborne II <i>Fayetteville, AR</i>
Richard C. Jordan <i>San Francisco, CA</i>	Kurt S. Lindemann <i>Kalispell, MT</i>	Dan T. Meadows <i>Memphis, TN</i>	Larry M. Over <i>Eugene, OR</i>
Nadim J. Jubran <i>Maryville, TN</i>	Dale R. Linton <i>Bountiful, UT</i>	Joseph B. Michael <i>Norfolk, VA</i>	Ernest N. Oyler, Jr. <i>Cleveland, TN</i>
Leslie Karns <i>Draper, UT</i>	Marshall S. Lipscomb <i>Denton, TX</i>	Andrew S. Middleton <i>Hattiesburg, MS</i>	Rosaura Pacheco <i>Fresno, CA</i>
Thomas W. Kauffman <i>Marietta, GA</i>	Todd C. Liston <i>Layton, UT</i>	Travis T. Miller <i>Orange, TX</i>	William B. Parker <i>Fort Lauderdale, FL</i>
Paul Kavanagh <i>Laval, QC</i>	Renee F. Litvak <i>New York, NY</i>	Stanley A. Montee <i>Clarksville, TN</i>	David C. Parsons <i>Queensbury, NY</i>
William J. Kemp, Jr. <i>Amarillo, TX</i>	Angela M. Lueck <i>Milwaukee, WI</i>	Lawrence P. Montgomery III <i>Chalfont, PA</i>	Gregory S. Peacock <i>Merritt, MI</i>
Jin Y. Kim <i>Diamond Bar, CA</i>	Steven O. Lusk <i>Tulsa, OK</i>	Arthur C. Morchat <i>Gladewater, TX</i>	Stephen J. Peirce <i>Bradenton, FL</i>
Kenneth A. King <i>South Jordan, UT</i>	David P. Lustbader <i>Quincy, MA</i>	Maritza Morell <i>Lawrence, MA</i>	W. Thomas Pelton <i>Yuba City, CA</i>
Michael W. King <i>Jackson, TN</i>	Harry R. Mack, Jr. <i>Nashville, TN</i>	Steven S. Moss <i>New York, NY</i>	Donald J. Peretti <i>Billings, MT</i>
David W. Klein <i>Bloomington, MN</i>	Derek R. Mahony <i>Surrey, United Kingdom</i>	Barbara A. Moyer <i>Littleton, CO</i>	Kenneth S. Peters <i>Highlands Ranch, CO</i>
Chase F. Klinester <i>Grand Rapids, MI</i>	Ronald M. Mancini <i>Bethesda, MD</i>	David J. Moyer <i>South Portland, ME</i>	Joyous C. Pickstock <i>Nassau, Bahamas</i>
Prabha Krishnan <i>Forest Hills, NY</i>	Maria C. Maranga <i>Aquebogue, NY</i>	Steven R. Nelson <i>Denver, CO</i>	Sherry C. Pippen <i>Monticello, MS</i>
William N. Langstaff <i>Villa Park, CA</i>	Richard Marcus <i>Scarborough, ON</i>	Mark M. Norris <i>Vancouver, BC</i>	Constantine L. Politis <i>Oak Park, IL</i>
Dave C. Lee <i>Fayetteville, GA</i>	David O. Marks <i>Tulsa, OK</i>	Terry L. Norris <i>Owensboro, KY</i>	Robert S. Portenga <i>Traverse City, MI</i>
Luis P. Leite <i>Charleston, SC</i>	Cynthia J. Marshall-Petroff <i>Norton, OH</i>	W. Benjamin Norris <i>Jasper, FL</i>	James L. Posluns <i>Toronto, ON</i>
Thomas E. Lenhart <i>Clayton, CA</i>	James E. Martin III <i>Pensacola, FL</i>	Reza Nouri <i>Vancouver, BC</i>	Peter H. Pruden <i>Huntington, NY</i>
Lynn M. Lepak-McSorley <i>New Berlin, WI</i>	Rand T. Mattson <i>Roy, UT</i>	Gayle Obermayr <i>Sebring, FL</i>	Robert P. Pulliam <i>Nashville, TN</i>
	Lee S. Mayer <i>Louisville, KY</i>		Wayne C. Radwanski <i>Austin, TX</i>

Curtis D. Raff <i>San Francisco, CA</i>	Todd R. Schoenbaum <i>Los Angeles, CA</i>	Stephen J. Spencer <i>Great Falls, MT</i>	Arnold E. Weingarten <i>Toronto, ON</i>
George F. Richards <i>South Jordan, UT</i>	Brian K. Schroder <i>San Antonio, TX</i>	Howard Steiman <i>Ajax, ON</i>	Rebecca C. Weinman <i>Atlanta, GA</i>
Robert D. Richards <i>Houghton, MI</i>	Gail E. Schupak <i>New York, NY</i>	William L. Steinman <i>Montreal, QC</i>	Bradley A. Weiss <i>Evanston, IL</i>
Paul L. Richardson <i>Loma Linda, CA</i>	Bruce A. Scott <i>Walnut Creek, CA</i>	John D. Sterrett <i>Maryville, TN</i>	Vernon R. Willcox <i>Edmond, OK</i>
Elizabeth Roberts <i>Randolph, NJ</i>	Tracy A. Scott <i>Escondido, CA</i>	Gregg A. Stewart <i>Winter Garden, FL</i>	Laura Williams <i>East Wenatchee, WA</i>
John F. Robison <i>State College, PA</i>	Phillip F. Sehnert <i>Lewisville, TX</i>	Steven J. Stoll <i>Neenah, WI</i>	Richard L. Williams <i>San Antonio, TX</i>
Tyrone F. Rodriguez <i>Moses Lake, WA</i>	Diane W. Sherman <i>Encinitas, CA</i>	Kurt D. Stormberg <i>La Mesa, CA</i>	Edwin L. Wilson, Jr. <i>Norman, OK</i>
Patrick L. Roetzer <i>Benicia, CA</i>	David M. Shipper <i>New York, NY</i>	Robert P. Stowe <i>Winston-Salem, NC</i>	J. Douglas Wilson <i>Conifer, CO</i>
Richard J. Rosato <i>Concord, NH</i>	Brian Shue <i>El Centro, CA</i>	Richard D. Talbot <i>Citrus Heights, CA</i>	Kevin Drew Wilson <i>Amherst, NH</i>
Toni M. Roucka <i>Burlington, WI</i>	Irvin B. Silverstein <i>La Mesa, CA</i>	Timothy S. Taylor <i>Trimble, MO</i>	Robert J. Wilson, Jr. <i>Gaithersburg, MD</i>
Joseph L. Rumfola <i>East Concord, NY</i>	Richard A. Simpson <i>Tuscaloosa, AL</i>	Robert H. Thalgott <i>Las Vegas, NV</i>	Michael D. Wise <i>Herts, England</i>
Debra M. Ryken <i>El Cajon, CA</i>	John L. Sinclair, Jr. <i>Kalamazoo, MI</i>	Joe J. Thomas <i>Vero Beach, FL</i>	Andrew M. Wojtkowski <i>Clemmons, NC</i>
Benjamin Saleh <i>Town of Mount Royal, QC</i>	Medha Singh <i>Newton, MA</i>	Stephen P. Tigani <i>Washington, DC</i>	Lawrence E. Wolinsky <i>Dallas, TX</i>
Javid J. Salehieh <i>Cupertino, CA</i>	William H. Smartt <i>Knoxville, TN</i>	Julia H. Townsend <i>Los Gatos, CA</i>	Mark E. Wong <i>Houston, TX</i>
Sergio Sanchez <i>Las Condes Santiago, Chile</i>	Allen D. Smith <i>London, ON</i>	Richard W. Van Gorp <i>Charlotte, NC</i>	Debra A. Woo <i>Boulder Creek, CA</i>
Gerald B. Savory <i>Boulder, CO</i>	Gerald M. Smith <i>Thunder Bay, ON</i>	Stacey K. Van Scoyoc <i>Bloomington, IL</i>	David C. Woodburn <i>Amarillo, TX</i>
Philip L. Schefke <i>Willow Springs, IL</i>	James A. Smith <i>Portland, OR</i>	Kent L. Vandelaar <i>Chippewa Falls, WI</i>	Carol A. Wooden <i>Smyrna, GA</i>
P. Michael Schelkun <i>Warminster, PA</i>	Kevin S. Smith <i>Oklahoma City, OK</i>	Alexa Vitek <i>DeWitt, MI</i>	Arthur Worth <i>St. Thamesville, ON</i>
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POSITION PAPER ON DIGITAL COMMUNICATION IN DENTISTRY

Officers and Regents of the American College of Dentists

Prepared by David W. Chambers

ABSTRACT

Digital communication offers advantages and challenges to dental practice. As dentistry becomes comfortable with this technology, it is essential that commercial and other values not be accepted on a par with professional ones and that the traditional dentist-patient relationship not be compromised by inserting third parties that introduce nonprofessional standards. The Officers and Regents of the American College of Dentist have prepared this background and position paper as a guide to the ethical use of digital communication in dental practice.

There are eight principles:

1. The professional relationship between dentist and patient should not be compromised by the use of digital communication.
2. Digital communication should not permit third parties to influence the dentist-patient relationship.
3. Dentists should exercise prudence to ensure that messages are professional and cannot be used in unprofessional ways by others.
4. Personal data should be protected and professional communication should be separated from personal communication.
5. Dentists should be generally familiar with the potential of digital communication, applicable laws, and the types of information patients have access to on the Web.
6. Practitioners should maintain an appropriate distinction between communication that constitutes the practice of dentistry and other practice-related communication.
7. Responses to criticism on digital media should be managed in a professional manner.
8. Dentists should be prepared to make more accommodations to patients than patients do to dentists in resolving misunderstandings about treatment.

Electronic media have created entirely new ways for people to communicate. New media have altered what we discuss. They also have the capacity to build new relationships and change existing ones, and they leave a footprint. Finally, they are evolving at a rate that is currently faster than most users can keep up with, faster than society can absorb and respond to, and in ways that are not easily predicted.

Digital communication media are exploding. While household budgets for clothing and other items are shrinking, the digital budget is increasing rapidly. In terms of convenience and content, tablets outperform movie theaters. Handheld devices have more computing power than computers that filled rooms a few decades ago. There are apps for selecting apps. Few can name all the social media programs that exist, and the list will change next month. The big-box stores that threatened to dominate American commerce a decade ago are being shouldered aside by online shopping. Students can “fact-check” their professors while the lecture is in progress.

Some dentists are digital communication mavens, both personally and professionally. Others are reluctant. Still others contract for media services. The majority are perhaps fragmentary users. Regardless of dentists’ attitudes and talents with digital media, their practices are affected by patients who are skilled in placing a digital interface between themselves and professionals.

Commercial firms have also inserted themselves into the dentist-patient relationship. They have not asked nor do they need permission to do so.

INTEGRITY OF DENTAL VALUES UNCOMPROMISED BY DIGITAL MEDIA

In October 2011, the Board of Regents of the American College of Dentists created a task force to explore the impact of digital communication on dentistry, with a view toward preparing a position paper on the subject. The resulting position paper was approved by the board in October 2012.

The intent of this position paper is to inform dentists of some of the effects of digital communication on dental practices. Dentistry is based on a set of professional values that guide practitioners toward improving oral health consistent with the dignity of the patient. These values are expressed in the objectives and codes of the American College of Dentists and the codes of other professional organizations. Digital communication is also embedded in its own value structure. These values are more diffuse and not necessarily consistent with professional values. The overarching theme of this position paper is that dentists should live their professional values uncompromised, regardless of their involvement in digital communication. Further, it is incumbent on dentists to be familiar with digital

communication and its potential impact on dentistry, regardless of the extent to which they use these media.

A Classification of Digital Communication

The term “digital communication” is intentionally general: it is used to indicate a broad class of technology and uses, including cellphones, Google searches, turnkey electronic dental records, customized Web sites, e-mail, YouTube, sites that gather and disseminate information about dentists, Facebook and its many cousins, health-related apps, tablets for patients to enter health histories, and many others. To the extent that traditional forms of communication such as the Yellow Pages, newsletters, and phone calls share the functional characteristics of digital communication their use is incorporated into this position paper.

The physical characteristics and business names of digital communication devices is diverse and rapidly changing. The best way to understand this field is in terms of functional features. Despite their range of manifestations, digital communication shares these characteristics:

- Rapid, almost instantaneous dissemination of content
- Extremely low cost for multiple distribution
- Longevity of content, will not go away
- Potential for anonymity and aliases
- Inexpensive and rapid creation, editing, and updating
- Privileging of short messages
- Privileging of visual content
- Partial regulation
- Increased difficulties maintaining security
- Conflicted understanding of privacy
- Large participation but fragmented across platforms

- Senders and receivers need not share time and place
- Easy and almost costless duplication and forwarding
- Potential for misrepresentation and unintended use by others
- Potential for sharing content out of context

The intended use of digital communication is an accepted means of classification. There are three broad categories: (a) broadcast, (b) relationship, and (c) transaction.

Broadcast. The broadcast function of digital communication is a one-to-many dissemination of a fixed message. The typical Web page or blog is just a fancy, inexpensive Yellow Pages ad, billboard, catalogue, or other general message. Some dentists are producers of broadcast digital communication; all are consumers. Wikipedia, online dental journals, information about dental products, and room availability for conventions are examples of sites to which dentists refer for packaged general messages. Organizations of all types, from a local restaurant to the American Dental Association, create an image of themselves and reveal selected information to targeted audiences. By extension, these images also affect the public’s perceptions of the dental profession generally.

Commonly, broadcast digital media are intended to distribute uncustomized information. Information is selected by the producer, not the consumer; it is not individualized, but instead tailored to a hypothetical “modal customer”; it is intended to put the best face forward; usually it has high visual content because attention span will be short. Sometimes called “Web 1.0,” broadcast-function digital communication is one-directional. The trend is for such sites to invite transfer to other two-way communication media (the second function), such as a phone number or Twitter feeds or to sections that handle business transactions (the third function).

Broadcast function sites often discourage interactive communication and may specifically state that no reply will be responded to. Success of Web 1.0 systems is measured in “hits” or “eyes.”

Relationship. Web 2.0 is the common designation for a second function of digital communication designed to build relationships through exchanges of messages. Those who are struck by the banality of Facebook postings have missed the point. The message is subordinate to the relationship. Twitter limits the number of characters in a message to 140, forcing canned abbreviations. The small screens on handheld devices discourage depth of communication or management of complex issues.

Social media can be used to very quickly spread tiny bits of information through a network, but the work of network building must have taken place previously. Relationship-building digital media define status. Celebrities lose much of their legal protection from defamation because they are “public” figures and the number of their contacts is media content. Social media represent a challenge to established power because it is not based on established position or depth and accuracy of information, nor is it vertically structured. Every user of social media is at the center of his or her Web, and importance is a function of the number and richness of the cascading relationships. Cellphones and text messaging can be grouped under this heading. Web 2.0 measures success in terms of followers, members, subscribers, and the like.

Transaction. Digital media are rapidly beginning to manage transactions, and this is the third function. Dentists and their office staff can purchase supplies, register for meetings, pay professional dues, participate in surveys, and contract with Web designers using electronic media. Patients can locate

dentists, make appointments, pay bills, and fill prescriptions on the computer. Within the office, functions such as obtaining informed consent, patient education, and graphically assisted treatment presentations are becoming electronic. The situation has come further in medicine, where patient questions to providers are taken on the computer, chronic conditions are managed by teams of mid-level providers reaching out to patients before symptoms appear, and consultations among professionals and even diagnoses are mediated electronically and in the complete absence of a physical patient. The impact of the transaction function of digital media is measured in traditional business terms of time saved, accuracy, number of transactions, and profit.

The reason for offering this brief categorization of the three functions of digital communication is to demonstrate its reach, to show that dentists may occupy various roles in the network, to draw attention away from the gadgets and the apps and focus it instead on the effects that can be expected from various patterns of use of digital media. It is the effects of electronic communication that count. Dentists will participate in digital communication in many ways, and success will be defined differently across practices. It is the fit between the practice and the media that matters, not just getting the currently most fashionable equipment.

Principles for Professional Use of Digital Communication

Eight principles are presented to guide the use of digital communication as an effective extension of dental practice. Where the relationship between new media and dentistry is synergistic, we have noted ways dentists can enhance oral health care by taking advantage of new ways to communicate. Where there are conflicts, these are pointed out, including possible adverse effects and

appropriate precautions. The term “should” and cognate phrases are used in their ethical sense, calling dentists to higher ideals. Although there are legal and regulatory considerations in the use of digital media, such as Health Insurance Portability and Accountability Act (HIPAA), the positions presented here are aspirational rather than requirements.

1. The professional relationship between dentist and patient should not be compromised by the use of digital communication.

The relationship between dentists and patient is special and essential to appropriate care. Although the term dentist-patient relationship will be used for convenience, this should be understood in the broadest sense of including the entire dental office team, the dental profession generally, and individuals who are not patients of record but are in need of oral health care. This relationship is based on trust. It is impossible for patients to know all the necessary details of their current oral condition, its likely course, alternative interventions, or even the competency of particular dentists to provide the best care. Similarly, dentists have to trust patients to provide accurate health status information, follow through on their part of care, and pay for services. Further, dentists have a wide range of individual strengths and skills, and patients represent individual combinations of medical, dental, and personal needs and values.

Dentistry is a relationship that is intensely customized and based on trust. It cannot be turned into a commodity without compromising it. A commodity is something of value that has been standardized and stripped of its unique features to the point where each unit is interchangeable and the only way to add value is to compete on price.

The professional relationship between dentist and patient should not be compromised by the use of digital communication.

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A traditional idea in dentistry, and one that the American College of Dentists believes should remain central to its identity, is the five Cs of comprehensive, continuous, competent, compassionate, and coordinated care. Appropriate care addresses all of the patient's oral health needs, not just ones that the patient picks out because of uninformed interest or the dentist identifies because of personal preference or potential for other returns. It is also continuous, both over the number of appointments needed to achieve stability and via recall. Competency for the level and type of practice is assumed by the patient and should be guaranteed by the profession. The phrase compassionate care is redundant, but it reminds us that "care" is not synonymous with "treatment." Finally, the capacity of one office should never place a limit on the potential for the health of any patient. Where appropriate, care should be enhanced by referral to a specialist while the general practitioner retains overall management responsibility, cooperation with insurance and other financial resources, and attention to total health by coordination with all health professionals.

This general ideal can serve as a standard against which to evaluate the use of digital communication.

New patients can be recruited by electronic means. It is certain that individuals use their computers and hand-held devices to make contacts and form first-impressions of potential practices. In this sense, the ethical issue is what image the practice provides for the general public in its broadcast of one-to-many messages. Information about practice type, including limitation of services based on advanced training or limited practice type, office location, hours, languages spoken, and even practice philosophy (family-oriented,

comprehensive, community-based) are all appropriate. Insurance acceptance, credit availability, and other features having to do with payment are more nuanced. It is assumed today that standard financial arrangements will be available in all businesses, so dentistry may be well served to avoid any reference that might be construed as suggesting that oral health care is a commodity. Perhaps the most informative statement along these lines would be that insurance plans are not accepted.

Because search behavior of electronic media is dominated by superficial and quick searches for "hits," a position near the top of a search algorithm and a quality visual image are critical. One gets to the top of a page by paying for it, by having been successful in previous searches, and by using key phrases that match the terms potential users will use in beginning their searches. A patient who is interested in "sleep dentistry" is not seeking a definition of sleep dentistry (they have already searched the Web in general if they have any appreciable level of curiosity). They want to see the term on the office Web page, surrounded by other symbols they associate with quality care. In general, Web 1.0 users are not interested in reading a Web page but they can, in a fraction of a second, form an impression of the office from the overall appearance of the page.

The ethical issue associated with broadcast digital media is the difficulty of establishing personal relationships with patients. Because it is difficult to honestly express factors associated with the quality of care indicated by Web 1.0 format, there is a temptation to emphasize other characteristics. The proportion of Americans visiting the dentist has not increased noticeably in the past decade (it may have actually decreased slightly), but the number of patients changing dentists has grown. It is likely that broadcast digital communication has promoted "churning": patients moving

from one dentist to another. This represents a threat to the value of continuity of care.

It should also be borne in mind that the use of broadcast digital communication is one-way and there is a certain generality about where the message is coming from. That means there is no opportunity in the communication itself for correcting misconceptions. What is more troublesome about the communication channel itself is that the message can be and usually is interpreted as coming from “dentistry.” The attractive expected outcome is what “dentistry” has to offer, and the one that most attracts the would-be patient’s attention is just the best of what dentistry has to offer. All digital communication between dentists and the public speaks for the profession as a whole. The potential for broadcast digital messages regarding dentistry to reach the multitudes underscores both the legitimacy and the importance of the profession as a whole, taking an interest in what individual dentists are saying to the public about oral health.

A second characteristic of broadcast digital communication, one that is not as large a concern for relationship building and transactions, is anonymity and image manipulation. Traditionally, individuals sought out professionals based on their reputations among acquaintances. This was followed by a face-to-face meeting and the beginning of care that, if all progressed satisfactorily, grew into a relationship. Positive relationships feed positive reputations. The dentist-patient relationship was personal, customized, and based on the outcomes of care. Digital communication has the potential for short-circuiting this cycle and distorting the dentist-patient relationship. When dentists seek patients based on a promised image of care, the

relationship collapses into one involving providers and customers. Dentists compete on criteria that can be standardized, such as appearance and price. Customers shop. What has happened in these cases is that expectations based on anonymous and mass-produced (or marketing-manufactured) images has been substituted for personal dental care. All five Cs are put at risk: comprehensive, continuous, competent, compassionate, and coordinated care are left off to the extent that they cannot be quickly depicted on a computer screen. It is a limp answer to say that digital communication allows us to better give the customer what he or she wants. This is a substitution of commercial for professional values. If such customers wanted veneers on periodontally involved teeth, no professional should accede.

A large positive potential exists for digital communication to build relationships between existing patients and the practice. This is the function that was managed traditionally by the office newsletter. Patients begin to identify with the practice when they see their comments or images on the office Web site. They will check to see whether their Facebook postings have been responded to. The practice is building a community by hosting a site. The important values promoted by an effective office Web site include all but one of the five Cs: comprehensive, continuous, compassionate, and coordinated care. These four are fertile fields for effective use of social media. Competence of the dentist and staff is the one value that cannot be enhanced through the use of electronic communication. Claims of competence, even indirect ones such as announcing that the dentist has been selected for some form of distinction, are inappropriate and unnecessary in electronic communication designed to build relationships between the office and the patient. Use of the initials FACD in electronic communication with patients is

contrary to the Code of Conduct of the College precisely because it can be misinterpreted as a claim of competence.

