The Ethics of Charity at Home

Spring 2014
Volume 81
Number 2
Communication Policy

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

Objectives of the American College of Dentists

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

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

Why does evidence-based dentistry still have a cachet, but quality never quite managed to catch on?

We could blame John Gies, a biochemist, who authored a 1926 report blasting dentistry and dental education for lacking the proper scientific foundations to call themselves professions and followed six years later with an ACD report noting with embarrassment the role of commercialism in dental journalism.

Good progress has been made on the first concern. Dental education found new homes in research-intensive universities where science was one of the languages spoken. This has enhanced dentistry’s reputation among the professions and given it credibility in the eyes of the public, to say nothing of supporting specular enhancements in the techniques available to fix problems in the mouth. Dentistry took on the prestige of the academy.

Gies was realistic in forecasting that oral diseases are complex and it would take several decades to move from a “fix-it” approach to prevention and cure, but he certainly expected the latter to be the proper focus for inquiry. I can imagine he would give a wrinkled grimace to find that 80 years later, the EBD label is primarily reserved for horse races between competing reparative technologies. I fantasize that he would be writing letters to the editors of journals pointing out that science and evidence are not the same things.

By contrast, little has come of Gies’s plea to escape the grip of commercialism. There was an initial period of perhaps 20 or 30 years when proprietary interests were pushed aside. Some practice acts at that time prohibited commercial exhibitors from attending scientific sessions of dental associations, while schools were scrupulous about protecting students from exposure to detail men and faculty appointments were terminated if conflicts of interest were found. Dental Cosmos, Gies’s bad boy of commercial journalism, carried about the same ratio of scientific copy to ads as does today’s JADA (4/1), although both articles and ads are of better quality now.

Evidence-based dentistry is the integration (by practitioners, not researchers) of patient values, the best outcomes of research, and clinician’s practical wisdom. That is an ambitious project. Patient values are sometimes overlooked or assumed to be the same as the dentists’. It is a bit of an epithet to say that practitioners are justified in placing faith in what “works in their hands.” Integration of diverse values and evidence at chairside is a fantastically complex art. It has received virtually no scientific study. That sometimes leaves the impression that EBD is essentially a matter of reading the literature or at least summaries of the “best” parts of it.

The computer, promotion and tenure requirements at universities, and commercial funding of “applied science” have changed research dramatically over the past half century. When I first taught statistics, the focus was on what insight could be gained from reading a single, well-conducted study. Today, we read abstracts and look for trends in numerous related studies. Study designs have to be standardized in order to facilitate computer searching and extraction of common features. Protocol—following the rules—is now the thing, and one cannot be published unless computer-ready.

Clinical guidelines have proliferated. A panel of experts is convened for a conference, usually under the auspices of a professional organization. Evidence-based clinical guidelines are agreed and published. There are clearing houses for clinical guidelines. In fact, this very moment I did a Google search on “clinical guidelines” and found 139,000 of them. A common research paper now is for investigators to survey practitioners in a field to find out whether they practice consistent with the guidelines or even know that they exist. Fifty percent awareness is generally the high end. The conclusion of such studies is typically that more education and research are needed.
There is much less to say regarding TQM. The goal there is to identify what is needed and work to raise the level of oral health; reduce unwanted variation; and reduce cost, time, and dangerous surprises for practitioners. TQM can be performed in individual offices, or better in groups of offices. It depends on good record keeping. In the place of statistical tests that editors like to see for publications, TQM works when dental practices thrive by improving the outcomes they are focused on. TQM looks to results (the dependent variable); EBD looks to materials and methods (the independent variable).

The ADA has invested heavily in EBD with training programs, study groups, and a Web site. TQM has received less attention, and that not always favorable. I can only speculate that EBD offers the advantage of associating dentistry with the positive reputation of science while leaving the choice of how to use the evidence to individual practitioners. That is less risky than publically setting quality outcome targets. The focus in EBD on materials and methods rather than oral health outcomes has certainly opened the door for commercialism to reenter the profession.