Electronic transactions are just beginning to become a part of dental practice. To the extent that they ease any perceived barriers to care they offer great potential. The largest issue with respect to digital support for transactions in the dental office is that most such applications are purchased from outside vendors. Care should be taken to ensure that the services match both the needs of the office and the characteristics of the range of patients served. Additional care is required to make certain that patient privacy, confidentiality, and security are honored. It is also appropriate to inquire of vendors with respect to the full-value proposition or business model. It can happen that the fee paid to vendors is only a small part of the benefit they derive from an arrangement. Access to information about patients can often be of great value to vendors, as can connection with the dentist’s business relationships, reputation, and even control over access to patients.

2. Digital communication should not permit third parties to influence the dentist-patient relationship.

Some dentists are quite adept at developing and using digital communication as an extension of their practices. Most copy general trends in the profession and must rely on commercial vendors and consultants. This situation is much like the relationships that exist between dentists and equipment manufacturers, brokers, insurance companies, and advisers, including practice management consultants. The role of third parties in dentistry is to assist the dentist in providing more and better dental care

than would be possible otherwise.

As dentists seek assistance in designing and implementing digital communication systems in their practices they should be aware of the potential for introducing the virus of commercialism that sometimes accompanies these applications. There is no value in equipment sales or software development that corresponds to the oral health promotion value or dentistry or the professional value of promoting the patient's long-term interests. Advice, services, and equipment are sold to dentistry as commercial transactions, and the standards governing these sales do not extend to cover the same range of values that prevail in dentistry. It is the dentist's responsibility to ensure that decisions about digital communication place commercial interests in a position subordinate to oral health.

Dentists are open to introducing third-party influences in all three types of digital communication: broadcast, relationship, and transactions.

Web designs, communication practices, building of electronic communities, and computerized interfaces with customers that are most effective in commercial applications are not automatically the best ones for a dental practice. The operative question is not what other users are doing or what financial rewards others have gained but whether patients have better oral health as a result of the practice adopting certain kinds of digital communication.

The common commercial index of success, number of "hits," is of doubtful value. The true professional value is oral health outcomes. Discounts and giveaways orient patients to cost rather than health. Chaining and hosting—rewarding patients for using their computers to promote your practice—

are mistaken notions of what dentistry offers. Advertising prices and offering guarantees may be acceptable to other clients for whom Web designers' work or some things which a practice might be tempted to copy, but they risk being false or misleading in dentistry because of its custom nature. Unqualified price offerings can drift toward "bait and switch" practices. The common thread in these examples is that nonprofessional, commercial values may creep in when digital communication is designed by outside vendors or borrowed from sources that do not understand the professional nature of dentistry. It is the dentist's responsibility to ensure that inappropriate third-party influences are kept in place.

In extreme cases, third parties insert themselves into dentistry by becoming co-providers of care. Groupon is an example where a for-profit company has attempted to broker increased numbers of patients to the dentist in exchange for lower cost to the patient. The prospect that a third party could make a profit from such a model presumes that there is an excess margin in dental fees. There are also third parties who are willing to provide ancillary dental services, such as lab testing, financial services, and patient education to be accessed from the Web pages of practices. This normally includes a financial return to the dentist for allowing others to become partners in patient care.

It is embarrassing to Google-search a dentist's name and find half a dozen sites introducing that dentist. It is sometimes the case that dental trade association groups that dentists join will sell personal and practice information to vendors as a source of non-dues income. The American College of Dentists does not engage in such practices. These sites offer unrelated services, such as listings for other dentists in the area, advertisements in the margins, and even an opportunity to rate the quality of the dentists one has not yet seen. Typically, such sites offer patient

education information about such topics as disciplined licenses (which they mine from public records available to all through state Web sites) as a value-added feature. Other vendors are more direct, offering to give an opinion without being asked. For example, organizations now notify dentists that they have been recognized and offer to publicize this fact for a fee. In all of these cases, a third party with some sort of commercial interest is seeking to insert itself between the dentist and the potential patient. This is perfectly acceptable in a commercial culture. Dentists should regularly monitor their electronic public image. To the extent that all dentists offer excellent care based on the five Cs, there is no commercial value that third parties can profit by selling. Third-party information is only valuable to the extent that it guides patients and others through a fragmented profession.

3. Dentists should exercise prudence to ensure that messages are professional and cannot be used in unprofessional ways by others.

The communication between dentists and patients is inherently individual, personal, and complex. The discussion of how best to manage oral diseases, their complications, and the effects these have on patients' lives is best done in an environment of trust, give and take, and where there is an opportunity for immediate responses to patient's concerns and an opportunity to evaluate nonverbal and other circumstantial factors.

There are aspects of dental communication that do not require this level of interaction and may be well suited to digital communication. These include information about the practice location and characteristics such as office hours, bills sent to patients on a monthly payment program, and information shared as a community outreach, such as back-

ground information about an upcoming public water fluoridation campaign.

Although it is impossible to prevent all cases of others misusing messages and information that appear in digital format, reasonable precautions include password protection and other security practices, legal disclaimers accompanying postings, care in distributing messages, and prudence regarding content. The last suggestion—not saying anything one would be embarrassed to read on the Internet with one’s name attached to it—probably affords the greatest degree of protection. Care should be taken to ensure that professional communication matches the media used. Three factors are especially important.

First, no claim should be made in a public forum that is not universally applicable to all patients or the public. If there is any question whether a statement on the office Web, in a text response to a patient, or through a commercial service will have to be qualified once there is a direct relationship between the dentist and the patient, it is questionable whether such a statement should be made. Claims such as “one-day tooth straightening” and “painless dentistry” either are misleading or involve puffery, a watering down of professional communication. An office that blogs about how friendly it is to everyone runs the risk of not being able to dismiss patients or cultivate a “select clientele” without broaching hypocrisy. Adding quibblers such as “generally” will make the lawyers happy but may still leave a bad taste about the profession as a whole in the mouths of patients. The ethical principle of veracity is defined by philosophers as not allowing others to maintain misbeliefs that are detrimental to them. This is a higher standard than telling the truth.

Second, care should be taken with claims and information where others can hijack the information for their own, nonprofessional purposes.

Politicians, CEOs, actors, and sports stars are not the only ones who have been bitten by an unflattering remark captured on a cellphone. The concept of “going viral” means that digital content has escaped the control of the originator.

That can be an attractive prospect in the case of flattering messages, but devastating if the message has negative overtones. The important thing to remember is that there are reasonable controls on the context of direct communication between dentists and patients that disappear when the content becomes digital. Digital content has a life of its own, and it is an indefinitely long life.

Third, consumers of messages on digital media are often unclear about the source of the message. The reputation of every dentist is affected by the actions of heavy users of media, regardless of their own attitude toward it. Many dentists or their office staff have been confronted with a computer printout of an unsubstantiated treatment or of price quotes from other offices. Some messages are naturally easier to express digitally. Usually attractive outcomes are better understood by the public than improvements in health. Simple and quick treatments are easier to explain than cases involving staging, tradeoffs, and complex decisions. Inexpensive, single prices are easier to grasp than fees contingent on the multiple factors of the case. Because digital communication favors short, standardized messages, it is intrinsically biased toward misrepresenting the most appropriate forms of oral health. That is the case before considering the attractiveness of digital media in the hands of those who intentionally misuse it for personal gain.

4. Personal data should be protected and professional communication should be separated from personal communication.

A traditional idea in dentistry, and one that the American College of Dentists believes should remain central to its identity, is the five Cs of comprehensive, continuous, competent, compassionate, and coordinated care.

Patients have unprecedented access to health information and misinformation on the Web.

United States law has established standards for healthcare professionals with regard to their communication about patients. Certain individuals and entities are entitled to access to this information, including patients themselves, insurance companies, and the courts under some circumstances. Others are specifically excluded from seeing the information. The HIPAA regulations are over 1,000 pages long. The “P” in HIPAA does not stand for privacy. The word is “portability,” as in Health Insurance Portability and Accountability Act. The underlying issue addressed in this legislation is that patient information will be ballooning in value and flying around at fantastic rates once it has become digitized, thus formal standards are needed.

The three fundamental standards in HIPAA are privacy, confidentiality, and security. These are not three terms for the same general idea; they are three ways that the information about people is part of the dignity of the person.

Privacy refers to the right to refuse to reveal personal information. If a patient is coerced or tricked into revealing information about their sexual preferences, their income, or their health status to individuals who have no business knowing this, their privacy has been violated. This is true even if that information is not shared with anyone else. In an electronic world where there is so much personal information in cyberspace, we have become concerned that we should not have to reveal anything more about ourselves than we choose to, unless that information is needed for legitimate purposes. Usually, we must be informed about privacy policies, although the notifications are now so ubiquitous, lengthy, and expressed in such legal language that in fact we may not actually be informed. Think of a violation of privacy

as looking for information that one should not have.

Confidentiality is sharing information you have, whether obtained by appropriate means or otherwise, with people who have no business knowing it. Most of the “privacy” issues involving electronic information are really concerns about confidentiality. Selling mailing lists, leaking classified information, and gossiping about famous patients are violations of confidentiality.

Security, the third function, means taking reasonable precautions to ensure privacy and confidentiality. Unauthorized individuals should not be placed in positions where they may overhear private details. Charts should be stored in locked cabinets. Staff should be trained. And suspected breaches must be reported according to the regulations of federal and state laws.

Broadcast digital communication is not likely to be an issue with regard to personal information—it is the dentist who is making revelations. Transaction digital communication is especially at risk as it contains health history, financial, and other sensitive matters. Relationship digital communication may become an issue as cellphone communications and texts can now be subpoenaed and may be inadvertently sent to the wrong people. Hosted Web sites may post information that later is recognized as inappropriate. The dentist should make a determination in building relationships where the proper boundary is between professional and nonprofessional communication.

It would also be out of bounds to brag about well-known patients on the practice Web site. If permission had been given for such posting it would not be illegal, just very bad taste. Facebook and

other social media sites should be closely and continuously monitored and inappropriate postings removed immediately in cases where that is possible. In fact, it would be good practice to have a clear policy regarding publication of personal information printed on the site.

Transaction electronic sites, such as payment systems, automated health histories, and insurance apps need to be carefully designed and monitored for conformity with HIPAA regulations. It is prudent to give training and guidelines to all staff members, and to log in from time to time as a potential user of one's own digital communication to see what it looks like from the outside.

A slippery area is the dentist's personal media use. Occasionally, the formal office protocol is immaculate, but the line between personal and professional communication of the dentist becomes blurred. Dentists should not become faceless, unreachable non-entities. Neither should they be everyone's "hangout buddy." Virtually all professions except dentistry have formal language in their codes of professional conduct regarding avoidance of dual relationships. Dentists should protect against the ambiguities of indistinct professional boundaries by maintaining separate e-mail addresses, Facebook and other social media accounts, and cellphones. One is for the dentist as a person and one is for the dentist as a professional. Communication to patients or staff that comes over the wrong channel is apt to be misinterpreted. A legal action should never open a dentist to requests for access to personal communications just because they have been blended with professional ones.

Although the dentist is ultimately responsible for all practice communication, it may prove useful to delegate continuous monitoring of the office social media site to a staff member for the sake of consistency and immediate

attention. First, the staff member has more time. Second, there needs to be a buffer in decision making between the request and the dentist as the ultimate responsible authority. And third, patients may overuse direct access to the dentist and they might interpret everything the dentist says as professional communication. Diagnosing on the cellphone is very risky business.

5. Dentists should be generally familiar with the potential of digital communication, applicable laws, and the types of information patients have access to on the Web.

Digital communication affects all practices, even those where the dentist is personally determined not to participate. Because of the nearly universal use of digital communication and the inevitability of having to make decisions about its benefits and its abuses, dentists should know enough in a general way to make ethical decisions and to seek competent advice when that would be helpful. At a minimum, dentists should be able to distinguish between those opportunities that help or harm patient care based on informed opinion rather than vague awareness of "trends."

There are no general laws or ethical principles that apply exclusively or in a special way to professional use of digital communication—with the exception of HIPAA and perhaps some others. Special cases may come to light, and dentists should seek the advice of qualified counsel if that is suspected to be the case. The obligation that cannot be avoided is to think through the effects of using digital communication and then to apply the same standards of law and ethics that would be applied to the same effects were they the results of any other action not involving digital media. The five Cs of comprehensive, continuous, compe-

tent, compassionate, and coordinated care can serve as a guide.

Dentists should also be familiar with applicable law and regulation regarding practices involving digital communication and ethics and professional standards that guide their use. Among the issues that are essential are relationships with third parties (as in responsibility for patients), relations with other practitioners (as in fee splitting), privacy, confidentiality, and security (as in HIPAA), and copyright, libel, and conflict of interest matters. Various codes of professional conduct and ethical guidelines are also relevant. For example, mention of branded products or treatment modalities on one's Web site may constitute an endorsement and create an undisclosed conflict of interest. Colleagues may come to regard claims or even the general appearance of broadcast sites as claims of superiority. And, of course, every practice or statement that is ethically questionable when presented in any other medium is equally suspect in digital format.

A 2009 study of all dental practices in San Francisco revealed that 11% of dentists practice in offices that market themselves by a fictitious name that does not include the identity of the dentists. It might be imagined that these practices have distanced themselves to some extent from direct personal relationships with patients. Disconcerting is the fact that less than half of these practices with fictitious business names have registered the name with the state dental board, a requirement for licensure. The same study found that 24% of practices list a Web site. Likely the number is

greater today. There was no difference in the average age of dentists who have Web sites and those that do not.

Patients have unprecedented access to health information and misinformation on the Web. No one can “unring” that bell. It then behooves dentists to be at least familiar with both commonly used patient sources of information and with the more widely circulating claims. A dentist should count it as fortunate when patients present questions about such claims and ask for a professional opinion. The alternative of patients simply matching their uninformed opinions with dentist Web sites that contain the key words they are looking for is borderline collective malpractice. But dentists should be informed well enough about what patients are finding to have an honest discussion that extends beyond their own scientifically-based knowledge. It is an irony that in an age of massive information available to the public, professionals now have the additional responsibility of being familiar with the misinformation that patients are apt to encounter and of having the skills to guide patients to sound oral health choices.

6. Practitioners should maintain an appropriate distinction between communication that constitutes the practice of dentistry and other practice-related communication.

Some dental treatment is accomplished without the use of a handpiece. For example, a patient may phone with postoperative pain and be instructed by the office staff to take analgesics and continue self-monitoring. It might be argued, if the case fails, that the staff member was practicing dentistry without a license. Similarly, patients may rely on information posted on the office Web site in a way that causes complications. Although disclaimers can be added to

digital communication, it is unclear at this point the extent to which this constitutes legal protection. There have been reports from the medical community that physicians responding to text messages from patients have increased legal exposure.

The fact that dental licensure in the United States is managed at the state level raises additional concerns because electronic media know no geographic boundaries. Charts, prescription information, photographs, and radiographs can be transmitted electronically, often with no clear identification of the location from which they originated. If patient advice, professional consultation, diagnosis, or direction of care given by staff is interpreted as constituting dental treatment that crosses jurisdictional boundaries, the dentists may be practicing without a license.

7. Responses to criticism on digital media should be managed in a professional manner.

It is unlikely that the growing availability of electronic media has or will increase the proportion of actual negative experiences in dental practice. The ratio of patients upset with their care and the ratio of patients who are difficult to manage are likely constants. What is rapidly changing is the capacity for these disagreements to be played out in front of a large audience and the prospect that third parties will become involved. In two studies of dentists' preferred response for managing issues of a technical nature or those involving staff, patients, financial matters, and office routine, the overwhelming “go-to” strategy was face-to-face communication. This is judged by dentists to be both the most commonly used approach to solving problems as well as the most effective one. Appropriate adjustments are made and reputation is maintained most effectively through personal conversations. Such conversations are increasingly taking place in public. It

will become more difficult for dentists to exercise control over oral health communication.

Increasing caution is required with regard to communication in the office regarding patients and one's professional colleagues. It has always been unprofessional to make disparaging comments about patients, especially those that involve value judgments. With more office records being in electronic format, even including texting and cellular phones, the prospect is growing that damaging remarks will be uncovered during the discovery phase of a legal action. Sophisticated electronic search algorithms exist for finding information, and data has an increasing life span and is becoming almost impossible to dispose of. A more professional level of discussing patients and of discussions with patients is now required. Training of the office to ensure that this standard is the dentist's responsibility.

There have been clear examples of dentists' reputations being unfairly impugned by patients spreading reports of what they interpret as poor treatment. Various electronic media have been used for this purpose, including postings on dentists' Web sites, postings on patients' own sites, and postings on public sites, as well as traditional word of mouth. Some of this damage has been justified and some has not. More people are reached by digital postings, messages tend to be more strongly worded because the writer must justify the position, blasts reach people who are not in a position to know all of the relevant facts. These circumstances narrow the possible actions a dentist can take in response.

The new reality of wider public scrutiny of practice invites any of several responses.

Improved patient relationships in the office are the preferred strategy. This

takes the form of full communication, more extensive involvement in informed consent, development of multiple channels of communication with staff, and clear signaling that the dentist is willing to listen and discuss concerns on a personal basis. In this sense, the best antidote to potential abuse of digital communication is effective use of non-electronic communication in the office.

Once patients have signaled, publically, that their sense of trust has been violated, the dentist has the options of ignoring the matter, denying the facts, offering excuses, promising reparations, apologizing, and taking or threatening legal action. Efforts should be made to obtain a copy of the electronic complaint. Failing to respond, denial, and making excuses (including blaming the patient) generally have the effect of creating further distance and potential escalation in front of an audience. Even when the original issue is ambiguous, a disgruntled patient is on very solid grounds in complaining to anyone who will listen when the dentist refuses to engage in a conversation. That will become the dominant voiced concern. Courts and malpractice carriers are sensitive to due process matters. Promising reparations is a decision about the costs of maintaining a patient or one's reputation. Some malpractice carriers still advise against professionals apologizing, although the literature shows that this does not increase and may actually decrease settlement costs in the event of legal action. It does have a strong effect on decreasing the likelihood of legal action. Apology includes a believable expression of regret over the outcome and openness to accept just responsibility. The apology should be extended in private and should be understood as an invitation to seek a mutually satisfactory resolution.

The literature on service recovery (effective management of customer complaints) shows that satisfied customers tell three friends and dissatisfied

customers tell seven to ten. Digital media magnify these numbers but probably do not change the ratio. The goal of service recovery is to convert an unsatisfied customer into a satisfied one. An open effort to do this is often effective, and surprisingly, recovered customers are actually more loyal than originally neutral ones. It is something like remineralized enamel.

A third alternative is to engage in positive reputation building through customers. Recently companies have very openly taken to "coaching" customers about responding to satisfaction surveys and openly soliciting testimonials and positive comments. It is not uncommon for service companies to instruct personnel to inform customers that they "expect a perfect 10 on the third-party survey you will be receiving." This has extended to language, often buried in consents and agreements that the customer can be used for promotional purposes at the discretion of the company. There are firms that will sell bulk Facebook "likes." At the homemade level, small businesses encourage employees to make positive comments on relationship-hosted sites and to recruit their family and friends to do the same. This local ballot box stuffing is sometimes so crude that it must be obvious. The ethics of professionals soliciting favorable public opinion is suspect.

The most reactive, and certainly the most damaging, response is for professionals to attempt suppression of negative opinions expressed in public. There are two forms this response takes. First is legal action under the head of prosecution for libel. Libel is the publication of defamatory remarks that tend to injure another's reputation. To prevail in a libel case the plaintiff must be able to show that the claim was made by a

The most reactive, and certainly the most damaging, response is for professionals to attempt suppression of negative opinions expressed in public.

person who knew or should have known that the damaging statements were false. A patient's opinion that he or she was not treated as they expected to be treated generally does not meet this criterion. A second strategy that some professionals have attempted to prevent negative postings to electronic systems is to require that patients sign a promise that they will not criticize the provider. Courts have almost universally rejected libel cases brought by dentists against their patients and have held that contracts precluding expression of opinions following treatment to be against "public policy" and unenforceable.

Sites such as Yelp, Angie's List, Healthgrades, Ratemds, Vitals, and Doctoroogole are commercial platforms that serve the public by hosting the opinions of users of professional services. They are lay ratings of professional services—uninvited electronic scorecards. Presumably there is an equal potential for an uninformed patient or a family friend to give a practice an unrealistically high rating or for an equally uninformed or biased individual to give an unwarranted low rating. The fact that third parties can make a profit by hosting such ratings demonstrates that professional reputations have value. Dentists should monitor these ratings and seek to diagnose opportunities to improve their reputations.

8. Dentists should be prepared to make more accommodations to patients than patients do to dentists in resolving misunderstandings about treatment.

There is a perception of a double standard for professionals and the public in terms of what can be said in public about their relationships and how far each should go to resolve differences. That perception is accurate, and professionals have to extend themselves more than patients do.

This is the case for two reasons: one ethical and the other economic. There is an implied contract between the professions and the public which includes, among other matters, an expectation that the profession will have exclusive markets and a degree of self-policing in exchange to its agreeing to serve the public's interests. This is different from the relationship between the public and commercial operations such as car dealerships or pest control. Professionals are granted a very large measure of trust from the beginning of any relationship that strictly commercial relationships must earn.

To the extent that dentistry is both a profession and a business, there is a risk that professional trust will be compromised when dentists signal an emphasis on commercial values. There is certainly ample potential for confusion. It would be inherently unethical for dentists to expect the full benefits of professional trust at the same time they counted on full access to the rewards of commercial enterprise. Digital communication, with its bringing previously private relationships between patients and dentists into public view and beginning to make a place for third parties in those relationships has drawn attention to the ethical dimension of this double standard.

The economic reason why dentists must extend themselves further to reconcile differences of perception between themselves and patients is because dentists are in a favored position in the relationship. Finding the "fair" balance between parties of unequal power is known as the Nash Bargaining Solution. John Nash won the Nobel Prize in Economics in 1994 for, among other things, pointing out that society pulls toward a balancing of conflicts of interest based on how much each party has to lose by not reaching accommodation. Generally dentists enjoy economic status, reputation, and positive standing in the communities where they live and work

that exceed those of their patients. Ethically fair resolutions of disagreements are based on adjustments that are proportional to what each party stands to lose by not coming to agreement. ■

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People Will Talk

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ABSTRACT

The rise of the social media phenomenon and its impact on dentistry are discussed in the paper. The relationship between dentists and patients is growing wider and more indirect. Social media can be roughly characterized in five categories: social, reference, review, coupon, and information networks. Opportunities and threats posed by social media are explored.

What is word of mouth? It is the human condition—to share experiences. Social media is changing the way people talk. It is changing how people talk to each other or about each other. It is changing the fundamental roles of dentist and patient.

A three-year-old boy was referred to our pediatric dental office by a general dentist. The child had multiple caries. The general dentist was unable to treat the child. Due to the extensive treatment required and the child's immature cognitive ability, we recommended oral conscious sedation. Informed consent was discussed and signed.

The treatment was completed uneventfully. The child did well for the procedure. The parents were satisfied with the results. The parents elected to return to the general dentist for continuing care.

Two years later, the same child was again referred to us for additional new treatment. While the child was older, he still exhibited situational anxiety. We reviewed the options with the father for treating the child. We mutually concluded oral conscious sedation would be the best option to treat the child. Due to the extent of the treatment needed, we split the treatment into two sessions. After the first session, the child again did great. The procedure was uneventful.

The mother called a week later. "I want my child treated on Friday afternoon. I want to be with him in the room

when you work on him. I want you to waive any co-payment or I will post bad reviews of you on 'X' site."

THE SOCIAL MEDIA PHENOMENON

Facebook, the iconic social media company, is credited by many with starting the social networking phenomena. It recently opened its IPO—creating a company value of \$137 billion. While there is controversy on the valuation, social media has fundamentally shifted how we communicate.

Of the many social media sites, Facebook alone boasts of 1 billion users. Each user can broadcast a message within a group or node. But then the message distribution can explode from node to node. The audience grows exponentially. The reach of the message occurs in seconds. Social media is fundamentally changing where consumers search for services. Eight years ago, the local Yellow Pages was nearly four inches thick. Today, the Yellow Pages or "business section" of the telephone book is less than a third of that size and seldom used.

Social media is changing the manner of seeking healthcare providers. Increasingly, consumers seek dentists on



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the open market. Social media sites such as Yelp tout that they can find “dentists, hair stylists, and mechanics,” and Angie’s List can help the consumer find “roofers, plumbers, house cleaners, and dentists.” In the eyes of the consumer, dentists are reduced to the comparable station in society.

Social media creates an egalitarian environment within a community. All participants are equal. Within a virtual community, borders are blurred between the formal professional conversation and the informal personal conversation. The once confidential conversation within the dental office is increasingly conducted in cyberspace.

Patients search for health information online. Dentists’ opinions, presumably knowledge-based, are increasingly being questioned. While informed health decision making by patients is desirable, the dentist as an authority figure is diminished.

There is a growing cautionary moral in the interplay of social media, social networking, and professional relationships. The challenge is to remain that of being the dentist.

THE CHOICE

In marketing, the conventional approach of a seller is to profess the attributes of one’s products or services to the marketplace. Your hope is that someone is attracted to what you have to offer.

From the frame of reference of the consumer, he or she relies on cues beyond the seller’s words or images. When a consumer chooses products, physical attributes are used to judge

comparative features of products among competitors. In computers, the discriminating features may be the size of the memory. In restaurants, it may be the menu choices.

When a consumer chooses services, there are fewer tangible attributes with which the consumer can discriminate among service providers. The consumer uses different cues to initially choose a provider. Without a personal experience with the provider, consumers make the selection based on brand identification or affiliation, reputation, and testimonials—or even price. The consumer does not have the professional experience or skills to recognize technical merit. The consumer relies on indirect, informal cues of a service provider when making their choice.

The single most persuasive factor in this decision making is the testimonial. The blind testimonial can be offered by a source unfamiliar to the consumer. The consumer does not know how sources form their opinions. Yet, the consumer takes the testimonial on face value.

From the frame of reference of the dentist, he or she believes the technical features, i.e., the margin, the occlusion, the shade, the anatomy of the restoration, should be the determinants of whether a patient will think highly of our work. Yet it has always been the nontechnical, informal cues, such as the courtesy of the staff, the attentiveness or empathy of the dentist, the décor or cleanliness, the timeliness of the appointment that lead the consumer to judge a “good service.” Price point is certainly a determinant.

Once consumers have first-hand experience, they have knowledge that others do not have. Consumers have a “power advantage” over those with whom they are in contact. They are now authorities. The power differential is the driver in the sharing of an experience. With social media, direct experience is no longer a precondition for having an

opinion. Any individual can rate a dentist online in any city in America, whether they have been a patient or not. Any dentist can rate himself or herself as well.

Social media now takes the testimonial and expands the range of this testimonial to a much wider distribution. Social media becomes the conduit or web between members within a social cluster. Clusters grow. Each cluster then becomes a nidus to expand the messaging to new social clusters. The message can travel far from ground zero where the message originated.

THE TARGET

Social media has become the darling of the marketing world. It is a low-cost, high-volume distribution vehicle to display your wares in the marketplace. Consumers increasingly do their shopping for products and service online. Responding to these market forces, there are growing trends for businesses to shift their marketing resources from traditional print and electronic mass marketing to social media tools. Businesses look for a return on investment of these resources. They seek a high conversion ratio of resources expended to how many buyers are secured.

A business sells its service or products to a range of different buyers. Buyers differ in their purchasing needs. There are buyers who are “price sensitive.” Companies offer promotional devices or discounts for these buyers to make purchases. This type of buyer tends to move from attractant to attractant. They tend to want to try the new “thing” in the social environment.

Buyers who are “brand loyal” seek enhanced value-added propositions. In Malcolm Gladwell’s book, *The Tipping Point*, these buyers are identified as late adopters or laggards. They tend to

need additional information about the features of their purchase before making a decision. Once they have made a decision, they are reluctant to change. They seek value for their purchases.

Sellers (of services or products) allocate resources to attract buyers. Marketing is the outreach of a business. The marketing must have a consistent messaging to identify and differentiate the seller from competitors. It must consider an overall strategy of costs, targeting, and monitoring to determine the effectiveness of the resources expended to attract buyers.

When using social media tools, from the seller's viewpoint, the strategy is not necessarily to secure a single point-of-contact purchase. The strategy is to reach into an existing social cluster or pool of potential customers. The business concept is termed "customer acquisition." A new entrant in the marketplace must expend resources to develop a customer base or buy access into an existing pool.

The strategy is to enable multiple points of contact with the business for those first-time purchasers. With social networking, conventional wisdom says the wider the net, the greater the likelihood of the catch.

THE MARKET

Social media is the vehicle that carries the message within a community or between communities. For the purpose of this article, there are five major types of social media:

1. Social networking community or blog
2. Referral network
3. Review network
4. Coupon network
5. Information hub or resource

The object of a social network or blog is to create a community. It enables connections. New entrants seek to establish a personality within that community. In social networks, people

talk. Sites such as Facebook, Twitter, LinkedIn, Yelp, and Google products (Google + and YouTube) typically have been Internet based. There is a lag time between the encounter and entering the message of the experience online. New variations emerge.

Mobile apps on smart phones and tablets are expanding exponentially. With each new product debut on the market, there is a drive for more real-time entry of the encounters. Access to information is in the hands of many, many more people. This "word of mouth" behavior is no different from moms on the baseball field sharing what dentists they take their kids to. The difference in the social network medium is that the participants in the network may be unfamiliar with the source of information. When a testimonial is shared, others in that network vicariously share the attributes.

The referral network is sponsored by a name-brand Web site company. It capitalizes on its name recognition in the market as its authority to direct new buyers to a market. In business, it offers a form of customer acquisition. It brings a community of potential purchasers that the seller would not likely have access to or does not have the resources to cultivate. The Web site sponsored by the component dental society is an example.

The review network shares similarities with the referral network. This network gathers reviews from past purchasers. The testimonial source is often unknown to the seeker. The review network may either directly refer or imply referral to the seller. There is typically a multiplicity of testimonials.

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The coupon network is a crossover for the price-sensitive buyer and the brand-loyal buyer. Depending on the structure, a potential seller will subscribe to this network. The seller is also “purchasing” access to a customer base. The seller hopes to capitalize on a finite audience who seeks price-sensitive incentives to purchase.

The information hub network presents itself as a consumer resource of information. It can be a company explaining its products or services. It can be institutional and provide generic information relative to their field of expertise. It can be proprietary and profess to be a self-described expert.

THE OPPORTUNITY

The object of engaging in social media is twofold. It is an electronic “word of mouth” media to introduce a practitioner to the market. It is also a virtual community to groom social capital to develop a presence and reputation.

Social media consumption is driven by the market. Contemporary patients get information, education, and news from electronic media and print media. Social media is distinct from traditional media, such as newspapers, television, and film. It is relatively inexpensive and accessible to enable anyone to publish or access information. The attractive features for a small business to use social media are low start-up, low maintenance costs, and broad reach.

THE CHALLENGES

Dental conventions are excellent venues to observe emerging trends in the profession. Companies designing computer software have evolved to Web site developers. Web site developers have expanded into the burgeoning market of

social media marketing. In the current down economy and the hunt for patients, practitioners desperately look for solutions. Social networking tools are positioned as salvation.

As social media infiltrates business marketing there is a shift from mass marketing to a faceless audience—to individuals, but in mass. As social media infiltrates the marketplace, there are emerging conflicts. As the health professions engage in a field out of their control, there are new rules of engagement. Dentists and patients are creating new and nontraditional roles. Social media brings rewards and risks.

The purpose of the following case histories is to identify potential risks and consider actions to prevent or mitigate them.

CASE HISTORIES

There are two sides to every story. On the surface, a company engages the use of social media to broadcast its wares to a wider audience. The flip side is if there is a disagreement between two parties. The following cases illustrate how disagreements can cascade far beyond an initial difference of opinion or even a common view of what is happening.

CASE 1: A MATTER OF ESCALATION

A pediatric dentist, Dr. W in Foster City, California, treated a four-year-old child with nitrous oxide and performed an amalgam restoration. As the child was walking back to the car, he vomited. The father, Mr. J, was angry and seeks a second opinion.

Dentist #2 implied that Dr. W missed seven cavities and he placed composites.

Mr. J researched the Internet and concluded that “the FDA had reversed its position with regard to the safety of amalgam” and that nitrous oxide is “a gas that causes general anesthesia.” He posted a review that he was misled by Dr. W.

Dr. W discovered the negative posting. She registered a complaint with Yelp about the review being untrue. Yelp referred her back to the author of the entry to resolve the dispute.

A Yelp.com representative offered to sell her advertising on the site. Advertisers have the option of promoting a favorable review to the top position on the site, though they cannot delete or edit unfavorable ones.

Dr. W felt her reputation had already been damaged. She did not want to buy into what she deemed a “protection racket.” Dr. W filed a lawsuit against Yelp.com and both parents.

As the litigation progressed through the courts, the traditional media escalated the profile of this case. The lawsuit encountered two barriers.

Mr. J asserted that Dr. W’s lawsuit was trying to prevent him from speaking against her in a legal maneuver known as SLAPP (Strategic Lawsuits Against Public Participation). He asserted the lawsuit was intended to censor, intimidate, and silence his critic by burdening him with the cost of a legal defense until the criticism was abandoned.

California and some other states have prohibited lawsuits aimed simply at harassing or intimidating people who want to exercise legitimate free speech. California’s laws governing strategic lawsuits against public participation give judges the right to dismiss lawsuits that do not seem likely to prevail on their merits.

The California Court of Appeal for the Sixth District issued an opinion supporting the right of consumers to post reviews of businesses on Web sites such as Yelp.com and to have lawsuits based on such reviews dismissed under the California anti-SLAPP law.

In the second hurdle, the court decided Yelp was protected under Section 230 of U.S. Communications

Decency Act of 1996. This Section holds operators of Web sites harmless for statements posted on their sites by third parties. Yelp argued that it did not generate the content.

The key issue in the case is whether the content of the review is libelous or if a topic of public interest (i.e., amalgam) is being suppressed. Dr. W asserted that the parent libeled her and publically defamed her professional reputation.

The court found that there is “public concern, discussion, and controversy about the use of silver amalgam because it contains mercury” and, therefore, the Yelp review was protected under the anti-SLAPP law because it contributed to the public discussion.

The parents’ attorney further asserted that the suit violated the client’s freedom of speech.

In the Santa Clara Superior Court, Judge Kirwan ruled against Dr. W. The ruling stated that Dr. W must pay attorney fees and costs incurred by the patient’s parents and Yelp related to the lawsuit. Yelp and the parents said they had incurred legal bills of \$113,620, but the judge reduced the fee award to \$80,714.

Analysis

The practitioner had several options as a response to the actions by the parent:

1. Ignore the posting on Yelp by the parent.
2. Attempt to persuade the parent to remove the posting.
3. Petition the site to remove the posting.
4. Negotiate with the parent to remove the posting. This likely entails some concession on the part of the dentist for the parent to give up the action.

5. Issue a refund, take the loss, to minimize further loss of social capital in the marketplace.
6. Initiate a lawsuit against Yelp and the parents.

The unintended results are illustrated in the description of the case. What the dentist assumed as damaging to her professional reputation has become more complex. This precedent-setting court case identified protections to the defendant that are not afforded to the dentist plaintiff. The courts upheld the freedom of speech over the reputation of the dentist.

The drive for vindication was translated into a higher economic cost beyond just the client’s legal expenses. It is difficult to quantify the risk or economic loss to business due to continuing heightened media and social media publicity.

CASE 2: CASCADING EVENTS

Following the extraction of a young child’s tooth, a California pediatric dentist was accused by an angry parent of mistreating his son. Mr. C claimed that the pediatric dentist extracted his five-year-old son’s tooth without anesthesia. He claimed his son vomited, screamed, and urinated on himself while being held down by several assistants during the procedure.

Angry, Mr. C created the “I Hate Dr. D of Bakersfield” Facebook page. In its first 48 hours, the page attracted more

than 200 viewers posting negative reviews. The news of this case, prompted by the Facebook page, escalated. Local television news picked up the story. It became a media event. Protesters picketed the office.

The situation escalated further. The parent posted disparaging attacks about Dr. D on the state pediatric dental society's Facebook page and then on the national pediatric dental society's Facebook page. The target audience expanded to a state and national audience of Dr. D's professional peers.

Still further escalation ensued with a national syndicated TV investigative news program, "Inside Edition," expanding the case to a national audience. The case has now become more than a case of a bad experience. The issue has become an "exposé" on the use of restraints on children by dentists.

Analysis

From time to time, conflicts will arise in any practice where patient expectations are not met. As with any activity requiring human performance, there are unanticipated events. Recognizing there are failures in any human performance is the start of conflict resolution.

Events in this case escalated the parent's response to the incident. The initial tipping point was the dentist's first response to the parent's complaint. The second tipping point was the escalation in a public venue such as Facebook. The third tipping point was the public response by apparently nonpatients of Dr. D to the TV and press media.

In typical disputes on treatment where the issue cannot be resolved

between patient and dentist, a complaint can be directed to either state association peer review or to the state dental licensure and enforcement board. In cases of egregious harm, malpractice suits ensue.

In this case, the parent expanded the issue to the "court of public opinion." The dispute extends beyond the actual treatment. The parent's action now fits a description of "cyberbullying." Cyberbullying is defined in legal glossaries as actions that use information and communication technologies to support deliberate, repeated, and hostile behavior by an individual or group intended to harm others. Examples of what constitutes cyberbullying include communications that seek to intimidate, control, manipulate, put down, falsely discredit, or humiliate the recipient.

CASE 3: ONLINE RATINGS AND REVIEWS

In highly competitive markets, companies look for a distinctive edge. In urban markets, the concentration of dentists is a drive to compete in the same venues. We are being graded in the public arena, whether or not we choose to participate.

An extreme example of concentration of dentists within a confined urban geographic space is a building known as 450 Sutter in San Francisco, California. This building has the single most concentrated aggregate of medical and dental practices. One hundred sixty-two dental practices (across all dental specialties and includes multi-specialty practices listed under fictitious names) are included in their directories.

Online listing sites have supplanted the printed Yellow Pages as the first place a consumer looks for information. Yelp has developed a growing market share as that online listing site. San Francisco is the headquarters of Yelp.

In competitive markets, companies must expend resources to enable the market (consumers) to be aware of

their existence. Companies such as Yelp become intermediaries. They have cultivated a body of potential customers. They create communication channels in the market between potential buyers and potential consumers.

The following excerpt comes from the Yelp Web site. It offers a view of what Yelp perceives they bring to the table for prospective clients:

- Yelp was founded in 2004 to help people find great local businesses like dentists, hair stylists and mechanics.
- Yelp had an average of approximately 71 million monthly unique visitors in Q1 2012.
- Yelpers have written over 27 million local reviews.

CASE 4: TRAPPED

San Francisco is a highly competitive market. Dr. R engaged Yelp, paying \$200 a month in 2004 and 2005 for online advertising. She canceled because she was unhappy with reviews she considered defamatory and untrue. She asserted that her Yelp reviews got even worse after canceling. Positive reviews disappeared from the site and negative ones became more prominent.

In 2011 she yielded to the solicitation from the site's ad sales team. She was paying \$500 a month for the ads. The principal advantage she gained was the right to choose a review that is displayed at the top of the results. Yelp says, other than selecting this one review, businesses cannot influence the order of reviews or which ones disappear from the site, no matter how much they pay.

Dr. R believed she was trapped and compelled to advertise on Yelp or

negative reviews could rise to the surface, impacting her practice. There have been lawsuits against the Internet review Web site Yelp.com alleging that it extorts businesses by posting more favorable reviews if they buy advertising.

The practice of “gaming” the site is described when business owners solicit favorable reviews or even hire people to write them. Ms. B accuses Dr. R of posting “dummy” positive reviews of her own practice. Yelp is wary of this practice.

Users and business owners may contest entries by petitioning to Yelp to report reviews that do not meet the site’s guidelines, such as reviews by people with conflicts of interest or those who make personal attacks.

From the dentist’s point of view, if the entry is untrue, incompletely true, or fabricated and not removed, the dentists can opt to respond publicly in an attempt to set the record straight or may file a lawsuit. This can be an arduous process to prove a negative or be handicapped by privacy laws to completely disclose one’s side of the story. Or the dentist can attempt to subordinate the negative entry with positive ones.

U.S. District Judge Edward Chen, in October 2011, dismissed two class-action suits filed by businesses that alleged Yelp threatened to degrade their ratings if they did not advertise on the site. There was insufficient evidence to prove the business practice of manipulating positions of reviews existed.

Analysis

This case is an interesting examination of power in the marketplace and how the marketplace drives decision making. Among the definitions of power is the possession of control, influence, or command over others. It is further described as the ability to make people (or things) do what they would not otherwise have done.

In the study of power, the following algorithms illustrate and are consistent with the interplay of social media and a practice.

- A has effects on B’s choices and actions.
- A has the capacity to move B’s choices and actions in ways that A intends.
- A has the capacity to override opposition from B.

The relationship between A and B described by propositions 1, 2, and 3 is part of a social structure and has a tendency to persist.

CASE 5: FALSE PROTECTIONS

A class-action lawsuit filed November 29, 2010 in the U.S. District Court for the Southern District of New York claimed that waivers Dr. M had patients sign prior to treatment violate New York law, misuse federal copyright laws, and violate dental ethics.

Mr. L of Huntingtown, Maryland, went to Dr. M’s office with a toothache in October 2010. Before treatment, Mr. L was asked to sign several forms, including a “Mutual Agreement to Maintain Privacy” that claimed the Health Insurance Portability and Accountability Act (HIPAA) contains “loopholes” that allow dentists to use patient information for marketing purposes.

By signing the agreement, Dr. M would promise not to use any of Mr. L’s information for marketing purposes. In return, Mr. L would agree not to denigrate or disparage the dentist on the Internet or other broadcast media, according to the complaint.

As the health professions engage in a field out of their control, there are new rules of engagement.

Dentists and patients are creating new and nontraditional roles. Social media brings rewards and risks.

Even though Mr. L wondered why he was being asked to sign such a form and whether it was even legal, he complied. Mr. L claimed that he was in excruciating pain for almost a week following treatment and did not have time to find another dentist.

Mr. L was also told he would have to pay Dr. M directly for his treatment and that her office would send the treatment plan to Delta Dental for reimbursement, according to the complaint. He was charged \$4,766 for two office visits, including a single filling. Dr. M's office subsequently submitted the claim, but told him it was rejected. Mr. L contends the claim was purposely sent to the wrong company.

He then asked for his records so he could submit the claim himself, but Dr. M referred him to a third party that demands 5% of the total bill for copying the records, according to the lawsuit.

As a result of his dealings with Dr. M, in August 2011 Mr. L posted negative comments about her on several Web sites, including Yelp and DoctorBase. The next day Dr. M sent Mr. L a letter warning him that he had violated the agreement he had signed prior to treatment and threatening to sue him for breach of contract and copyright infringement.

The following month Dr. M sent letters to the two Web sites demanding that Mr. L's comments be removed. The letters also disclosed Mr. L's personal information, a HIPAA violation, the lawsuit claimed. The Web sites refused to remove the comments, saying they regard purported copyright assignments as legally unenforceable.

Dr. M then began sending invoices to Mr. L, charging him \$100 per day for copyright infringement. She also sent another letter threatening to sue him.

Mr. L engaged a public interest group, Public Citizen, to file a lawsuit against Dr. M. The lawsuit is the first to directly address the issue of restricting online criticism. It sought an injunction against imposing the agreement on Dr. M's future patients and a declaration that the agreement with Mr. L was null and void. In addition, the lawsuit alleged that requiring patients to sign the agreement violates dental ethics and is a breach of the dentist's fiduciary duty. The suit asserted that being forced to sign these documents before care was rendered placed her interests above those of her patients. It also misused copyright law to stifle public criticism.

Analysis

On the surface, it may appear reasonable from the practitioner's frame of reference that a patient should agree to sign waivers before the dentist renders care.

A power dynamic emerges. When one party has something that a second party wants, the first party now has power over the second. This is described as a power differential. The dentist is seen as withholding care, coercing the patient to agree to conditions under duress. By withholding care, the dentist exerts an unfair advantage over the patient. In the extreme, this may constitute extortion. In addition, the legal system holds a higher value to protect rights guaranteed by the Constitution, particularly the Bill of Rights, which includes the First Amendment Right to Free Speech.

There is an unfair leverage of power over a patient. The action creates an ethical challenge for the dentist. An unanticipated effect emerges where the

court protects the patient's rights over the actions of the dentist as a protection from litigation.

EMERGING OPPORTUNITIES AND THREATS

The use of social media is opening new variations in how professionals engage patients.