At present, the champions of TQM are a few closed panels, large group practices, and even insurance companies.

Gies became interested in dentistry in 1909 when members of the First District Dental Society of New York visited his lab and offered to fund his inquiries into stopping caries. That is a TQM question defined by results rather than methods. John Gies would be disappointed, I think, that we have permitted such a wide gap to emerge between science and practice. The gap has not always been filled by individuals whose first goal is to improve oral health. Fancy trappings of science bring rigor to the protocol of that enterprise but they do not bend its purpose to finding the best way to make mouths healthy.

An advocate for TQM would start by asking what barriers exist to optimizing oral health and how those barriers could be reduced. That is a bold move, as it would require an upfront recognition that professionals are not the only ones with some legitimate claim to opinions about what constitutes good oral health. Touting scientific methods is safer than pursuing quality results.
Abstract
Student Community Outreach for Public Education, SCOPE, is a student-led community outreach program at the University of the Pacific that provides leadership opportunities, service experiences, and a chance to understand the oral needs of all Americans. The organization and activities of the program are detailed, along with a description of the type of individuals served. The complex range of motives for community service and the relationship between the private system and the safety-net system are explored.

My responsibility is to promote the health of the community and the persons I serve. I will not discriminate against any person in my decisions and care. I am responsible for contributing to an improved community. I will strive to prevent disease and to correct adverse social conditions. I will serve as both a teacher and a role model for my patients, my successors, and the public.

—Excerpts from the University of the Pacific Arthur A. Dugoni School of Dentistry Professional Oath

At the start of second year, every University of the Pacific dental student recites these words at the White Coat Ceremony. As specialized providers of oral health care, we bear a tremendous obligation to contribute to the well-being of our respective communities. What are the clinical care examples and lessons taught in school about upholding that responsibility? What are we to glean from our education about the ethics of charity care? While we are in school, we see a wide variety of patients in our clinics, but certainly not a representation of all the members and age range of a community. People who are the working poor, infirm, destitute, incapacitated, or the very frail elderly are all essentially excluded from receiving care at the dental school, despite the school clinics being a more affordable option in a cutting-edge facility. How, then, are dental students able to gain experience with these marginalized groups that so desperately need the attention of the dental profession?

For about three weeks in our final year of dental school, we will have the opportunity to do extramural clinical rotations in community clinics and hospitals that will allow us to diversify our patient experiences. Another way that we gain experience with a cross-section of the community and exposure to challenges with access to dental care is through projects sponsored by on-campus committees like SCOPE, which stands for Student Community Outreach for Public Education.

The three authors of this article are heavily involved leaders of this group. Professor Christine Miller is the founder and has been the faculty advisor for years, Peter March and Amy Blake are the current presidents, a position held by junior-year students. SCOPE is a leadership development, peer mentoring, and student-directed volunteer community oral health organization. Designed and initiated over 20 years

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ago by a core group of students and faculty, the mission is to develop dental professionals engaged and committed to improving the oral health of all people.

SCOPE officers coordinate projects and events throughout the Bay Area in many different venues, such as health fairs, community centers, dental clinics, and hospitals, and make volunteering opportunities available to the student body. As SCOPE leaders and dental students, we see various reactions: the eagerness with which our fellow students jump at the chance to volunteer and sometimes the apathy of students.

In the second year, the curriculum officially presents 18 community health modules that provide the “meat and potatoes” of what we need to know when we work with underserved groups. When the modules were introduced to us, they were met by a chorus of grumbling. Further, there is almost no conversation about improving the system of providing care to include disadvantaged groups. The majority of students want to become private practice dentists or specialists serving patients who have insurance or the means to pay for services, not to work in community health or address healthcare policies that have left vulnerable populations with little or no access to dental care. At the same time, when we post events for volunteer sign-up, we are usually inundated by a flood of responses and often need to turn students away.