Information Web sites

By providing health information online, Web sites gain social capital in the marketplace. They position themselves to be the authority on the information.

In our frame of reference, we value peer reviewed, professional association-based, even government institution-based resources. The consumer is less likely able to differentiate credible science from junk science. Consumers with predisposed points of view will choose a reference that favors their position. However:

- For those consumers who are truly trying to be informed, how can they determine legitimate sources from those with hidden agendas?
- If the link is sponsored, is there an underlying message to sell something? Advertising placement is planted in customer pools most likely to consume their products. Is there risk of implied commercial influence?
- If a case history is used to illustrate a condition, can the patient be identified and therefore violate privacy or HIPAA regulations?
- When a previously unknown consumer solicits professional advice from a Web site, is there an implied dentist-patient relationship?
- Is there diagnosis and advice without a visual or hands-on exam or insufficient info?

- Does the rendering of an opinion constitute a practice of dentistry outside of the licensure jurisdiction of the source?

Blogging or Answering Patient Inquiries Online

- How do you know who is the recipient of the information on the other end?
- Can this be further transmitted against the consent of the patient?
- Given the information by the sender online, is this a complete picture with which you render an opinion.
- Can the statement be taken out of context?

Professional Criticism

- Is there risk of negatively commenting or implying about treatment rendered without looking at it directly or considering complete analysis of the variables when care is rendered?
- Is there is risk of providing uninformed, unqualified opinions?

Secondary Risk Via Office Staff

The office staff's use of social media can pose risks:

- Offhand comments about patients (disparaging or violating privacy)
- Obtuse violations of confidentiality statements
- Lack of calibrated responses from the office social media
- Dispensing advice beyond the scope of their duties

When a previously unknown consumer solicits professional advice from a website, is there an implied doctor patient relationship?

INTRODUCTION TO SOCIAL MEDIA

Michael Meru, DDS

ABSTRACT

This overview of social media categories some of the typical types and uses of this form of communication and suggests common courtesies and effective strategies for participation in the social media culture.

Whether by choice, coercion, or sheer necessity, each of you reading this has most likely, in some form or fashion, participated in social media and electronic communication. To define social media, let's look to the wiki of wiki's, Wikipedia, which states that social media is "media for social interaction, using highly accessible and scalable communication techniques. Social media is the use of Web-based and mobile technologies to turn communication into interactive dialogue." To break that down further, social media would be a Web site or Web portal that does not just provide information but creates interaction and user generated content while giving you that information. Thus regular media would be one-way communication while social media would be two-way communication.

With the millennial generation nipping at our bootstraps and seeing that 22% of time spent online is on social media sites (<http://thesocialskinny.com/99-new-social-media-stats-for-2012/>), and with 65% of adults now interacting via social media, it is essential that we become familiar with this phenomenon. In 2010 Kaplan and Haenlein categorized social media into six types: collaborative projects, blogs, content communities, social networking sites, virtual game worlds, and virtual social worlds (*Users of the world, unite! The challenges and opportunities of social media*. Business Horizons, 53, 59-68). These sites and portals come in various forms that the layperson is more familiar with includ-

ing: social networks, Internet forums, wikis, blogs, video-sharing, photo-sharing, microblogs, podcasts and videocasts, and consumer rating sites, among others.

So why do 62% of the worlds population connect through social media and 85% through email (www.huffingtonpost.com/2012/03/27/email-connects-the-world_n_1381854.html)? How did the social media epidemic take hold of that many in just a decade? While the answer to this inquiry is complex, there are three main reasons for why our world uses social media: connectedness, ease of communication, and the gossip factor. While use of social media has increased the ability to stay connected to a larger number of people than ever before and has made communication as easy as 140 characters in a message, the gossip factor is what draws in many people. The cliques at the country club no longer have to gather to get the skinny on who is thinking of running for state office or to find out which supplier is offering bargains. Now all they have to do is pull their sleek phones out of their pockets and log into their favorite social media site. And to look sophisticated doing so. It is human nature to want to gossip and social media plays right to that attribute. While it is only the minority of users who regularly post, the majority of social media users are



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voyeurs who sit back and watch the egos and drama that occur online. In times past you had to be a part of the clique to be in the know, now all you have to do is log in.

With more than 200 well-known social networking Web sites in existence—and that only covering one of six categories—it would be difficult to describe each here. With that said, the following sites are some of the most popular within the dental profession:

- *Facebook* is the most widely used social networking website in the world that was created to connect friends, family, and business associates. As of the day this article was written, Facebook had 960,930,020 users.
- *Twitter* is a microblogging and social media site that allows users to send and read text-based messages (tweets) of up to 140 characters to those who choose to follow them or that they choose to follow. There are currently over 500 million active users.
- *Wikipedia* is an online, user-generated encyclopedia that anyone can add to or edit. A wiki is any Web site that allows users to create and edit content online.
- *Instagram* is a social networking site for posting and sharing photos that can then be linked into users Facebook, Twitter, and Tumblr pages.
- *Pinterest* is a virtual pinboard where users can share photos found on the Internet that interest them. With this site users can also follow other users whose content they find interesting.
- *Yelp* is an online city guide that helps people find places to eat, shop, play, go to the dentist, physician, etc. The guide is completely user generated, and reviews are completed by those who have been to the place of business (it is hoped).
- *LinkedIn* is a business oriented social networking site where its 175 million members can build relationships and find information about prospective employment. Members can search for jobs, research companies, network with business colleagues, and share resumes.
- *FourSquare* is a location-based social network where users check in at locations via GPS on a mobile device and share it with friends. This encourages users to frequent locations that receive a high volume of check-ins, thus indicating its value or trendiness.
- *Google+* is what some call Google's answer to Facebook, though that only scratches the surface. Google+ is core to Google's mission "to organize the world's information." This information network has photo sharing, video-sharing, videoconferencing, video broadcasting, a social network, games, and a local Yelp-type site, among others.
- *E-mail*. While the experts are split on whether e-mail truly is social media, it is a modern form of communication that is ubiquitous in our

While it is only the minority of users who regularly post, the majority of social media users are voyeurs who sit back and watch the egos and drama that occur online.

world. It can be as simple as a one-way broadcast advertisement or an in-depth conversation to as many people as we can CC.

While there are so many others that could have made this list, it is hoped the point has been made that using social media is the way the world communicates today.

As with any form of communication, ethics, professionalism, and proper etiquette still apply, though they may be much easier to forget or breach due to the speed of the communication and lack of intimacy in the contact.

Social Media has changed the way we hear each other. The tone has become less personal, more intrusive, and even ruder. There is something like a civility blanket that has made e-mails less personal than face-to-face communication. It is a wise rule of thumb to assume that those reading your messages will not have the nonverbal cues that normally aid communication and the filter will work selectively in the negative direction. Assume that anything that can be misunderstood will be. Humor is difficult, and sarcasm and irony are invariably DOA. Extremely abrasive remarks that are assumed to be protected behind the anonymity of the electronic firewall are called “flaming.” Don’t flame.

When the typical person today wakes up to a smart phone alarm clock, checks e-mail while laying in bed, heads to the office to spend a good portion of the day in front of a computer, plays with an iPad at lunch, heads home with smart phone in hand, and finishes the night watching a movie that is streamed to a

smart TV, we must ask ourselves, what is the limit of the social media viewers’ attention? The sheer volume of electronic communication has diminished attention span. Like it or not, we are all competing for the eyeballs and interests of our friends with a hoard of slick propagandists armed with batteries of electronic weapons. When our friends throw out the dirty bathwater of commercial racket, we are in danger of being the baby that goes out as well. Further, we may compose our messages on full-sized screens in the comfort of our offices only to have them read on handheld devices with tiny screens on short elevator rides. This is not a counsel to stop saying things that are important or to trivialize complex topics, but help must be given to those who receive our messages. It is a good idea to announce the topic in the first sentence. If there is more than one subject to be mentioned, number them. If action is requested, say so and underline it. These techniques were articulated by Winston Churchill in one of the first (dictated and typed) memos he issued as prime minister at the beginning of the Second World War.

Social media triage is now a required skill. As soon as the message is received, do one of the following: (a) delete it—just gossip; (b) block the sender—prevents further solicitations from unwanted sources; (c) respond or forward and delete—if no research is needed to answer, do so quickly; (d) acknowledge—say when the request will be answered. The worst thing you can do is let the messages pile up, usually leading to embarrassment. If the techniques above are used, you have converted your e-mail system into a “to-do” list. If someone responds to a request you have made, thank them.

With the constant exchange of information that occurs in social media, who should be the ones to receive our

messages? The average user on Facebook has 229 friends (12 <http://pewinternet.tumblr.com/post/23177613721/facebook-a-profile-of-its-friends-in-light-of>), and each time a user posts, each of those 229 friends will see that message. E-mail has slightly more control, but there always is a danger that e-mail messages may get to people for whom they are not intended. It is all too easy for a friend to tap the “forward” or “reply all” button and send your note to someone you would have preferred not get the message. The best protection in such cases is not to say controversial and negative things in the first place. If that advice cannot always be followed, limit the number of people who get the message and be clear about the sensitivity of the material.

For e-mail, use the “bcc” field in the address function to control chatter among recipients of your messages. There may be no reason why all those getting your note need to have the e-mail addresses of everyone else (they might even value their privacy), so consider broadcast messages addressed only to “bcc” lists. If various individuals have different roles to play in a shared activity, send the base message and background attachments to everyone and short customized separate messages to individuals.

The aforementioned courtesies and best practices differ slightly for each social media application, though in a broad sense they apply to them all. This issue of the *Journal* will delve further into social media and provide a White Paper on the ethical implications of its use within our profession as well as a list of best practices to guide you in your use of social media. ■

SOCIAL MEDIA POLICY IN OTHER ORGANIZATIONS

Carl L. Sebelius, Jr., DDS, FACD

ABSTRACT

Most professional organizations have developed policy for use of social media by their members and several have developed Web sites to help members with ethical media use. It is common among businesses, nonprofit organizations, and government agencies to have policies governing use of media by employees when communicating with the public and provide employee training. This article samples some of the best practices in social media policy. Development of such policy represents an attractive opportunity for dentistry.

Dentists' reputations have cash value. Recently a small army of enterprising people has emerged to help manage this resource—for their own good, of course. The low cost of using electronic media and the ability of those with little training in the science of marketing has fueled something like an epidemic. It is called, in the jargon, “going viral.” There are two dangers to watch for and avoid. On one hand, dentists can use social media as a substitute for good dental care or even, in rare cases, compromising it. Second, others can use social media to diminish the reputations of dentists who are providing excellent oral health.

American industry, the nonprofit community, and professional organizations have recognized the need for guidelines and standards to promote appropriate use of social media. Some of these standards are presented here.

POLICIES IN OTHER PROFESSIONS

The American Medical Association (AMA) policy statement, *Professionalism in the Use of Social Media*, is an excellent guide (ama-assn.org/ama/pub/meeting-professionalism-social-media.shtml). It places “outgoing” communication by physicians in the context of professionalism. The AMA’s standards specifically references to the professional-patient relationship and notes that “physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any

other context.” Patient privacy and confidentiality are cited as requirements. It is urged that physicians establish separate systems for personal and professional communication and use available privacy settings. Because privacy protection is not always adequate, physicians are urged to monitor their own sites.

Point (e) in the AMA policy is worth quoting at length and verbatim. “When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate action. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.” This policy is grounded in an additional policy point that the postings of any physician affect the reputation of all physicians.

The American Bar Association (americanbar.org/groups/bar_services/resources/socialmedia.html), the American Nurses Association (nursing-world.org/socialmedia), the American Institute of Architects (aia.org/about/



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aiab083034), and many other professional organizations have similar policies. In some cases, these organizations have online resources that help professionals participate ethically in social media. The Canadian Dental Hygiene Association has an excellent site with a moderator designed to assist hygienists. The site is hosted by the Canadian Dental Association (blog.cdha.ca/?p=404). The thrust of professional organizations involvement in social media appears to be to offer assistance in responsible use by professionals.

POLICIES TO PROTECT ORGANIZATIONS

Virtually every large organization has a social media policy. The policies are intended to recognize the free-speech rights of employees to express their opinions while simultaneously protecting the interests of the organization.

Some companies encourage employees to blog and carry on professional communication (content.dell.com/us/en/corp-comm/social-media-policy.aspx; hp.com/hpinfo/blogs/codeofconduct.html; forums.com/t5/welcome-news/best-buy-social-media-policy/td-p/20492)

Social media policy in corporations is intended to guide the behavior of employees and customers alike—but in different ways. Corporate policy for employees establishes guidelines for blogging, responding to customer communications, and general e-mail use. The most common themes across these policies include:

- Be civil, thoughtful, and professional
- Be transparent, always disclose who you are, what your capacity in the organization is, and why you are communicating
- Do not break the law by defaming or slandering; revealing corporate, copyrighted, or other protected information; or misrepresenting products or services

- Where corporate policy regarding electronic communication from customers exists, it is for the sake of establishing expectations regarding participation in media conversations hosted by the company (corporate.walmart.com/social-media-guidelines; blogs.cisco.com/news/ciscos_internet_postings_policy). Corporate policies for customers who want to use company media platforms, including responses to company bloggers, typically mention:
 - No foul or offensive language
 - No advertisements or self-promotional material
 - No product support, refunds, or other business transactions (these are handled through other channels)
 - No illegal activity, including comments that defame others
 - No spam or repeated postings of the same message
 - No anonymous postings or postings attributed to those other than the writer

Generally, companies that host sites reserve the right to review and decline publication of outside comments. The Mayo Clinic has a very strongly worded comment policy (mayoclinic.org/blogs/comment.html), and the American Red Cross has a liberal one (docs.google.com/document/pub?id=1peevqnjjvknybdllhx4).

There are a number of not-for-profit organizations that offer suggestions and services to others, especially individuals and nonprofits, to help write social media policy (socialfish.org/2009/10/drafting-socmed-guidelines.html; socialvoice.liveworld.com/blog-entry/bryan-persons-blog/creating-social-media). One excellent example is Shift Communications (www.shiftcomm.com), which invites imitation of its

ten-point template, as follows:

1. Be transparent about who you are and who you represent.
2. Never misrepresent anything about the company.
3. Stay on topic and be meaningful.
4. Use common sense and check with others if in doubt.
5. Do not speak beyond your area of expertise.
6. When disagreeing, be polite.
7. Be very careful, diplomatic, and factual when writing about others.
8. Avoid legally protected topics.
9. Never comment online about a crises or emergency situation.
10. Always bear in mind that electronic communication can be discovered by almost anyone, not just the person you have in mind when communicating.

There are also organizations that take a very liberal stance on free speech. This ranges from the Associated Press (ap.org/images/social-media-guidelines_tcm28-9832.pdf), which has developed a useful set of standards, with concrete examples, for journalists to the Electronic Frontier Foundation (eff.org/wp/blog-safely) that offers online advice on establishing anonymous blogs for employees who want to criticize or bring legal action against companies. The Media Law Resource Center (mlrcblogsuits.blogspot.com) maintains a Web page listing the status of current law suits involving challenges to online speech.

I have not been able to locate a corporate policy that attempts to dictate or curtail what customers can say on third-party sites. Recent court cases suggest that that would be a violation of freedom of speech.

POLICIES IN DENTISTRY

A letter was sent from the Office of the American College of Dentists over my

name to all (46) executive directors of state dental associations. The letter took the following form:

What has the [name of the state] Dental Association done to address actual or potential problems related to the use of social media by dentists, dental staff, and patients? We are especially interested to learn what policy statements or training opportunities you have planned or undertaken designed to promote appropriate ethical behavior on the part of dentists in this challenging new world.

Responses were received for 17 of the 46 associations (37%). It is very likely that the non-responding associations do not have formal social media policies. Of

those that did respond, three said they have a policy, and two of these have published their policy. Nine state associations reported providing some form of social media training, including articles in their journals or other publications. Among the activities states have pursued in this area are the two policy statements that appear in the sidebars, continuing education courses in four states, journal or newsletter articles in three, changes to judicial or ethical committees in two, publication of an “employee handbook” and Web comments. Five states have recognized the ADA Council on Ethics Bylaws and Judicial Affairs advisory opinion on Groupon/fee -splitting. It should be noted that the two policies provided apply only to staff and officers

in their capacities as representative of the state associations. They are not intended as policy for dentists practicing in the states.

While the response rate was low, this is probably a fairly representative national picture in dentistry. It appears that the use of social media is becoming a more widely recognized situation, which has been affecting the public in general, and no less the dental profession. In view of the fact that no state associations have developed policies for practitioners, there is potential concern that discussion leading to profession-wide standards for the use of social media would be helpful. ■

NEVADA DENTAL ASSOCIATION Social Media Policy

The following applies to Staff, Officers, and Dental Volunteers who create or contribute to social media, including but not limited to: blogs, social networks, wikis, and online forums,

A social media changes the way we socialize and conduct business, it is important to remember that what you do online is ultimately linked to your personal and professional views, and that your “virtual footprint” can be tracked and traced.

The NDA respects Staff, Officers, and Dental volunteers’ right to participate in online forums for personal reason during non-work hours.

All NDA Staff, Officers, and Dental Volunteers participating in social media and online commentary are expected to use their professional judgment prior to posting anything online and to adhere to all NDA policies as detailed in the Employee Handbook.

Content posted on blogs, social networks, wikies, and other online forums should comply with the association’s confidentiality and employee ethics policies. Any work-related comments should be respectful and

relevant in a way that protects the association’s brand and reputation and follows the letter and spirit of the law. Written consent is required to use a NDA logo.

Your online presence reflects upon the NDA and its brand. Be aware that your actions captured via images, posts, or comments can reflect that of the association, regardless of whether it occurs during work hours. Tips for maintaining your and the NDA’s professional image online:

1. Keep your personal and professional lives separate to help protect your own privacy. However, if you use professional networking sites like LinkedIn, please do promote your role in the NDA in a positive way.
2. Remember that even anonymous comments can be traced back to your IP address, so use NDA internet access for work-related purposes only per the Employee Handbook. Do not use you NVDA.org e-mail address as the address associated with any personal social networking sites.
3. Post meaningful, respectful comments that positively promote your role as

a NDA employee and reflect on your co-workers/ colleagues, department and organization.

4. Respect Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.
5. Be transparent. Do not misrepresent yourself.
6. Respect copyright laws and reference or cite sources appropriately.
7. When disagreeing with others’ opinions, keep it appropriate and polite. If you find yourself in a situation online that looks as if it’s becoming antagonistic, disengage from the dialogues in a polite manner.
8. Never participate in social media when the topic being discussed might be considers a crisis situation.

When in doubt about posting a comment or image, don’t! Protect yourself, your privacy, and the NDA’s confidential information and its reputation. What you publish is widely accessible and will be around for a long time, so consider the content carefully. Google has a long memory.

OKLAHOMA DENTAL ASSOCIATION NETWORKING DRAFT POLICY

BACKGROUND

Asocial networking has become a popular means of networking and quick communication. Because of its intense popularity, the ODA has been compelled to enter into new territory in order to more effectively communicate with member's dentists, staff, committee, boards, and councils.

Online communicates and commutation mediums have helped people connect in many positive ways. Through these online mediums, ODA members, staff, and other affiliations with the ODA now have the ability to create relationships of those with similar interests, formed groups to explore and learn about the profession, and transformed the ways that we communicate with each other in formal and non-formal means. The Association realizes the impact these mediums may have on its members, staff, board members, and affiliations.

There are multiple social networking mediums and as the market continues to change, the intent of this policy is to protect the Association and its members and staff equally. Examples of current key social networking sites are:

- Facebook
- Twitter
- LinkedIn
- MySpace

Policy Scope

1. The requirements of this policy do not apply to the use of personal profiles unless used in the capacity of official Association business. This applies to any individuals serving on councils, commissions, consultants, or any position that directly works with the operations and presentation of the Oklahoma Dental Association. If you are utilizing Association Services as allowed to manage your personal profile the policy is applicable.
2. This policy applies to the use of any social networking medium intended for consumption by members, and to the use of social networking media on behalf of the Association for any purpose.

3. This policy applies to any interaction with any social; networking site whereby "Association Services" (defined below) are utilized in the viewing, posting or any other interaction with any such social networking site. For the purposes of this policy, "association Services" means any services performed by ODA personnel, any services performed on ODA personal property, and any services performed on behalf of or at the request of the ODA.

OKLAHOMA DENTAL ASSOCIATION PROTECTION

Social networking sites are a useful and effective tool in communicating with the Oklahoma Dental Association member and general public. Thus, certain sites have been identified as a means for the Oklahoma Dental Association's marketing and technology efforts, and communication efforts for committees, councils, and board operations. When a group, page, event, profile and the like are created with representative Oklahoma Dental Association, it becomes a direct representation of the ODA to the members and participants of these social networking sites, and can be perceived with as much credibility as a news article or Association position or advertisement, in the best interest of the Association, this communication may be monitored in conjunction with an administrative awareness of all forms of outreach on such sites. As a public operation, ODA is held to the highest ethical standards and is accountable for the way it is represented to all internal and external audiences. Staff, committee, council, consultant, and board members of the Oklahoma Dental Association are seen as role and representative models in the dental community and profession. As staff representative of our members, employees directly representing the Association have the responsibility to portray the Association and themselves in a positive and respectable manner at all times.

Recognizing both the effectiveness of social networking sites and the need for a form of official management to protect the interests of the Oklahoma Dental Association and professional relations

this policy is to manage and outline the policy involving the Oklahoma Dental Association's social networking accounts.

Social networking at/through the Oklahoma Dental Association is encouraged, but must be managed through the Communications Advisory Board and reported to the Executive Director and Board of Trustees of the Oklahoma Dental Association to ensure the integrity of the account and any information communicated on behalf of the Association.

PURPOSE

The purpose of a social networking policy is to ensure that all appropriate Association policies are followed while working within or outside of the confines of the Oklahoma Dental Association network and media.

DEFINITION of Official

Official ODA social media sites are sites that were started with the directive and permission of the ODA Executive Director and the Communications Advisory Board. These sites are managed by ODA staff or volunteers under the supervision of the ODA Executive Director and the Communications Advisory Board.

REQUIREMENTS FOR USING SOCIAL NETWORKING SITES FOR OFFICIAL ASSOCIATION BUSINESS

1. In your capacity as an employee, volunteer, council or committee member, board members of consultant, or when posting on ODA social media or on behalf of the Association, the intellectual property that you create and publish to social networking sites (postings, messages, etc.) can and will be considered the property of the Oklahoma Dental Association.
2. The direct operation and format of social networking sites, or any third-party application service providers, is not under the control of the ODA, and therefore the ODA will only seek to maintain that content over which it has reasonable control.