An example of our school’s interest in volunteering has been our participation at the Bay Area CDA Cares events. In 2013, there were 165 Pacific volunteers, and in May 2014, 180 students out of a student population of about 420 students volunteered. Big events held on Saturdays allow more students to volunteer without clinic conflicts or limits on attendees.

Why Participate?
This dichotomy in attitude is difficult to make sense of, and its implications regarding charity care and the upcoming crop of dentists is unclear. We wonder what exactly motivates students to volunteer, and we have identified what we think are some key reasons.

For one, it has become a routine and often “required” part of education generally for students to volunteer. Many high schools and colleges now have a community service requirement, and thus students are not only accustomed to volunteering, but actually expect it as part of their education. This contributes to creating a culture of volunteerism, it is something people do to socialize, and they do it because their friends are doing it. Another aspect is the increased awareness dental students, along with the general public, have about the dental care crisis in America. For example, “Dollars to Dentists,” a 2012 program produced by PBS’s Frontline, exposed the inequities in dental care in the United States. Huge free dental events like CDA Cares, Missions of Mercy, California Care Force, and Remote Area Medical, always

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draw media attention and have done their part to raise awareness of the access problem.

In 2009, California curtailed its Medicaid insurance program, which led to a spike in demand for low-cost dental services and emergency room dental visits. The situation at hand is both heartbreaking and overwhelming, and dental students are motivated to address it.

On the other hand, we believe that there are other motivations for volunteering that are not so philanthropic. The job prospects for new dental school graduates look very different than they did two decades ago. The market is extremely competitive, and some students are saddled with enormous debt. Further, postdoctoral residencies are now sought out by the majority of dental students. For example, in our school alone, the number of students accepted into GPR/AEGD in 2009 was 23. In 2013, the number was 51. For those of us applying for jobs, associate positions in private practice, GPRs, AEGD, or specialty schools, it is a necessity to have extracurricular activities like volunteering and student leadership on our résumés to even have a chance for an interview.

In other words, students are sometimes more motivated to volunteer in order to propel their own self-interests than to help needy communities. Regardless of their motivation for showing up to volunteer, we hope that the experiences students have will open their eyes to the problems the profession faces in providing services to all Americans.

Adapting to an Ever-changing Landscape

Starting over 20 years ago, community oral health projects have been available to volunteer students through SCOPE. Decades ago, five dental students and the Director of Community Programs launched the student-directed program to benefit students and the underserved public. A hallmark of SCOPE is the peer-mentorship design. Today, the program expanded by student recommendations, is known as Community Campus Partnership Projects [CCPP], which now includes, SCOPE, Project Homeless Connect, major events, and selective course options in the curriculum.

Prior to dental school, many CCPP-SCOPE officers directed or volunteered in community health service projects in college. Each year more students arrive to dental school anticipating continued engagement with underserved people and with health projects in the community.

Some of the professionally proposed and current solutions on access prompt lively discussions among students. Additionally, in regard to practice options after graduation, students envision and discuss potential alterations in the current healthcare delivery system, including changes in financing of dental services and incentives to providers to promote prevention and other health outcomes. These environmental changes, plus the health policy recommendations to diversify and expand the dental workforce, weigh on the minds of students.

SCOPE and CCPP community projects are strategically designed to meet both the community oral health needs as well as the professional and clinical preparation of tomorrow’s dental practitioners. The SCOPE-CCPP community health projects form the foundation and bridge between the dental school and underserved...
communities. Public health reports and dental health profession shortage areas are used to target specific low-income neighborhoods, school and preschools, and senior centers. The program is governed by about 12 leadership council officers under the supervision of the Director of Community Programs.