3. All Association or department level social networking accounts must be managed by an approved, general e-mail account so dual role or responsibility is shared. No single individual is responsible for a social networking account outside of the ODA network system.
4. All profile, group, and fan page originators that communicate and establish relationships on behalf of and for the Association will sign an agreement granting ODA ownership of the profiles, group, and fan page. Should the originator's relationship with the ODA change or terminate, the ODA will retain ownership of the profile, group, fan page, and established relationships.
5. All official ODA social networking accounts created/and or/ maintained must be reported to the Executive Director of the ODA and the Communications Advisory Board of the ODA by sending the following information via e-mail to: Information@okda.org general, ODA e-mail address, the names of all members and their departments, titles, ODA e-mails, and ODA phone information. Requests for general ODA e-mail address (aliases and/or domain e-mail) may be sent to Information@ okda.org.
- 6a. If social networking gathering sites such as "groups" or "pages" must provide appropriate language for ODA's legal and policy information:

Visitors: You are hereby on notice that the ODA does not control all aspects of this Web site. While employees, volunteers, members, consuls, and committees, and consultants of the Oklahoma Dental Association community post to this public third party site, the ODA is not responsible for the views, opinions, and postings by others found on this site. The legal policies and procedures, for members, by which the ODA operates, are posted at www.okda.org.

- 7a. All paid placement marking advertisements place on social networking sites must be developed and approved by the ODA Executive Director and the Communications Advisory Board prior to implementation.
8. Content must be current, reliable, accurate, and grammatically correct, but may utilize Web 2.0 language such as "@username," and other generally recognized methods of online communication.
9. When determining the appropriateness of personal online public material, consider whether it upholds and positively reflects personal values and ethics as well as the Oklahoma Dental Association's Professional Community and the value to the General Public. Remember, always present a positive image and do not do anything to embarrass yourself, your family, or the Association.
10. Personal pages should adhere to the policy when discussing official ODA business. Users should not have a reasonable expectation of privacy on any content posted on a social networking site.

The policies are intended to recognize the free-speech right of employees to express their opinions while simultaneously protecting the interests of the organization.

BEING PROFESSIONAL IN THE SOCIAL MEDIA WORLD

Steven D. Chan, DDS, FACD

ABSTRACT

What is at stake for dentists in the world of social media? Because it is unrealistic to completely avoid the new network, dentists should master some of these skills: risk management, crises management, and reputation management, as well as understanding that the playing field is not even. Guidelines for professional use of media are presented, along with some suggestions for effective participation.

Our editor shared this story with me. An Austrian philosopher, Ludwig Wittgenstein, had been pestering the economist John Maynard Keynes about getting a teaching position at Cambridge. In a particularly pushy letter in 1929, Wittgenstein wrote: "Please don't answer this letter unless you can write a short and kind answer... So if you can't give me a kind answer in three lines, no answer will please me best." Social media is a powerful weapon, but we cannot make it only cut the way we want.

MANAGING DIGITAL COMMUNICATION

Since it is unreasonable to expect that dentists will be able to completely sidestep the effects of social media, they should be prepared to actively engage in managing risk, crises, and their reputations.

RISK MANAGEMENT

The object of risk management is to anticipate harmful behaviors and unanticipated consequences of business processes. The purpose of risk management is to institute practices to avoid and mitigate complaints that impair reputation in the marketplace, complaints to regulatory agencies, or disputes leading to litigation.

Risk management principles are gathered from case history experiences. As risk managers gather a portfolio of experiences, they see patterns of human behavior. Some observers believe that experiences in social media that negatively impact a dentist are only early manifestations in the life cycle. There are

too few cases at this time to see patterns. One must gain a retrospective experience with large enough samplings in order to identify patterns for risk management involving social media.

One of the sidebars at the end of this article outlines some of the principles of good risk management.

In human behavior where anger is aroused, there is an excitation or agitation phase characterized by a strong desire to express the experience. Then there is the infectious phase or the need to share the experience with others. Eventually, there is fatigue and finally the behavior is extinguished. The incident is then forgotten and we go on with our lives.

Entries on the Internet, however, never go away. The risk of social media is the reemergence of the entry, thereby agitating and inflaming old wounds and renewing angst.

DEFAMATION, LIBEL, AND SLANDER

Generally speaking, defamation is the issuance of a false statement about another person that causes that person to suffer harm. Legal definitions vary in statute from state to state. For example, in California, slander includes "imputations that a person is generally unqualified to perform his or her job or tending to lessen the profits of someone's profession, trade, or business.



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Slander is defined as oral defamation, in which someone tells one or more persons an untruth about another, which untruth will harm the reputation of the person defamed. Slander is a civil wrong (tort) and can be the basis for a lawsuit.

Libel involves the making of defamatory statements in a printed or fixed medium, such as a magazine or newspaper.

Damages are typically to the reputation of the plaintiff, but depending upon the laws of the jurisdiction, it may be enough to establish mental anguish. Damages for slander may be limited to actual (special) damages unless there is malicious intent, since such damages are usually difficult to specify and harder to prove.

Some statements such as an untrue accusation of having committed a crime, having a loathsome disease, or being unable to perform one's occupation are treated as slander per se, since the harm and malice are obvious and therefore usually result in general and even punitive damage recovery by the person harmed.

CRISIS MANAGEMENT

Where risk management attempts to anticipate events, crisis management institutes measures for damage control. The characteristics of a crisis are: surprise, insufficient information, intense escalating flow of events, loss of control, scrutiny from the outside, siege mentality, panic, and short-term focus. Key principles in handling crisis:

- Control information
- Isolate a crisis team from daily business
- Define the real problem short-term and long-term
- Recognize the value of a short-term sacrifice
- Resist the combative instinct

MANAGING ONE'S PROFESSIONAL REPUTATION

THE IMPORTANCE OF REPUTATION

Benjamin Franklin reminds us that "It takes many good deeds to build a good reputation, and only one bad one to lose it."

In building one's career as a dentist, there are many things we hope to achieve. We work at performing our craft well. We work at making a living from our craft. We work to build our reputation from our craft. What is reputation?

For many, building a reputation means accruing a favorable array of attributes and experiences among members in a community. The drivers are egoistic and economic. Reputation is considered a component of identity or image. It is a series of beliefs about a person or entity based on the opinions of others. To be more precise, reputation transmission is a communication of an evaluation without knowledge of the specifications of the evaluator.

In developing a reputation, there is a life cycle. As any new entrant to a

It is probably an illusion to believe that one might opt out of the social media world. Under the circumstances, it is prudent for professionals to assume that they must act professionally at all time.

The practitioner must defend a negative in the court of public opinion but is gagged by patient privacy concerns when doing so.

community, one is unknown to the members of that community. The title of “Doctor” may bring some immediacy of respect due to the elevated status afforded in society. However, as an unknown to that community, you now have to prove yourself.

At first, reputation begins with a declaration to the marketplace of an image. It is a self-description of how one wishes to be identified to the consumer. In the early stages, the image is most likely transmitted via traditional advertising vehicles such as ads in various print and electronic media. In these early stages, there are few experiences among members of a target community that have personal experience with the practitioner.

One’s reputation is also revealed by behavior. Does one’s actions support its claims? Does one own up to an imperfection or flaw in the product or service? A reputation is revealed by action in the face of adverse events. When Johnson and Johnson was faced with the crisis of cyanide laced Tylenol in 1982 and 1986, it immediately chose to pull all product off the shelf. Thirty-one million bottles were removed at an estimated value of \$100 million. Tylenol was a core product for Johnson & Johnson. The crisis enabled the company to reposition its image when it introduced tamper-resistant packaging to the market place.

As a community’s experience with the practitioner matures, the transmission of one’s image expands from testimonials. Eighty-seven percent of U.S. consumers consulted friends or families and professional or online reviews when researching a product or service.

MEDIA THREATS TO REPUTATION

The greatest reputation threat online to companies is negative media coverage (84% of surveyed Americans say so). The next two greatest threats are

customer complaints in the media or grievance sites online (71%) and negative word of mouth (54%). This negative word of mouth could be not only from dissatisfied customers but from employees as well.

Historically, disputes between dentists and patients have involved only those two parties. Social media is changing this interaction. Social media brings an audience to a broader conversation.

There are emerging hazards of practitioners engaging social media. At the core of the dark side, social network exposes the vulnerability and fragility of reputation. It is the fear of damaging or impairing one’s reputation in the market place.

The social phenomena of “word of mouth” or informal transmission of a person’s experience with a service provider to others is not a new concept. The conveyor of information is described in sociological terms as a “vector”—transmitting information from one social cluster to another. Social media broadcasts the transmission far beyond the social cluster of origin. Social media propagates both positive as well as negative messages of a professional reputation. Social media now brings a new audience unfamiliar to the original source.

In a well-known experiment, as messages are passed from person to person, the initial message becomes altered, embellished, and exaggerated with each recitation of the message. The downstream message becomes much different than the original incident.

When the exchange in social media becomes adversarial, another disadvantage is the anonymity of the attacker. Attackers do not have to identify themselves. They can adopt fictitious names and personas. It takes time for the recipient of the attack to sift through the entries to determine if the attackers are patients. Then recipients must petition to the site to remove the attack. Meanwhile, the attack has been made,

the damage is done, and no retraction of the falsehood is entered.

The economic damage to a practice is difficult to quantify. Each point of contact with that knowledge now potentially translates to patients deciding not to choose the dentist to service the patient's needs. The net result is "income not realized" due to an unverified rumor.

Ego is a significant factor affecting a professional's decision to defend that reputation in the market. In defending one's good name in the marketplace, ego can affect how far one commits personal economic resources. Recovery may take time and therefore the practitioner may have income not realized from the damage. "It takes 20 years to build a reputation and five minutes to ruin it. If you think about that, you'll do things differently." That is the advice from Warren Buffett.

THE PLAYING FIELD

There is an uneven playing field from the perspective of the practitioner. In disputes referred to local peer review committees, a panel of uninformed, impartial dentists objectively reviews the facts of the case. They render an opinion based on those facts regarding whether the performance meets the "standard of care."

Complaints to a state dental board are sent to consultant dentists to review the records. Typically, the investigation looks for egregious outcomes and gross negligence. While there are state-to-state differences in adjudicating claims, these reviews typically undergo a series of administrative processes before determining an outcome. Only if the findings are decided against the dentist do the outcomes become public.

In complaints to third-party carriers, review is performed by consultant dentists. Typically, review of the records and

clinical review will lead the insurance company to decide whether the treatment is consistent with a standard of care. The outcomes are shared with the patient, the dentist, and the third-party carrier. Typically, there is not a public disclosure.

In social media, a patient can make claims, perhaps unsubstantiated, unverified, and not technically reviewed. The practitioner is enjoined from the conversation largely due to the specter of violating patient privacy. The practitioner must defend a negative in the court of public opinion but is gagged when doing so.

A difficult dilemma for the professional is the norm of granting prima facie credibility to patients' personal remarks while grounding professional responses in objective evidence.

PROFESSIONAL CONDUCT

Historically, professional conduct was monitored wholly by the individual professional bodies. The codes established by the professions were sufficient. These are self-imposed. In order to join, the candidate agreed to abide by the same standards that hold for all colleagues.

A code of ethics marks the moral boundaries within which professionals in that body agree to be ethically bound. In certain areas, where the public interest is considered to be heavily engaged, legislation is imposed on the professional body. Either legislation replaces professional self-regulation with statutory legislation or a statutory body is given authority to supervise the professional association.

Many principles from the *ADA Code of Conduct* can be implied but are not specifically cited in the context of social media. In the current *ADA Code of Ethics*, there is no language pertaining specifically to the overall subject of social media, as there is in the code of the American Medical Association.

Social media is challenging traditional paradigms of dentist-patient relationships. Traditionally, dentist-patient communi-

cation has been a private conversation. Social media now inserts an audience into those conversations.

Social media is creating conflict in traditional dentist-patient communications. Social scientists study the position and role of the professional in the dynamics of that conversation. In this paradigm, there is a "social distance" or separation from the professional to the patient. Social media encourages a leveling of the status among members of virtual communities.

Sharing a bad outcome through word of mouth has always existed. It was often self-limiting through fatigue or merely limited to the contact of the offended party. In social media, parties unknown to the offended party and the dentist now share this complaint. The "posted" complaint never goes away. If there is a resolution between parties, it takes a conscious effort to remove the complaint or publicize the resolution.

GUIDES TO PROFESSIONAL CONDUCT

The following are references to existing standards that serve as useful guides to professional conduct under the heightened scrutiny of social media.

Federal Regulatory Overlay

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information. It applies to health plans, health care clearinghouses, and those health care providers that conduct certain healthcare transactions electronically.

The rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients' rights over their health information, including rights to

examine and obtain a copy of their health records, and to request corrections.

The Privacy Rule is located in 45 CFR Part 160 and Subparts A and E of Part 164.

State Regulatory Overlay

Business and professions regulatory statutes governing and protecting privacy of patients and clients vary from state to state in language and content.

California Rules of Professional Conduct (CRPC) 3-100: "A member shall not reveal information protected from disclosure by Business and Professions Code section 6068, subdivision (e)(1) without the informed consent of the client."

American College—Ethical Handbook

The American College of Dentist's *Ethical Handbook* contains standards on advertising, confidentiality, disclosure and misrepresentation. These continue to be applicable as guiding principles for professional conduct in social media. [See sidebar.]

ON THE EDGE

It is probably an illusion to believe that one might opt out of the social media world. Under the circumstances, it is prudent for professionals to assume that they must act professionally at all times.

The important questions then become those of being a professional participant. A few useful standards for all online communication include:

- Avoidance of overtly or obtusely self-promoting material
- Objective explanations and advice to minimize selective addition or omissions of facts leading the reader to biased conclusions

- Suppression of personal opinions or criticisms of treatment by others
- Full disclosure of risk
- Grounding remarks in evidence

Clean Marketing

Any marketing strategy should be well constructed. Variables such as start-up costs, return on investment, maintenance costs including personnel and personal time to monitor should be considered. Social media is only one tool in that strategy.

Marketing strategy identifies a known target audience and tailors the message which differentiates the practice. Particular attention should define the image you wish to portray to the market.

If engaging a vendor to develop this campaign, there should be a frank discussion of risks and benefits. A "what-if" scenario of an eventual negative review should be a part of this tactical discussion. Here are some ideas to think about:

- Flood your site with good reviews.
- Ask your patients to write good experiences. The object is to dilute or subordinate posted negative reviews.
- Avoid fake user reviews. In some jurisdictions, fake reviews, whether written by the dentist, a staff member, or a third-party marketer, can lead to possible fines, jail time, and loss of license
- The Federal Trade Commission monitors truth-in-advertising, including online review sites. Section 16 CRF Part 255 defines "Guides concerning the use of Endorsements and Testimonials in Advertising." The social networks are governed by federal interstate commerce laws.
- Sites such as Yelp have algorithms that identify artificial entries of positive reviews. They are alert to ploys that "game the system."
- False and misleading dental advertis-

ing is under the jurisdiction of state dental boards.

- Flood your site with community news of what you did. Develop virtual social capital by counteracting negative images with good things you do in a community.
- Go to the host site and inquire about the process to remove false statements.
- Deflect an accusation with a positive spin. From "Dr. X does horrible work" to "Dr. X gives advice on how to recognize substandard work."
- Hire services of Internet reputation companies such as Reputation.com or Demand Force, which propose to manage reputations online.

The Groupon Gambit

This variation of a social media networking site does not fit the model of abuse seen in the prior case histories. The business model of a social coupon network is based on the seller offering a discount or other incentive to purchase their wares. The network collects a fee from the seller to gain access to the pool. For every "hit" from the network, the dentist remits a percentage of that fee to the network.

The Groupon business model brings several principles for the marketing practice. The social couponing company brings customer acquisition. When a new business enters a market, it must expend resources to capture consumers. The social coupon company brings a pool of customers.

The social couponing company brings communication channels. It delivers messaging to the pool of customers that a subscriber company would have to expend resources to continuously connect with those new customers.

The object of marketing is to attract consumers to a product or service offered by a company. Consumers vary

in needs and what attracts them to a product or service. A company should design its marketing to the profile of consumer it wishes to attract.

Groupon consumers are considered to be “price sensitive.” They are more likely driven to seek and consume episodically. They tend to shop from place to place—looking for the next bargain. In Malcolm Gladwell’s *The Tipping Point*, the profile is the innovator. The innovator wants to be the first to try the new thing within the social system. Their drive is to be the first to share the experience with others.

The resources used to attract this profile of patients have to be continuously renewed. This consumer is less likely to be sustainable. The hypothesis—that once the vendor’s wares are sampled, the consumer is likely to be a repeat customer—has not been demonstrated. The risk of engaging this profile of customer is the episodic behavior.

Contrast the “brand loyal” consumers who tend to stick with that vendor or product once they make a decision to consume a service (or product). They are more likely to continuously reaffirm the brand to others in the marketplace.

The ADA Council on Ethics, Bylaws and Judicial Affairs believes that this business model is fee-splitting and therefore an unethical practice. It issued an Advisory Opinion at its March 2012 meeting (See sidebar).

This same ethical concern is expressed in associations such as the American Medical Association and the American Bar Association.

Epilogue

Perhaps we are experiencing social media in just one phase of its life cycle. It is much like every other social phenomenon.

All social phenomena undergo life cycles. Social phenomenon experiences the following stages in a life cycle: discovery, curiosity, novelty, experiment, excitation, infection, expansion, adop-

tion saturation, fatigue, and then they become extinguished.

The growth in the adoption of a social phenomenon is typically seen as an “S” curve. When a social phenomenon is introduced to society, there is a low rate of adoption in the novelty phase. In the growth or exponential phase, there is an explosive rate of adoption. Finally the adoption rate plateaus then declines precipitously. There is a belief that we are experiencing the exponential phase of the social media phenomenon.

While we are in this phase of the life cycle, we do not have the benefit of seeing if the challenges are transient or an integral fabric of the phenomenon. If we adopt media, we should consciously acknowledge both the benefits and tradeoffs of the phenomenon.

Some evidence of the evolving nature of social media is the pushback seen in the marketplace against wholesale, unqualified adoption.

There have been class action lawsuits challenging alleged unfair business practices of online review companies. While the suits have not prevailed, and challenges have favored the online companies under the Communications Decency Act, online companies have adjusted their policies responding to resistance in the market.

In general, as social phenomena become adopted by the greater whole of a population, the phenomenon adjusts to market forces. It undergoes corrections to accommodate that greater part of the market.

Meanwhile, from the current vantage point in the life cycle, one can only see the immediate threats—the negative

A difficult dilemma for the professional is the norm of granting prima facie credibility to patients’ personal remarks while grounding professional responses in objective evidence.

reviews, the attacks. One does not yet have the benefit of perspective. As with many social phenomena, the manifestations vacillate to extremes. All social phenomena are best seen with clarity in hindsight. There are times to take a deep breath and be patient.

SUMMARY

In the face of some emerging adversarial elements of social media, a dentist is still held to a higher level of conduct by society. He or she should be a professional. There is an unwritten code that the dentist should be unemotionally attached in delivering or receiving the message.

However, a dentist does not operate in society in isolation. In today's marketplace, he or she could choose to:

- Be optimistic. The marketplace will self correct.
- Adapt as the phenomena changes.
- Be patient. Wait to see what early adopters do. Observe the mistakes, successes and failures, and what survives in the marketplace.
- Not participate. Recognize that the niche you wish to serve does not use social media as its decision-making determinant.

Social media is a social phenomenon. It is continuously evolving. Social scientists and business scholars who study it are still gathering experiences. New legal challenges and new precedents emerge. The phenomenon is organic. It continuously adapts to market forces. The research presented in this article reflects only a snapshot in time. ■

ADA ADVISORY OPINION ON SOCIAL COUPONING

4.E.1. Split Fees in Advertising and Marketing Services. The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting.

The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected.

AMERICAN COLLEGE OF DENTISTS ETHICS HANDBOOK

ADVERTISING

While the practice of advertising is considered acceptable by most professional organizations, advertising, if used, must never be false or misleading. When properly done, advertising may help people better understand the dental care available to them and how to obtain that care.

Advertising by a dentist must not:

- Misrepresent fact;
- Mislead or deceive by partial disclosure of relative facts;
- Create false or unjustified expectations of favorable results;
- Imply unusual circumstances;
- Misrepresent fees;
- Imply or guarantee atypical results;
- Represent or imply a unique or general superiority over other practitioners regarding the quality of dental services when the public does not have the ability to reasonably verify such claims.

Dentists should seek guidance on advertising from their professional organizations. The best advertising is always word-of-mouth recommendations by satisfied patients.

CONFIDENTIALITY

The accepted standard is that every fact revealed to the dentist by a patient is, in principle, subject to the requirement of confidentiality, so that nothing may be revealed to anyone else without the patient's permission.

This standard has several accepted exceptions. It is assumed that other health professionals may be told the facts they need to know about a patient to provide effective care. It is also assumed that relevant ancillary personnel, such as record keepers, will need to know some of the facts revealed to them by the dentist to perform their job.

Further, relevant facts may be communicated to students and other appropriate health care professionals for educational purposes. If maintaining confidentiality places others at risk, then the obligation to breach confidentiality increases according to the severity of the risk and the probability of its occurrence.

DISCLOSURE AND MISREPRESENTATION

Dentists should accurately represent themselves to the public and their peers. The dentist has an obligation to represent professional qualifications accurately without overstatement of fact or implying credentials that do not exist. A dentist has an obligation to avoid shaping the conclusions

or perceptions of patients or other professionals by withholding or altering information that is needed for accurate assessment.

The dentist has an obligation to disclose commercial relationships with companies when recommending products of those companies. The dentist has an obligation to disclose commercial relationships in professional presentations or publications where the dentist promotes or features products of those companies. The dentist may ethically have ties to commercial entities, but the dentist should fully disclose such relationships to patients and professional colleagues when nondisclosure would lead to differing conclusions, perceptions, or misrepresentation.

Incomplete disclosure and misrepresentation may also adversely affect dental research and journalism. In the course of evaluating research and dental literature, dentists are cautioned that such problems may exist and can lead to incorrect assumptions and conclusions. If such incorrect assumptions and conclusions are adopted, less than proper care may result. It is important that dentists critically evaluate dental research, literature, and advertising claims.

PRINCIPLES of Risk MANAGEMENT

- Identify, characterize, and assess threats.
- Assess the vulnerability of critical assets to specific threats.
- Determine the risk (i.e., the expected likelihood and consequences of specific types of attacks on specific assets).
- Identify ways to reduce those risks.
- Prioritize risk reduction measures based on a strategy.

Immediate steps:

- Respond to all negative reviews promptly.
- Don't be defensive.
- Take the discussion offline.
- Give them back their money.
- Negotiate to remove the review. Go to the host site to inquire how to remove a false statement. It will likely take time. Meanwhile, the review stays in full view of a continuously renewing audience.
- Apologize if necessary ("I'm sorry you had a bad experience").
- Turn a positive into a negative.
- Potential new consumers will see how you solve a dispute.
- Be a real person, empathize, don't be contrived, don't be high-handed, authoritarian.
- Risk prevention.
- Monitor via Google alerts: Go to www.google.com/alerts, and fill in your name and a new alert with your practice name. This will give you quick notice, via e-mail, so you can visit the offending review and decide what to do about it.
- Ask patients to create real, positive reviews.
- Ask patients to go on Yelp or Facebook and write a positive review about you. A case study. A testimonial.
- Be careful of contriving positive reviews or "gaming the system." These sites have algorithms that identify changes in volume, velocity (or increased rate), contemporary entries.
- Establish an office policy on staff engagement on social media and confidentiality agreements on the subject.

Social media is a social phenomenon. It is continuously evolving.

ISSUES IN DENTAL ETHICS

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for Dental Ethics

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DIFFERENT LABS

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ABSTRACT

In this case a young dentist has signed onto a managed care plan that has several attractive features. Eventually, however, he notices that he makes little or no net revenue for some of the work that he does. A colleague recommends that he use different labs for different patients, with labs matched to each patient's dental plan and coverage. Offshore labs are used for managed care patients. Three knowledgeable experts comment on the case, two with many years of private practice experience, two who are dental educators holding master's degrees in philosophy and bioethics.



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THE CASE

After dental school you sign on with a managed care organization because they offer to help pay your student loans. The plan sends plenty of new patients your way.

You begin to notice that you feel “ripped off” with patients who have this plan because your fixed costs are constant, yet the payment you get for taking care of these patients is low, nearly the same as your overhead for the procedure and sometimes actually lower! This means that all of the discount comes out of your “labor,” leaving you with significantly less to take home.

You have lunch with an old dental school friend who has also signed on with a managed care firm and she says, “That was a problem for me at first too, but I figured out a solution. I use two different labs; one for the managed care patients and one for cash-paying or indemnity plan patients. The lab I use for managed care is offshore. It isn't quite as good, but they are much cheaper. It evens things out, and it's fairer to me. I'm not working for free anymore.”

INTRODUCTION

This case has important current implications as the American economy struggles and dental plans continue to evolve in more and more complex ways. The price of dental education is high, and the costs associated with establishment of a new dental practice increase each year. At the same time, the quality and convenience of “offshore” labs continue to improve.

Three experienced practitioners and educators respond to the ethical and practical dimensions of this case.

DR. VERNILLO'S RESPONSE

A dentist meets with a colleague who acknowledges the problem of inadequate financial reimbursement from a managed care organization. To stanch the financial hemorrhage, however, the dentist's colleague decides to use two different labs. The dentist admits that the quality of the work from one lab is not quite as good but reserves it for her managed care patients. The first dental lab is more costly but offers higher quality work. This dentist reasons that she can thus charge a higher fee for her services by passing that increased cost on to her cash-paying patients. She further argues that such a solution is fairer in terms of economic outcome for the practice. It is not necessarily unethical for that dentist to charge a higher fee for better quality lab work if a cash-paying population is willing to pay for better quality, preferred treatment. Yet it is not more equitable for the managed care patients who will likely receive a lesser quality of treatment. Whose well-being is most important?

A financial conflict of interest exists when a clinician entrusted with the interests of a patient tends to be unduly influenced by a secondary interest (Emanuel & Thompson, 2008). The patient's health must be the dentist's primary interest and should take precedence over financial self-interest or

the interests of a third party such as a managed care insurance plan. No one begrudges the dentist a comfortable income, and loan repayment from professional school represents a major financial burden. However, managed care systems might provide incentives to decrease the quality of healthcare services or even withhold beneficial care (Kassirer, 1998). In vulnerable populations or those from lower socioeconomic groups, extracting a tooth as a treatment of choice rather than endodontic treatment with fixed prosthetics may exemplify its greatest negative physical and psychological impact.

To determine whether dentists are acting in the patient's best interest, dentists might ask what they would recommend if they were working under the opposite reimbursement system. Dentists in managed care might ask whether they would recommend the intervention under fee-for-service. Similarly, fee-for-service dentists might ask what they would recommend if they would lose money performing that procedure. Economics do matter, but financial considerations should not distort a clinician's reasoning. When dentists face a conflict of interest, the dentist must reaffirm that the patient's interests are paramount, disclose conflicts of interest, and manage the situation to protect patients (Lo, 2009). Individual dentists and the dental profession need to reaffirm their fiduciary responsibility.

When dentists face a conflict of interest, the dentist must reaffirm that the patient's interests are paramount, disclose conflicts of interest, and manage the situation to protect patients.

Several ethical concerns may arise when clinicians contract with managed care organizations (Lo, 2009). First, high-quality care might not be provided to all patients. Patients who are more socially privileged or persistent in demanding services are more likely to obtain the desired procedures. Second, the fiduciary role of dentists might be undermined. Dentists are entrusted to look after patient interests as well as their own. Third, a dentist may even use deception to obtain insurance coverage. Such deception may be more common when dentists believe that it is unfair when a plan fails to cover a more expensive procedure that they perceive to be necessary. However, deception undermines social trust. Within the constraints of managed dental health care, dentists should act as advocates when a patient could receive significant clinical benefit from a procedure that the plan disallows for that patient.

Dentists should disclose all treatment options to patients along with payment implications, allowing patients to exercise their autonomy to make decisions in their own best interests. Imagine a physician who fails to disclose all treatment options to a patient with disseminated cancer. If that patient knew that other treatments existed, then that patient might choose another option (regardless of greater cost) if it could be reasonably expected to prolong the patient's quality of life. Failure to disclose such information would undermine that patient's autonomy and capacity to choose more beneficial treatment.

If the dentist is to get involved in a balancing act between who can and cannot afford certain types of treatment,

then the fairest way to negotiate that situation at minimum is to disclose all options to each patient. Perhaps dental patients in a managed care plan may then be able to obtain additional financial support from another source (such as family members or a loan) to elect more beneficial and desirable treatment. If the cash-paying patients pay more, then they likely permit the dentist to remain in practice for managed care patients who would perhaps not receive any treatment at all. However, it is ethically (and perhaps, legally) problematic to assert that some treatment, even of lesser quality, is better than none.

DR. GIUSTI'S RESPONSE

Controlling overhead expenses can be challenging for the new dentist. Inexperience in management of the finances of a private practice combined with the very real burden of debt service for educational and practice loans can send a young practitioner into full-tilt mode. It has been observed that, over the past 13 years, mean office overhead has increased every year while compensation from capitation plans has decreased dramatically (Rhodes, 2010). Unsurprisingly, solo practitioners with average overhead may perceive that capitation rates constitute compensation that is incompatible with dentists' income objectives and therefore unfair.

Recent increases in the cost of gold as well as lab components such as those used in implant restoration have motivated many private practitioners to turn to overseas laboratories. Laboratory overhead costs have dropped from 10-12% of production to 8-10% in a managed care office (Jones, 1998). The local dental lab is now competing with facilities in China, Korea, the Philippines, Costa Rica, and Mexico, where low labor and production costs enable these "offshore" operations to flourish. These labs do not have to concern themselves with FDA or ADA compliance rules requiring the use

of approved materials. American labs struggle with the high cost of setting up labs, with an average minimal capital investment of \$200,000 (Napier, 2011). There are no states in the United States where technicians are required to be licensed, and the number of graduates from certified technician training programs in America now number only 300 annually (Napier, 2011). The difficulty in attracting a trained technician combined with the steep cost of equipment drives many local dental labs to respond to Internet advertisements for low-cost lab work done in other countries. These labs can promise a seven-day turn-around for work sent via UPS or FedEx to Hong Kong or Zhuhai City. This can turn a local lab into a broker as well as a producer.

The American dental lab market is huge, and to offshore entrepreneurs it may look like low-hanging fruit. In 2010 \$1.32 billion in overseas dental laboratory fees were generated by American dental offices. This represents 20% of U.S. sales and nearly 40% of actual restorations (Napier, 2011).

So what's wrong with this picture? As it turns out: plenty.

Practitioners in Sweden have found overseas labs to be eager to serve them. A study by Ekblom, Smedberg, and Moberg published in the *Swedish Dental Journal* in 2011 compared single crowns and fixed bridges done in Swedish labs with those done by Chinese technicians. While Chinese fixed partial dentures cost less than half the price of those done in Sweden, there were problems. The authors found that the general quality of the bridges made in China was comparable, but the dimension in some cases was too weak. The gold alloy that the dentists ordered was often not the alloy used in fabrication, and the

chromium-cobalt alloy contained small amounts of nickel.

The seal attached to a restoration is an Identalloy certification of the metal content that was used, and it is designed for inclusion in a patient's chart. Research has confirmed that this may or may not be the actual metal used by an overseas lab (Ekblom et al., 2011). The practitioner, however, must uphold this standard, managed care or not. Patients depend on us. They have no idea where the materials come from, and they will be living with them in their mouths for decades, perhaps the rest of their lives.

While offshore labs may seem attractive, there are downsides in addition to the ones noted by the Swedes. Difficult restorations which require multiple fittings may be more conveniently fabricated by a local laboratory so that shade or contour adjustments can be performed expediently. Whose responsibility is it when an undersized bridge framework fractures? (The dentist's). Will a foreign lab make good on a failure such as this? Remakes dramatically impact the bottom line in all practices, more painfully in a managed care office where reimbursement is less. If a patient has an allergic reaction to a non-precious metal such as nickel and a crown needs to be replaced, the dentist must stand behind that restoration and get it remade. It has been estimated that one denture remake negates the profit completely, as lab expenses constitute as much as half of the dentist's fee. Are distant labs willing and able to satisfy the functional and esthetic requirements of an American dentist or patient? Private practitioners who participate in managed care plans continue to have a fiduciary relationship with their patients, identical to that which they uphold for all of their other patients. If the dentist chooses to maintain his or her profit margin by decreasing lab expenses, both the dentist and the patient could pay a heavy price for the use of an overseas lab.

There is an educational "cost" involved, as well. A relatively new practitioner profits in many ways by working with a seasoned dental technician. For example, an experienced lab tech can quickly recognize weaknesses in the dentist's techniques and "mentor" the young dentist by troubleshooting impression-making techniques, for example. This type of relationship allows the dentist to ascend the learning curve much more quickly and avoid costly mistakes early on. Repairs to fixed or removable prostheses can be done expediently when working closely with a local lab. A solid relationship with a lab benefits the dentist who can provide rapid service to patients who may require a quick esthetic remedy such as a stayplate. By collaborating on an ongoing basis with the same laboratory it becomes easier for the lab to "rush," and the extra time just becomes part of managing that account. Custom shade matching is easily done by a local lab, but how do you make small adjustments when the lab is 8,000 miles away? There will be no noontime visit by the dentist to consult with the lab technician on a demanding case when the work is done in Hong Kong or Mexico.

What about the ethics involved in this dentist-technician relationship? Is the dentist required to inform the patient that the lab work involved in a case is done overseas? Can the dentist reasonably assert to the patient that he or she is overseeing the fabrication of a long-span bridge or complex veneer case when it is actually being completed in Asia? Would patients care?

It is well-known in the lab industry that laboratories used by managed care offices are likely to use non-precious alloys for work done on behalf of their patients due to the lower cost of the

Difficult restorations which require multiple fittings may be more conveniently fabricated by a local laboratory so that shade or contour adjustments can be performed expediently.

alloy. These non-precious alloys have different casting properties and porcelain-bonding abilities than their more expensive counterparts. Is it fair to use a higher quality alloy for a private patient whose fee is also higher? Does the patient with the "better" job whose dental plan reimbursement rates are "better" also get a "better" crown? I would assert that the dentist treating two patient populations will more willingly go the extra mile when reimbursed at the higher fee. It is human nature. A careful and conscientious practitioner may have to dig deep to take the energy and chair time required to remake an impression for a managed care patient when such an expense cuts into an already narrow

profit margin. If patients with the full fee profile are used to “underwrite” the work done on patients with lower reimbursements we face another moral conundrum.

If the dental practice is a microcosm of the society in the area, redistributing money to benefit those less “able” might be a way to approach resources, but it is really not fair to raise the fee of the full-fare patient to accomplish this goal. Nonetheless, a dentist might decide to use the same lab and materials for every patient and average out the profit over both populations as an alternative resolution.

Finally, while dentists are not directly responsible, the local economy and perhaps the quality of life in local communities are impacted by the use of offshore labs as jobs move overseas.

There are probably better ways for this young dentist to solve his problem, but they require that he take the “long view.” Another way to protect the bottom line in a new practitioner’s office is to “grow” the practice by taking really good care of existing patients and encouraging those patients to refer their family members and friends. This method takes time, but it is the soundest way for a practice to enlarge its base. I would encourage new dentists to take the old-fashioned route to a successful career. Excellent care and high quality service are practical in the long run. Analyses of revenues from capitated and managed care plans may demonstrate that increasing the number of those patients will never help the bottom line, and participation in those plans creates inevitable quandaries, as we have seen. New dentists can also team up with each other (I think this is an especially good way for young women with families) to provide the best possible coverage,

energy, and overhead expense containment for an office. A private practitioner could also hire a marketing consultant to analyze the demographics of the area in which the practice is located to better understand whom the practice serves, and decide if the mission of the practice is in alignment with the patient base. Adoption of any or all of these strategies instead of using a foreign lab is a better choice in the long run for the young dentist.

DR. JENSON’S RESPONSE

Crowns are not restorations. Though these terms are commonly interchanged they are not the same thing. A crown is a manufactured object, whether it is made of acrylic, stainless steel, non-precious metal, gold alloy, or ceramic material. A restoration is something that the dentist does with a tooth. A restoration is the act and result of returning a tooth to its original (or sometimes an improved) form and function. The quality of the restoration depends upon the skill and conscientiousness of the dentist. It is the dentist that makes the decision to restore a tooth with a crown, what type of crown to use, and the ultimate acceptability of the restoration. Thus the ethical considerations of restorations involve the care and judgment of the dentist and not the laboratory, CAD-CAM machine, or box from which the crown was produced.

For example, in the scenario presented, the dentist has a source of manufactured crowns that she deems inferior to another more expensive laboratory. This may or may not play a role in the final restoration of a tooth. If the dentist is able to use the crown to achieve acceptable margins, contacts, contours, and esthetics, she can fulfill the ethical obligations involved in restoring teeth. This, of course, may require considerable additional work by the dentist; however, it is still possible. Again, it is the resultant restoration that

is the dentist’s responsibility. To make this more obvious, we would not say that a near perfect crown (object) is an adequate restoration if the crown were cemented onto the tooth improperly, creating an open margin and a high occlusion. In that case, the restoration is a failure regardless of the attributes of the crown.

With this in mind, let’s take a look at the ethical issues in the scenario presented. It is clear that the “old dental school friend” is trying to save money by purchasing crowns that are in some way “inferior” to those from her usual laboratory. Is there an ethical problem with finding ways to reduce costs? Quite the contrary. In *Dental Ethics at Chairsides*, Ozar and Sokol (1994) point out that dentists have an ethical responsibility to use dental resources in an efficient manner. Finding a cheaper laboratory is fine as long as the dentist accepts the responsibility for the final restoration as discussed above. However, whenever cost-cutting tactics reduce the quality of care provided, a higher ethical value, the patient’s oral health, has been compromised and the tactics are thus unethical. As stated above, if the final restoration meets the standard of care, its price is not an issue.

Another consideration is the actual materials used in fabricating the crown. If a lower crown price has been achieved by using cheaper materials that may not have the longevity of the higher-priced crown or are possibly toxic in nature, this does present an ethical problem. Every dentist is ethically required to know the content of the materials used in any restorative procedure. This requires him or her to work with laboratories that can reliably report the exact content of metal alloys and ceramics used in the manufacture of the crown. If the dentist cannot get this information

from the laboratory or does not trust the laboratory's reporting of the materials that they use, he or she must find a laboratory that can be trusted. Patients have little expertise in evaluating crown content and structure and must rely upon and trust the dentist to determine these things for them. Misrepresenting the quality of the crown to the patient violates this trust and violates the autonomy of the patient to make an informed choice. In this scenario, are the patients in the managed care program informed that the crowns being placed in their mouth are in some way inferior? Is the insurance company that pays for the crown being informed that the crowns are inferior? If not, the dentist is misrepresenting the work and is therefore being unethical. In the case of the insurance company, it may actually amount to fraud.

These principles apply to any crown source. We often see advertisements for "crowns-while-you-wait" these days in offices that use the new CAD-CAM technologies. Are patients being fully informed about the nature of these crowns? Are these crowns really as good as the gold or porcelain fused-to-metal standard of the industry? Do they break more frequently? Will they last as long? Do patients realize that more tooth structure must be removed in order to make these crowns work? To a patient, a crown is a crown is a crown. It is the responsibility of the dentist to discuss the limitations of any restorative material or procedure. To represent these new types of crowns as an equivalent to the traditional gold or porcelain fused-to-gold crown without the supporting science is ethically questionable at best.

To continue with the scenario, is fully informing the patient as to the quality of the crown enough? One might ask if it is ever acceptable for a dentist to create a restoration that does not reach the level of quality of his or her best work? Might a patient of limited finan-

cial resources request a lower quality restoration in order to achieve some therapeutic benefit? I think we can all agree that this is an accepted practice in dentistry. It is certainly clear that there is a broad range of restorative choices that are offered in the typical dental office. Let's take the example of a stainless steel crown. Dentists have provided stainless steel crowns to patients for many years as a compromise treatment. Most dentists would agree that a stainless steel crown meets many of the requirements of tooth restoration but the margins, contours, and contacts are, generally speaking, far less than ideal. And yet in many cases, this type of crown is better than doing nothing at all; there is some therapeutic benefit to be obtained by doing these types of crowns.

There is no question that dentists and patients often work within an economic structure that constrains what is meant by the phrase "best possible treatment." Every day in practice, patients and dentists engage in discussions that try to balance treatment goals with the economic resources of the patient. For many patients, the "best possible treatment" is simply not possible due to financial reasons, and dentists are frequently compelled to find a compromise treatment plan that maximizes the resources of the patient and yet still provides an enhancement to the patient's oral health. This is an ethically accepted practice under the following circumstances: (a) The specific procedures done by the dentist do no harm to the oral health of the patient and achieve some benefit for the patient. (b) The specific procedures are done to a level of quality commensurate with the dentist's best efforts. For example, if one chooses to do a stainless steel crown, one is required to make the best stainless steel

A relatively new practitioner profits in many ways by working with a seasoned dental technician.

crown one is capable of making. (c) The patient is fully informed and understands the risks involved with any treatment compromise.

The ethical piece missing in this scenario is an open and honest discussion with the patient regarding material, structure, and long-term expectations of the intended restorative procedure. Hiding important information from the patient in order to obtain a financial gain should be seen as unethical—whether it is a lower laboratory fee or, as in the case of a CAD-CAM crown, a competitive edge.

SUMMARY AND CONCLUSIONS

Three accomplished dental practitioner-educators have presented thoughtful commentary on this intriguing case, one that has timely practical implications. "Offshore" dental laboratories represent a resource that every practitioner must

consider. The majority of dental practices in the United States treat patients with a variety of payment configurations, some “better” than others. During a recessionary economic period, dentists and patients alike will reasonably search for efficiencies and other ways to cut costs.

The commentators aptly describe the numerous difficulties and pitfalls associated with the variable use of local and offshore labs, and all three come to the conclusion that no matter what labs put out, the final restorative result is a dentist’s fiduciary responsibility. They point out that this responsibility is effectively and properly discharged when patients fully understand and consent to their specific treatment and when the result meets the standard of care. Dr. Jenson writes that “To a patient, a crown is a crown is a crown.” I would go further and note that to most patients a crown is actually a “cap.”

Four scenarios seem possible:

First of all, there is a materials issue. The dentist has a responsibility to discern the content of any crown that he or she places in someone’s mouth. It is potentially disastrous for a lab to use toxic materials, and it is the dentist’s job to figure this out. We cannot rely solely on advertisements or the informal “word” of representatives of a laboratory on this question. There is a due diligence responsibility when a dentist uses any lab, offshore or not. If a dentist discovers that a lab uses dangerous or suspect materials, he or she must avoid the use of this lab. Patients rely on dentists to do this.

The second scenario is when the materials or crowns or bridges produced by the offshore lab are safe but inferior in some way. If this poorer quality is

likely to result in a restoration that is unlikely to last as long as one that used more expensive lab products, this must be discussed with patients. As Dr. Jenson points out, trade-offs are not categorically unethical as long as patients understand the implications of the arrangement.

Dr. Vernillo worries that the reimbursement structure of managed care plans irresistibly causes better care for some people and worse care for others. He agrees with Dr. Jenson about full and honest disclosure to patients. It is clearly unethical to make clinical trade-offs behind a patient’s back. If trade-offs in quality are to be made, patients should be invited to participate in the decision making, and Dr. Vernillo points out that some patients will find additional resources when they know what is at stake. Many dentists articulate a reluctance to do anything that does not represent their “finest” work, but this position seems rigid, impractical in the real world, and perhaps elitist. That said, it is hard to defend dental care in court when it is not a dentist’s best, especially when the dentist knows it is not his or her best work. Dr. Jenson resolves this issue by asserting that no matter what lab product a dentist uses, he or she can still do their “best” technical and clinical work when using that crown or bridge. Some patients at some points in their lives prefer a less expensive solution that their dentist might not favor. That said, the final clinical outcome obviously must fall within the standard of care for crowns in general. The matter becomes a bit more complicated when we acknowledge that patients’ standards do not always match the standard of their dentist. Sometimes patients would be happy with an outcome that is less than the one envisioned by the dentist and sometimes a patient seeks a standard of perfection that the dentist knows is unachievable. The use of a less expensive lab seems more acceptable when both patient and doctor agree about the results.

The third scenario is a variation on the second one. The young dentist might find that when he uses the less expensive lab he ends up using more time to make the crown or bridge fit properly (which is his duty, independent of the quality of the lab work), thus burning through any financial advantage he thought to gain by using that lab. To use a cheaper lab and leave margins open is difficult or (more likely) impossible to justify. Dr. Giusti points out the problem of actual lab work failures. The dentist is on the hook when a cheap bridge fractures prematurely. Time and money are both at stake when that happens. You do often get what you pay for.

The fourth scenario occurs when the less expensive offshore lab produces work of adequate quality or better. This may turn out to be a realistic future scenario. As an example, many Chinese products continue to improve in quality, and it was not that long ago that Americans snickered at the phrase “Made in Japan.” No one snickers at a Japanese automobile any more. The biggest problem with this scenario, as Dr. Giusti notes, is that the dentist loses an important personal relationship with the lab and its people. This is a serious matter, as close coordination can result in a much better outcome for present and future patients, as well as a quicker turnaround time. Difficulties related to working with a lab that is 11 time zones away are lessening, but will never completely resolve.

There are complicated issues of fairness in this case, some real and some rationalized. The normative ethical principle of justice is clearly in play. First, is it fair to patients who receive lab work that is not as good? Obviously not when materials are toxic or dangerous. But when the lab product is safe and

adequate, commentators insist that it is the dentist's responsibility to ensure that the final restorative outcome is sound and meets the standard of care. Readers must decide whether it is okay for dentists to provide "better" care to some patients based on financial wherewithal. It is difficult to imagine a world where that would not, in actual practice, be the case. The fairness matter turns on the question of whether or not the concept of "you get what you pay for" applies to health care, and many dentists (and patients) are uncomfortable with that idea. If health care and treatment of disease and the human body are a special circumstance that should not be treated in a commercial way, then it seems unfair to provide multiple levels of clinical care. But if that is the case, someone has to pay, and therein lies the rub. In the United States, from a practical, cultural, and political point of view, there seems insufficient enthusiasm for the notion that we should all chip in to ensure that everyone receives a premium level of health care. One could even note that dentists have priced themselves out of the mainstream market by evolving treatments that are better than the economy can support. Multiple implants and truly beautiful cosmetic solutions are out of reach for most cash-paying, middle-class Americans, and employers would obviously prefer to keep the cost of dental benefits as low as possible.

It seems appropriate that both groups of patients be informed of all the reasonable treatment options. Perhaps a high-end patient might prefer a lower-cost restoration for some reason and, as Dr. Jenson notes, some patients lacking excellent dental coverage might find a way to pay for the use of a better lab if they understood the implications. That said, it must be noted that many patients have zero interest in this kind of information and decision. They prefer to leave such matters to the discretion of

their dentist, and trust him or her to do the right thing.

The question of whether or not the reimbursement structure of a managed care program is fair to a dentist is another matter entirely. To assert that those arrangements are unfair is a rationalization. Dental plans have no obligation to ensure that a dentist's financial goals are met. There are hundreds of plans out there, and it is a dentist's duty to evaluate them and sign binding contracts only after due diligence has been done. To somehow assert that one "has to" participate in one of these plans is pure rationalization. If a plan is that bad no dentists will enroll or participate, and the plan would be forced to change or go out of business. On the other hand, to participate in a less than attractive plan in order to serve patients who would otherwise not receive care is noble indeed. But then, whining is not allowed. It is truly great to choose to make a professional contribution to the community, and there is a price to be paid. That is why it is called a contribution.

Dr. Giusti recommends that young dentists take the long view and develop their practices the old-fashioned way, by providing excellent care so that word-of-mouth reputation is your marketer.

I also recommend a discussion between the young dentist and his lab. Do lab owners have any practical suggestions about how to deal with the managed care dilemma? In order to maintain a lasting and productive relationship with this young dentist, the lab may be willing to create some sort of win-win that has not occurred to the dentist. Local labs, you can be sure, are well-aware of the threat from across the ocean. ■

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IS GENERAL DENTISTRY DEAD?

HOW MID-LEVEL DENTAL PROVIDERS WILL AFFECT THE PROFESSION

Eric K. Curtis, DDS, MA, FACD

ABSTRACT

The rhetoric concerning mid-level providers and their impact on general dental practice is building in intensity. This is a complex issue and there is no clear picture of either the benefits or dangers to the public of such a delivery model, whether such plans are economically sustainable, or the role of general dentists in the configuration of future practices. The opinions of a representative sample of thinkers from various perspectives are sampled.

An internist friend of mine is predicting the demise of his profession. “Primary care medicine,” he says, “will be dead in five years.” The reasons involve a complex, long-simmering stew of government machinations and shrinking third-party reimbursements, which threaten to squeeze the already-dwindling supply of American general internists, pediatricians, and family practitioners out of a job. The internist acknowledges that there will be mid-level providers to take his place. “I’m not going to be able to afford to practice,” he says. “My job will be to watch over six physician assistants [PAs] and make sure they each see 40 patients a day.” He foresees an increasingly scrambled healthcare structure in which nurses and PAs refer patients directly to secondary- and tertiary-care providers. “The system is upside-down for primary care doctors,” he says, some of whom now make less than some PAs. But he believes that the biggest losers in this brave new medical world are the patients, who face increasing costs and fragmented, overall lower quality care. “I look forward to the day,” he says, “that a nurse practitioner operates on President Obama.”

My friend is not alone in his worry: A 2006 position paper by the American College of Physicians, “The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation’s Health Care,” begins by proclaiming, “Primary care, the backbone of the nation’s health care system, is at

grave risk of collapse due to a dysfunctional financing and delivery system.” The potential failure of general medicine is an alarming development. But there is another one that might make you squirm even more: General dentistry could be next.

THE DEATH OF DENTISTRY FORETOLD

Is general dentistry a dead profession walking? Many fear that dentistry, the first specialty of medicine but also its historical outcast, is finally going the way of primary care medicine, poised to sink with a sigh into a mire of competing providers. If the public’s next physician will be a nurse or a PA, then its next dentist may well be a dental hygienist, a dental health therapist (DHT), or even a desperate internist. “The train has left the station,” writes dental coach Marc B. Cooper, DDS, president and CEO of The Mastery Company in Ashland, Oregon, in the online article “Mid-level Dental Providers and You.” The arrival of non-dentists to perform extractions and fillings, he declares, is no longer an experiment, but a fait accompli: “Most private practitioners will perceive it as a threat to their survival. It won’t matter. It’s going to happen.”



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Bryan C. Edgar, DDS, of Federal Way, Washington, chair of the American Dental Association Commission on Dental Accreditation, likewise warns that the future has arrived. “The idea of a competing provider of dental services is very alarming to most of the profession,” he says. “I am from a state where we view the reality of an independent mid-level as something that will happen, whether we like it or not.”

Some believe that dentistry as now practiced will indeed soon be gone. Public attitudes are primed and grievances loaded. In the popular imagination, it is said that general dentists, whose average income approaches that of primary care physicians, make too much money. Dentists charge too much, a situation rendered all the more visible by the fact that most third-party plans pay only a portion of the total fees. Dentists also are perceived as standoffish, even selfish, rarely playing ball with Medicaid and its state analogs, and never with Medicare. They do not work on Fridays and avoid practicing where people really need them, such as in community clinics and small towns. What is more, their work, although technical, is essentially easy. At least one university president has suggested that dentists ought to be trained in community colleges. So, the thinking goes, let someone who can deliver the care more easily and cheaply—and, to scratch below the surface, more sympathetically—go ahead. The specialists will still be there to do the hard stuff.

General dentistry certainly will not die immediately among mid-level

providers, but its traditional activities—and identity—may well be altered. Richard W. Dycus, DDS, Cookeville, Tennessee, chair of the Academy of General Dentistry Dental Practice Council’s Workforce Subcommittee, describes the resulting shift in focus that my internist friend dreads. “When the federal government is involved,” he says, “70% of a practitioner’s time will be spent on administrative tasks.”

Dr. Cooper tells his dentist clients to embrace the inevitable change by preparing to become practice administrators rather than constantly bending over the chair themselves. Educators suggest that dentists may need to incorporate some part of the business model into their professional training. Richard J. Simonsen, DDS, MS, founding dean of Midwestern University College of Dental Medicine-Arizona, identifies another change in emphasis: “Dentists will spend more time in diagnosis.”

CONFLICTING PERCEPTIONS OF ACCESS TO CARE

A February 2010 paper published by the Pew Center on the States (“The Cost of Delay: State Dental Policies Fail One in Five Children”) declares, “A ‘simple cavity’ can snowball into a lifetime of challenges.” But the Pew Center estimates that more than 10% of the nation’s population “has no reasonable expectation of being able to find a dentist.” (In some

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Because the perfectionist, one-on-one culture of private practice is so single-minded, dentists consider alternative providers—from denturists to independent registered dental assistants to foreign-trained dentists—to be not just competitors, but hacks.

states, it says, that figure rises to one-third of the general population.) Concentrating its interest on children, the Pew Center identifies three causative factors in “the national crisis of poor dental health and lack of access to care”: lack of widespread sealants and fluoridation; lack of dentists willing to treat Medicaid-enrolled children; and its own conclusion that “in some communities, there are simply not enough dentists to provide care.” The Pew Center’s fourfold solution includes two preventive measures—more widespread school-based sealant programs and community water fluoridation—and two proposals to increase treatment: Medicaid improvements that would enable and motivate more dentists to treat low-income children, and “innovative workforce models that expand the number of qualified dental providers, including medical personnel, hygienists, and new primary care dental professionals, who can provide care when dentists are unavailable.”

Such calls for mid-level dental providers clearly mark a response to social demand. “Society has gotten the word out,” says Kenneth L. Kalkwarf, DDS, MS, dean of the University of Texas Health Science Center at San Antonio Dental School. “People would like improved access to oral health care, and they would like the cost of care to be more reasonable.”

Dr. Dycus agrees. “Healthcare reform of all kinds,” he says, “is happening because the public could not get the care it wanted at the price it wanted.” The perfect price point, of course, is none at all. “The American public believes health care should be free,” Dr. Dycus says, explaining that external payment mechanisms during the past decades have lulled and confused policyholders. For example, 1970s-era laws allowing third-

party payer checks to be assigned directly to dentists yielded an important unintended consequence: Patients nowadays do not understand the costs of care.

Some argue that the push for mid-level providers reflects not just dentistry’s failings but its faults. Dentists have focused on individual practice growth through more expensive services, virtually ignoring the public health problems of restricted wider access to dental care. In a newsletter article, “Can’t Get There from Here: The Futile Attempt to Resolve the Access Issue” (available at www.masteryofpractice.com), Dr. Cooper observes that within the context of private practice dentistry, dentists are acculturated to “doing highly technical work to restore health and beauty to patients who can pay for it.” In this world, access really is not an issue. Because the perfectionist, one-on-one culture of private practice is so single-minded, dentists consider alternative providers—from denturists to independent registered dental assistants to foreign-trained dentists—to be not just competitors, but hacks. At the same time, dentists fail to recognize the inadequacies of volunteerism, efforts akin to pouring individual buckets of water into a burning building.

Dr. Dycus counters that dentistry’s focus is not narrow, but realistic. Regardless of their proponents’ good intentions, care-stretching medical models such as mid-level providers simply will not work for dentistry—which is, for the most part, surgery rather than medicine. “Legislators think dental mid-level providers will be like nurses,” he says, “but dental practice is much more complicated than writing a prescription.” Mid-level providers also may contribute to tiered treatment inequities, with the mid-level provider seeing patients from cut-rate plans, while the dentist sees the “good” patients. What is more, mid-level providers do not provide a “dental home.” “They are pain- and urgent care-focused,” Dr. Dycus says, “not prevention-focused.

That's why the ADA is experimenting with an alternative community dental health coordinator [CDHC] model. Prevention is the key to controlling caries and periodontal disease."

Dr. Dycus contends, in fact, that mid-level providers do not even benefit medicine, where efficiency has declined as a result in two key respects. The first is timeliness of care: "When people go to PAs and nurse practitioners first," he says, "diseases do not get treated as soon." The second is cost control: "MDs make less and mid-levels make more, and costs just rise and rise."

All this, Dr. Dycus contends, sidesteps the underlying reality: mid-level providers are simply not needed. First, they are too limited in scope to solve the access issue. No mid-level will be able to provide definitive, final care. Second, in most circumstances, the problem is not that dentistry is unavailable but that it is underutilized. Because dentists have become much more efficient than old delivery models recognize, the traditional dentist-patient ratios are inaccurate. "The dental office capacity we have now is sufficient," Dr. Dycus says, "and existing capacity, including better use of expanded-function dental assistants, could be expanded more inexpensively, safely, and efficiently than creating a new position." Increased utilization of dental services, he says, is a function of not only population growth, but of oral health literacy, financial incentives, and mandated care. In any case, the existing workforce is sufficiently elastic: "We can give care at a lower fee as long as the fee covers overhead."

THE PLAYERS: WHO STANDS TO GAIN FROM MID-LEVEL PROVIDERS?

Regardless of dentists' existing capacity, other parties see opportunities—and profits—in developing mid-level providers.

Large group clinics and HMO-centered practices may employ mid-level providers to leverage their facilities. State dental practice acts typically allow physicians to practice dentistry, so primary care MDs and DOs—even emergency rooms and urgent care centers—could hire dental mid-level providers to supplement income. Insurance companies also may anticipate a possible profit center as the presence of more providers encourages more potential plan enrollees. Hygienist groups hope to use the mid-level position as a springboard to expand their scope of practice or move toward independent practice.

Dental educators also may have a vested interest in training mid-level providers. The University of Minnesota, for example, educates non-dentist dental therapists alongside dental students, while the University of California, Los Angeles—consistent with recent changes in California law—trains expanded-function registered dental assistants to place restorations. Yet, understanding that a non-dental school-based alternative exists for each of these mid-level directions as well—Metropolitan State University in Minnesota and Sacramento City College in California—could turn even doubting dentists into philosophers. "Isn't dental education best accomplished in a dental school?" asks Midwestern's Dr. Simonsen. Midwestern University investigated the development of a mid-level training program but chose not to pursue it.

Dental education is again a growth industry, albeit one with results more modest than practicing dentists might expect. According to a 2009 article in the *Journal of Dental Education*, "The Impact of New Dental Schools on the Dental Workforce Through 2022," authors David Guthrie, Richard W. Valachovic, DMD, MPH, and L. Jackson Brown, DDS, PhD, describe how, following a spate of dental school closures between 1986 and 2001, three new dental schools opened between 1997

and 2003, and eight more are in various stages of development over the next decade. By 2022, 8,233 new dental graduates will have joined the U.S. workforce, adding about three dentists per 100,000 people. The authors conclude that this jump in new dentists likely will result in a stable dentist-to-population ratio, but not one that by itself will noticeably increase access to care for low-income or rural populations.

While some interested entities are simply opportunists looking to cash in on a trend, the direct catalysts for the creation of mid-level providers are institutions further removed from dentistry. "What makes this a very complex issue," says Dr. Edgar, "are the dynamics of various groups outside our profession wishing to push their 'solution' to access." He identifies two such groups in particular—state legislatures and nonprofit charitable foundations. "We all know that the economics of dentistry will not allow an independent mid-level provider to solve the access problem without some meaningful funding, such as increases in Medicaid rates or tax incentives," he says. Any increase in access to care requires funding, and lawmakers nowadays are suspicious of handing over the cash to dentists. "The legislatures are beginning to view our scope issues as turf protection rather than public protection," Dr. Edgar says. Certain foundations, for their part, are flexing their money muscles as change agents. The Pew Center's February 2010 paper calling for the development of mid-level providers identifies three philanthropies networked in that intent: the Pew Center, the DentaQuest Foundation, and the W.K. Kellogg Foundation.

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THREAT OR OPPORTUNITY? RESPONDING TO MID-LEVEL PROVIDERS

Dentists, deeply conflicted about the existence and role of mid-level providers, also are divided in their response. Dr. Dycus says, “One camp wants to draw a line in the sand, dig deeper moats, and build higher walls. The other side, citing the argument that you are either at the table or on the menu, says that we have to be on board with the concept, or the government will impose something on us without our input.” What dentists on either side cannot afford to do is ignore the situation. “If we do not stand up, no one will,” Dr. Dycus says. “The AGD needs to be clear that demand can be met using the existing structure of auxiliaries more efficiently. Expanded function dental assistants could perform reversible procedures, such as placing restorations.”

“A lot of people can do certain dental procedures cheaper than dentists,” Dr. Kalkwarf says, “including dental assistants, hygienists, denturists, and dental students. It is a matter of who is in control.” Dr. Edgar agrees that dentist control is crucial. “We need to push as hard as we can to retain supervision over these new providers and make them truly ‘team members,’” he says. “We need to maintain a credible peer-to-peer accreditation process of any educational system that trains these individuals.” Dr. Simonsen sees the Minnesota programs as accomplishing that aim: “They are putting the mid-level under the license of the dentist, which leaves the dentist in total control.”

Mark I. Malterud, DDS, of St. Paul, Minnesota, past president of the Minnesota AGD, says that once a mid-level law was passed in his state, dentists were obligated to support it. He says, “Even

though we do not believe that there is a need for a dental therapist and that the impact will remain minimal for quite some time, we wanted to be sure that the training and testing of these para-professionals would be adequate and that they also would be able to join into a team concept so that the patients receive the quality of care that they deserve.”

The first question for any proposed change in dentistry is how the public will fare. “A self-interested point of view has no place in determining what is best for the public,” says Dr. Simonsen. The priorities, Dr. Kalkwarf says, must proceed in this order: “What is good for society comes first, then what is good for patients, and finally, what is good for self.”

Dr. Malterud sees potential advantages to society in a mid-level provider. “There are situations,” he says, “where rural access clinics with a heavy load of patients may benefit from this, too, as long as it is within a team concept.” But he also worries about the risks. “In a non-team environment,” he says, “I see the potential for the general public to actually be open to injury. There are so many interoperational diagnostic situations that come up that move a ‘simple’ procedure to another category outside the mid-level’s scope of practice. If a mid-level provider is functioning outside the dental team, resolution of such situations cannot be completed safely.”

In “The Disappearing Dentist,” a segment of *Slate* magazine’s 2009 five-part analysis, “The American Way of Dentistry,” author June Thomas calls not just for more dentists, but for more general dentists, to improve access to care. “Just as in medicine,” she writes, “there are too many specialists and too few general practitioners.” Ms. Thomas reports that in the 1980s, about 20% of dental graduates pursued specialty programs; by the turn of the 21st century, the figure was closer to one-third.

PROPOSALS FOR INCREASING ACCESS TO DENTAL CARE WITHOUT A MID-LEVEL PROVIDER

1. Extend the period over which student loans are forgiven to ten years without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;
3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as the Indian Health Service (IHS), programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
7. Actively recruit applicants for dental schools from underserved areas;
8. Assure funding for Title VII general practice residency (GPR) and pediatric dentistry residencies;
9. Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
 - a. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees
 - b. Eliminate extraneous paperwork
 - c. Facilitate e-filing
 - d. Simplify Medicaid rules
 - e. Mandate prompt reimbursement
 - f. Educate Medicaid officials regarding the unique nature of dentistry
 - g. Provide block federal grants to states for innovative programs
 - h. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
 - i. Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments
 - j. Utilize case management to ensure that the patients are brought to the dental office
 - k. Increase general dentists' understanding of the benefits of treating indigent populations;
10. Establish alternative oral health care delivery service units:
 - a. Provide exams for 1-year-old children as part of the recommendations for new mothers to facilitate early screening
 - b. Provide oral health care, education, and preventive programs in schools
 - c. Arrange for transportation to and from care centers
 - d. Solicit volunteer participation from the private sector to staff the centers;
11. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups, to establish and provide service;
12. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
13. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
14. Provide information to dentists and their staffs on cultural diversity issues which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
15. Pursue development of a comprehensive oral health education component for public schools' health curricula in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
16. Increase the supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
17. Expand the role of auxiliaries within the dental team that includes a dentist or is under the direct supervision of a dentist;
18. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
19. Strengthen alliances with the American Dental Education Association (ADEA) and other professional organizations such as the Association of State and Territorial Health Officials (ASTHO), the Association of State and Territorial Dental Directors (ASTDD), the National Association of Local Boards of Health (NALBOH) and the National Association of County & City Health Officials (NACCHO);
20. Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
21. Increase funding for fluoride monitoring and surveillance programs, as well as for the development and promotion of a new fluoride infrastructure.

Source: AGD White Paper on Increasing Access to and Utilization of Oral Health Care Services, 2009

Mid-level providers are simply not needed. First, they are too limited in scope to solve the access issue. No mid-level will be able to provide definitive, final care.

Dr. Malterud thinks that help from a few mid-level associates might free up those general dentists to perform more effectively. “Working in a team concept can facilitate delegation of duties that would allow the lead dentist to provide higher levels of care and accomplish more difficult procedures,” he says. “This can open up avenues of education for the general dentist to get advanced training to help more patients with more complex cases.”

Dr. Edgar also thinks mid-level providers could provide an unexpected boon to general dentistry. “In some other countries that have dental therapists, dental education programs have been expanded to train dentists in more complex patient care,” he says. “The same could happen here.”

THE FUTURE OF DENTISTRY: WHERE WILL WE BE IN TEN YEARS?

Neither planners nor pundits can predict to what extent the public’s unmet dental care needs actually translate into demand. “Access to care is a multifaceted problem that needs to be addressed on many fronts and on several levels,” says Dr. Simonsen, noting that mid-level providers represent only one of many approaches. Dr. Kalkwarf suggests that the survival of mid-level dental practitioners, much less their widespread entrenchment, is not assured. “There are a lot of pieces in play,” he says. “Because mid-levels are trained less, they may be able to provide care less expensively. It sounds good in theory, but the marketplace may direct something else.”

The mid-level concept is amorphous. Potential mid-level providers include a cumbersome assortment of healthcare figures encompassing a broad range of training, from dental assistants to supervised or independent dental hygienists, to dental therapists of either undergraduate or graduate status, to nurses, to primary care physicians. It is largely untested. And it is fragmented. “This is a fifty-state issue,” Dr. Dycus says, “one that will be fought state by state. Mid-level dental care is not a national issue per se, because dental practice acts and insurance rules are different in each state.” What’s more, there is no guarantee that mid-level providers will end up working with the underserved populations any more than dentists will, as legislatures and foundations envision.

While Dr. Simonsen characterizes the acceptance of mid-level providers as potentially “painful” to dentists, Dr. Edgar minimizes the threat. “I do not believe that dental therapists as they currently exist will kill general practice,” he says. “Mid-levels are constrained by both the narrow scope of treatment procedures allowed and the limited populations that they are able to treat. Dentists will remain the leader of the team.”

Dr. Kalkwarf also believes that reports of the death of dentistry have been greatly exaggerated. He describes a study in the 1970s that predicted there would be no future need for endodontists or pediatric dentists. Instead, he says, “Those specialties evolved, broadened their scope, and they have continued to be successful.”

General dentistry itself has been written off before. In 1984, *Forbes* magazine published an article, “What’s Good for America Isn’t Necessarily Good for the Dentists,” which announced the end of the profession. As fluoride cut the

decay rate in half—cavities, Forbes declared, “are going the way of polio and smallpox”—and dental schools pumped out too many graduates, fees and incomes would fall. Dentists would work on salary, and the profession would dramatically contract, attracting less qualified students who would lower overall standards of care.

Obviously, dentistry did not die. It did not even contract. In 1999, David Plotz wrote a *Slate* essay, “Defining Decay Down: Why Dentists Still Exist,” concluding that dentists prospered in the face of predicted extinction because they evolved. They made dental visits more pleasant, advanced their skills in esthetics and implants, and changed patient attitudes. “Americans under age 60 believe keeping all their teeth is an entitlement,” Mr. Plotz observed. “The transformation of American dentistry... is...a case study in how a profession can work itself out of a job and still prosper.”

Many observers believe general dentists will again figure out a way to thrive in the face of mid-level challenges. “While the details may evolve and may not be all chairside, smart dentists can develop a quite satisfying career for themselves,” Dr. Kalkwarf says. Dr. Edgar sees dentistry’s future adaptability as being based firmly in education. “What I do in practice is very different from many of my colleagues because of the educational opportunities that the AGD has offered me,” he says.

“When I was in dental school 30 years ago,” says Dr. Malterud, “a lecturer on the future of dentistry predicted the rise of a new level of practitioner that he termed a ‘super-generalist.’ I have kept that in mind and used it as a target for my education. I believe that many of our AGD members are positioned to become

super-generalists already by achieving their Mastership in the AGD.” Regardless of the future of mid-level providers, Dr. Malterud contends, AGD super-generalists are poised to flourish. Dr. Edgar agrees: “I see comprehensive general dentistry in ten years thriving beyond our current expectations.”

The mid-level challenge places dentistry at a crossroad. “We can either get in control of our profession and find models to provide greater access to care,” Dr. Kalkwarf says, “or we can keep doing what we have been doing and see the erosion of the profession.” The profession’s movement as it approaches the puzzle of mid-level providers feels something like that of the International Space Station circling earth. Some worry that dentistry is plummeting, while others have faith it can remain aloft, safely, usefully, and indefinitely. It is important to realize that a freefall and an orbit are the same thing. In orbit, however, the craft is also moving forward. The difference is control. ■

The priorities, Dr. Kalkwarf says, must proceed in this order: “What is good for society comes first, then what is good for patients, and finally, what is good for self.”

DENTISTS DEMONSTRATING PROFESSIONALISM

DENTISTS IN PRIVATE PRACTICE SETTINGS PROVIDE FREE OR REDUCED-FEE CARE

Matthew Kramer, DDS

ABSTRACT

Access to oral health care is an issue that has received attention at the local, state, regional, and national levels. This study focuses on how dentists in private practice settings attempt to address problems regarding access to care through personal initiatives. These dentists donate or discount services in their own offices to individuals who face access barriers. These donated or discounted services may go unreported and unnoticed. The research question addressed in this study is: What was the amount and type of free and reduced-fee care that dentists in the community of Brookline, Massachusetts, provided during the 2008 calendar year.

Individual capacity for obtaining needed dental care may be reduced for a number of reasons: loss of private dental insurance benefits due to retirement or loss of employment; retirees living on fixed incomes; a challenging economy may also contribute to complex access issues. With the exception of trauma or oral cancer, Medicare does not provide dental coverage, making elders one of the largest demographic groups lacking insurance for needed dental care (Special Commission on Oral Health, 2000). Elders face unique barriers to care. In 2007, of adults 65 years and older, among those with private dental insurance, 51% had contact with a dentist within six months as compared to only 32% of those over 65 who only had Medicare health care coverage which provides no dental benefits (Pleis & Lucas, 2009). From 2006 through 2008, the percentage of adults age 18 to 64 in Massachusetts who had a dental visit within twelve months increased from 67.8% to 75.5% (Long & Masi, 2009).

Due to the access challenges that segments of the population face and their lack of oral health care, some dentists have been accused of being self-serving by outside groups, when in fact, many dentists do pro bono work and are involved in their own special projects for which they have never charged patients. The aim of this study was to investigate the amount and type of free and reduced-fee care that dentists in Brookline, Massachusetts, provide to patients during calendar 2008. The survey assessed the extent and type of care provided without

fee and the characteristics of the dentists who provided such care.

Before conducting the study, several hypotheses were formulated:

- Older dentists would donate more care than dentists who graduated from dental school more recently. The expectation is that younger dentists still have a great amount of dental school debt; therefore they may be less likely to donate care than established dentists who have paid off their loans and dental school expenses.
- Dentists who graduated from a private dental school would be in more debt than those who attended a public dental school and therefore may be less likely to donate care.
- Dentists who own their practices would donate more than associates of a practice because owners have the decision-making ability and authority to donate care, whereas associates may not have the option to donate care.
- Dentists would be more willing to give free care to patients referred to them by a religious organization or colleague than from a professional organization or local schools.
- Dentists would be more willing to donate care to children than to adults.

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- Dentists who have practiced in Brookline for a longer period of time would be more likely to donate care. This assumption is predicated on a community-based, “giving-back” culture in the town of Brookline.

Methods

The research protocol, including the survey created for this study, was submitted to the Boston University Medical Center Institutional Review Board (IRB); it was determined to have exempt status. A survey was created to explore the amount of free and reduced-fee care that dentists in the Brookline, Massachusetts, community provided. The survey contained a table in which dentists would estimate the number of patients to whom they donated free care and the number of patients for whom they provided care at a reduced-fee during the 2008 calendar year.

The survey was divided into three sections. The first section focused on the age of patients and the amount and types of free or reduced-fee care provided. The patients were categorized by age groups into children (under 18 years of age) and adults over 18, including senior citizens. To distinguish between routine and emergency care, dentists were also asked to specify the number of free and reduced-fee emergency procedures (trauma, pain, etc.) and the number of free and reduced-fee routine procedures for children and for adults and seniors. Finally, dentists were asked to estimate the total monetary value of free and reduced-fee care for children and adults.

The survey included a question regarding the sources of patient referral for free or reduced-fee care. The second section on the survey addressed demographic characteristics of the practice. Questions included the amount of clinical hours worked per week, the number of total patients seen in a week, and the type of practice (general/specialty; solo/group). The third section of the survey contained questions regarding demographics about the dentist, including sex, ethnicity, year graduated from dental school, type of dental school attended (public/private), specialty, and number of years practicing in Brookline.

Initially, postcards were sent to the 186 dentists with a Brookline mailing address alerting them that a survey would be mailed to them within the next seven days and requesting their participation. The names and addresses of all dentists with mailing addresses in Brookline were obtained from the Board of Registration in Dentistry in Massachusetts. Assurances were provided that all responses would be anonymous and that results would be reported in the aggregate only. Three days after the postcards were sent, the surveys were mailed to the population of dentists. The surveys were numerically coded to determine non-respondents and placed in envelopes along with a self-addressed envelope for the dentists to return the survey. Non-respondents were deter-

While critics state that pro bono care is not a healthcare system, this study suggests that many dentists take it upon themselves to address access to care and to serving the underserved in our society.

Table 1. PERCENTAGE OF RESPONDENTS WHO PROVIDED FREE OR REDUCED-FEE CARE BY DEMOGRAPHIC CATEGORIES OF PRACTITIONERS.

<i>Categories of Respondents</i>	<i>Provide free or Reduced-fee care</i>
Male	52%
Female	22
Attended Private School	49
Attended Public School	0
Work in a Solo Practice	55
Work in a Group Practice	47
Work in General Practice	48
Work in Specialty Practice	42
MassHealth Providers	60
NOT a MassHealth Provider	45
In Brookline > 10 years	54
In Brookline 6-10 years	50
In Brookline < 5 years	25
Caucasian	45
Other than Caucasian	33
Graduated > 20 years ago	52
Graduated < 20 years ago	22

mined using the numerical codes on the survey. Two weeks after the initial mailing, a second request was sent to non-respondents. Coding sheets were destroyed immediately after the second mailing and before any data were recorded or analyzed. After the additional responses were received from the second wave, the data was tabulated and analyzed.

Results

Forty surveys were received for a 21.5% response rate, however, one respondent wrote “retired dentist” at the top of the survey and another stated “full-time academics.” Neither of these respondents completed the survey. Therefore, the analysis is based on 38 valid responses. Table 1 shows the number of respondents who provide free or reduced-fee dental care according to demographic categories. There were no significant findings that show these demographics as predictors for donating care.

Of the surveys returned, the mean percent of children treated in the practices was 18%. The average number of patients seen per week by the respondents was 82 and the average number of hours worked per week was 37. Of these respondents, the range of patients seen was 3 to 400 patients per week. The hours worked per week ranged from 3 to 110.

As shown in Table 2, among respondents who did not provide free or reduced-fee care, those dentists reported on average that children represented 16% of their practice. The average number of patients treated per week by those who did not provide free or reduced-fee care was 63 patients, and they worked an average of 29 hours per week.

For those who indicated that they did provide free or reduced-fee care, the mean percent of children they treated was 21%. These respondents estimated that they saw an average of 104 patients per week and worked an average of 46 hours per week.

I queried dentists about the referral sources of patients who receive donated care. Respondents were asked to check all categories that applied. Since many respondents treated patients from multiple referral sources, the total percentages exceeded 100%. The largest source of recipients of donated services was current patients of the practice. Of the 17 dentists who indicated they provided free or reduced-fee care, 13 (76%) indicated that the individuals they treated were current patients. Five (29%) indicated a religious organization as a source, five (29%) stated professional organizations as a source of patients, four (24%) cited a social service agency, and four (24%) indicated a colleague as a source of patients receiving donated care. Only one (6%) cited schools as a referral source of patients.

The amount of free or reduced-fee care provided to children and adults varied substantially. For children, free care values ranged from \$0 to \$5,000 with a mean of \$1,500 and a standard deviation of \$1,856; reduced-fee values ranged from \$0 to \$4,000 with a mean of \$1,378 and a standard deviation of \$1,352. For adults, free care values ranged from \$0 to \$60,000 with a mean of \$14,000 and a standard deviation of \$19,289; reduced-fee care ranged from \$500 to \$95,000 with a mean of \$19,225 and a standard deviation of \$31,358. Figure 2 shows the variation in the number of patients who receive free and reduced-fee care for routine and emergency procedures.

Discussion

From these results it is noticeable that donations of both free and reduced-fee care is not uniform across the profession

Table 2. PERCENTAGE of child and adult patients, hours worked per week, and number of patients seen per week by practitioners who do and who do not provide free or reduced-fee care.

	<i>Child patient %</i>	<i>Adult patient %</i>	<i>Hours worked/ week</i>	<i>Patients seen/ week</i>
Total Respondents	18%	82%	37	82
Free, reduced-fee care	21%	79%	46	104
No free, reduced-fee care	16%	84%	29	63

of dentistry. This can be seen in the standard deviations of those donating, especially donations to adults. While there are dentists who donate large values in free and reduced-fee care, others do not donate nearly as much. Some of the respondents did not donate at all. Of the dentists who did not respond, it would be easy to imagine that the number of non-contributors is larger than in those who responded. I have no way of describing the practices or philanthropy of non-responders.

As seen in Figure 1, the majority of free and reduced-fee donations went to adults. This was an interesting finding because it can be often assumed that charity from dentists goes mainly to children. It is also seen in Figure 2 that the majority of care provided by respondents was reduced-fee and routine care. It is true that adults were the preponderance of patients in the participating practices, and it is also true that there are many financial resources for children’s dental care, including Medicaid (there is no adult oral healthcare coverage in Massachusetts) and S-CHIP programs that are not available to adults.

A statistically significant finding in this survey was that dentists who work longer hours per week were more likely to provide free or reduced-fee care

Figure 1. NUMBER of dentists who reported donating dollar amounts of free and reduced-fee care to children and adults.

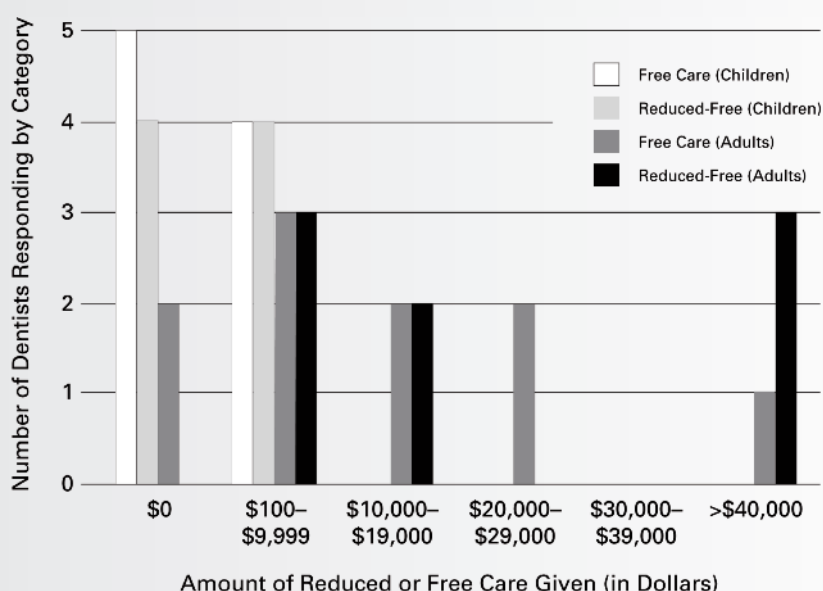
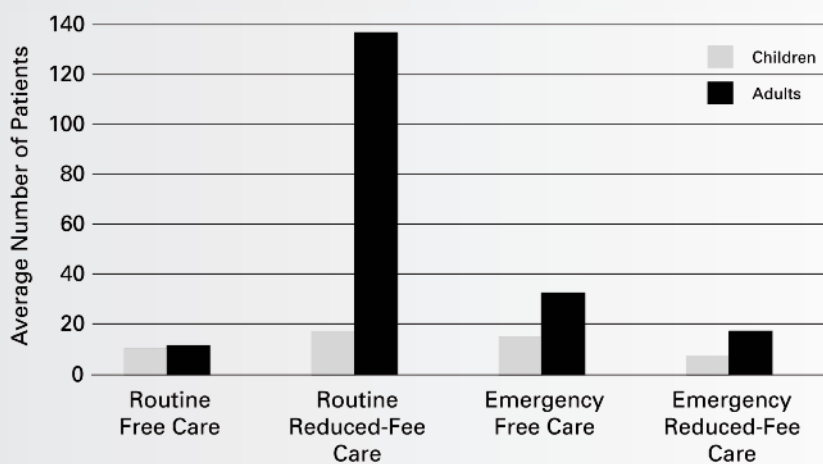


Figure 2. AVERAGE NUMBER of children and adults receiving free and reduced-fee care for routine and emergency procedures.



In future studies of donated and reduced-fee services, follow-up questions may be helpful in gaining more insight into the pro bono care that dentists provide.

(ANOVA, $F=5.174$, $p<.03$). The results show that among respondents, those who donated care worked an average of 46 hours per week, while those who did not donate care worked 29 hours per week. One possible explanation for this finding could be that those who work longer hours might have the financial resources from working longer hours to donate care to those in need. Another possibility may be that by being in the office for a greater period of time in the week, they may be more likely to fit patients who need donated care into their schedule with more ease than someone who is not at their office as long. In addition, those who worked fewer hours per week may have been part-time associates or newer in practice and not in a decision-making position to donate services. Of the respondents who worked fewer than 30 hours per week, three of ten graduated from dental school less than 20 years previously. Two of the three worked in specialty practice and two of the three worked in group practice. Also, of the respondents working fewer than 30 hours per week, four of ten graduated from dental school more than 35 years previously. These numbers show seven of ten respondents working 30 hours or fewer per week being either a recent graduate of dental school or a dentist who may be toward the end of his or her career. Other possibilities include that the dentist was semi-retired or worked in more than one practice site, part-time in a hospital or teaching facility.

Of the dentists who had graduated from dental school 20 or fewer years previously, only two of nine indicated that they had donated care, while for those who had graduated from dental

school more than 20 years previously, 14 of 27 indicated that they had donated care. This result could be due to younger dentists not having the financial resources available to them to donate care. They may still be in the process of paying off loans for dental school and the need to make and save money may result. These younger dentists also may be less likely to own their own practice and may not have the authority to offer free or reduced care to patients. Of the nine dentists graduating from dental school 20 or fewer years previously, six indicated they worked in a group practice or as an associate.

In terms of gender, 15 of 29 (52%) male respondents said that they donated care, while two of nine (22%) of female respondents donated care. This is an interesting result because people may predict females to be more giving and therefore to donate more care than males or to expect no difference at all. Another question is whether female dentists worked part-time as opposed to full-time, and were employed in versus owners of practices. Our study did not address those questions.

For dentists practicing in Brookline for more than ten years, 15 of 28 (54%) donated care; two of four (50%) who practiced in Brookline for six to ten years donated care; and one of four (25%) who practiced five or fewer years in Brookline donated care. This result supported the hypothesis that those who practiced in Brookline longer would be more likely to donate care due to the “giving-back” philosophy of the town. These results may also reflect that the longer one is in practice, the more likely it may be that services are donated free or provided at reduced-fee.

Of the three respondents that graduated from public dental schools, none donated care. Even though there were few public school respondents, it was thought that graduates of public schools

would be more likely to donate care since they may have less debt from dental school. In contrast, 17 of 35 (49%) graduates from private dental schools donated care. This may show that many dentists still find it important to donate care to those in need even though they may have large educational debts to pay off from dental school. It may also reflect a community-based “serving the underserved” philosophy of private academic dental institutions. I wondered whether public school graduates were recent graduates of dental school and therefore limited in their ability to donate care. This was not the case. Two of the three public school graduates had graduated more than 30 years ago, in 1977 and in 1968. Due to the small number of respondents in this category, I was unable to draw any inferences about public versus private school graduates.

Three of five (60%) MassHealth (Medicaid) dentists provided free or reduced-fee care to patients along with their participation in MassHealth. This may show that dentists who are MassHealth providers have a propensity to treat individuals based on need.

Fifteen of 33 (45%) dentists who are not MassHealth providers donated care to individuals in need. These results show that dentists do find a way to serve the community and help needy individuals, even if they do not participate in the MassHealth program. This is a very important finding because the lack of participation by dentists in MassHealth may be recognized, yet the donated services that many of these dentists provide to their patients are not always acknowledged.

The dollar value of care that adults received was higher than that provided

to children. This may be reflective of higher fees related to adult dental services. Other possible explanations for this finding may include a low caries rate among child patients in Brookline practices, or that services for children treated in these practices are covered under Medicaid/MassHealth. The total value of donated services in this population was \$177,500, and the total of reduced-fee services was \$250,600.

Although the response rate (21.5%) was low and the generalizability of results is limited, it is believed that if the study were replicated, the trend of giving and professionalism would be reflected throughout private practitioners in the United States. Another limitation of the study was that the survey instrument was not pre-tested for validity or reliability. Also, it was not possible to determine whether the mailing addresses received from the Massachusetts Board of Registration in Dentistry (BORID) were home or office addresses. BORID confirmed through personal communication that the addresses they are given may be either a dentist's home address or office address. Therefore, it is possible that the survey includes data for services provided in other communities.

Other limitations include the following: All data were self-reported; there was no attempt to validate the accuracy of the amount or type of donated services. The population was small (n=186) and the response rate was limited. I had no way to compare the results of respondents with non-respondents. I have no data that enables me to compare the respondents to all dentists in Brookline. Dentists in Brookline may not be representative of dentists in all communities in the United States, although I have no reason to believe that they differ substantially from other practicing dentists in terms of giving back to the communities in which they practice.

CONCLUSIONS

The results of this study indicate the extent of pro bono or reduced-fee dental care that dentists provide. While critics state that pro bono care is not a health-care system, this study suggests that many dentists take it upon themselves to address access to care and to serving the underserved in our society.

In future studies of donated and reduced-fee services, follow-up questions may be helpful in gaining more insight into the pro bono care that dentists provide. Possible questions may include the following: Why do you provide pro bono or reduced-fee care? How do you determine which patients in your practice will receive free or reduced-fee care? How do you determine from which sources you will accept referrals? How do you determine when you will accept referrals? How do you determine how many referrals will you accept? How do you determine how much free and reduced-fee care you will provide? Answers to these questions will provide a greater understanding of how individual dentists contribute in helping to overcome barriers in access to dental care in the United States. ■

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2012 MANUSCRIPT REVIEW PROCESS

Nine unsolicited manuscripts were received for possible publication in the *Journal of the American College of Dentists* during 2012. Three were sent for peer review. Two manuscripts were accepted for publication following extensive modifications suggested by peer review; one is awaiting further modifications before a decision can be made. Thirteen reviews were received for these manuscripts, an average of 4.33 per manuscript. Consistency of reviews was determined using the phi coefficient, a measure of association between review recommendations and the ultimate publication decision. The phi was .365, 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.

Instructions for authors and instructions for reviewers can be found on the Web site of the College. 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.

The Editor is aware of five requests to republish articles appearing in the journal and seven requests to copy articles for educational use received and

granted during the year. There was one request 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. Eleven manuscripts were nominated for consideration. The winner was Lisa Deem's article, "College Students Practice Dentistry in Third World Countries," which appeared in the May/June 2011 issue of the *Pennsylvania Dental Journal*. Eighteen judges participated in the review process. Their names are listed among the Journal reviewers below. The Cronbach alpha for consistency among the judges was .938.

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 2012.

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Washington, DC

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SUBMITTING MANUSCRIPTS FOR POTENTIAL PUBLICATION IN JACD

Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of JACD. These can be found on the ACD Web site under “publications.” In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not

publish clinical case reports or articles that describe dental techniques. The communication policy of the College is 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.”

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A “desk review” is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer review process typically takes four to five weeks.

Authors whose submissions are peer reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on this site and is labeled “How to Review a Manuscript for the *Journal of the American College of Dentists*.” An annual report of the peer review process for JACD is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts reviewed and the consistency of the reviewers is in the phi -.60 to .80 range.

This journal has a regular section devoted to papers in ethical and professional aspects of dentistry. Manuscripts with this focus may be sent director to Dr. Bruce Peltier, the editor of Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.

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