The mission of SCOPE is related to one of the elements in the school’s mission: to develop dental professionals committed to and engaged in improving the health of all people. Major objectives of SCOPE include:

- Provide students community-based experiences for risk assessment, screening, triage, and referral to “health homes” in a wide variety of oral health community service projects.
- Expand experience for oral health prevention education and preventive dental services for the underserved members of the San Francisco Bay Area and Central Valley communities.
- Use “best practices” for data collection and analysis and report risk and disease status, services utilized, the number of participants served, and other demographic information.
- Collaborate with professionals, such as nursing, medical, and social services, and students, residents, community dentists, and hygienists.
- Refine the peer-mentoring system while in school for students to actively lead, design, implement, and assess outreach projects year after year.
- Communicate with the public, agency staff, health professionals, and others in an empathetic and culturally competent manner.
- Promote leadership while in school and lifelong professional engagement directly with underserved community members.

In the next decade, dental education programs must make available opportunities that engage students in community-based experiences or service learning experiences. Significant changes, challenges, and innovative solutions to address the underserved populations surround the profession. Dental disease is increasingly being viewed by medical and dental professionals as a chronic disease. Community settings such as school-based health programs, preschool programs, and senior centers will increasingly be used as sites to deliver specific preventive and restorative services. With these changes and other healthcare system changes, dental professionals and graduates will likely interact with a broader group of social and health professionals in more diverse practice settings.

Provision of community-based “practice ready” experiences has become an important component of higher education. Integrating community service-learning into dental curricula fosters graduates who are better prepared to work effectively among diverse populations and to function dynamically with related health and social service professionals. Dental education can apply the concepts of experiential education for developing students’ skills in understanding human diversity, critical thinking, and the dynamics of integrated professional education and promotion of community oral health.

Lessons on the Ethics of Charity Care

An example of one of the major outreach events in San Francisco is Project Homeless Connect, a one-day event that happens about every three months to provide a number of services to the homeless population. One of the most demanded and popular services is dental care. SCOPE has had a relationship with Project Homeless Connect for over five years. We provided student volunteers and faculty members to screen patients at a community center and then refer them to receive hygiene, restorations, or extractions. During the December 2013 event we saw 44 patients, extracted 255 teeth, and provided more than $33,000 worth of treatment. One senior faculty member stated that participation in Project Homeless Connect and SCOPE is one of the most enriching clinical experiences for students and strongly encourages participation. He facilitated course flexibility in the regular curriculum to allow alternative sessions so students could attend the Project Homeless Connect events.

One of the questions that comes up about large events is whether or not these outreach events raise ethical questions for the students about the continuity and nature of the care being provided. When we posed this question to students who frequent these events, the general consensus is that it is just not something they think about. Some large events strive to link the underserved public to dental health homes. Others are designed in a way to highlight and praise what appears to the public as heroic dentistry with abundant media attention. This gives the impression that all of the care and volunteerism is positive and the focus is...
more on what was done and not the needs after the event. As a first-year student, I was very impressed with the results from single-day dentures, which I assumed would be too difficult to do fast in a normal clinic setting. After gaining more experience in school, I came to realize that almost all dental care should be given in a comprehensive, continual care setting where dentures are monitored for fit and restorations periodically examined. It was not until going to several events that I began to consider the ethics of this kind of sporadic dental intervention in which continuing care is treated as an after-thought and the treatment is still focused on single, high-priority treatments.

Is it fair or beneficial to the patients who show up at these events but do not have a dental home for follow-up care? Where does the denture recipient go for the inevitable adjustments they will need? What about the indirect pulp caps that are often placed at these events if they turn into pulpitis?

And the biggest questions of all: Is the fee-for-service business model ethical when a disproportionate burden of disease is borne by poor and vulnerable populations? Is it fair to practice a different standard of care in charity settings despite the good intentions on behalf of the volunteer practitioner?

The standard and continuity of care for large event charity work is quite different from private practice. Continuity of care starts with referring and directing the individuals attending large events to realistic nearby “health homes or dental homes.”

As already mentioned, inconsistent and episodic treatment without follow-up pushes the boundaries of the standard of care. I have personally been to events where fillings and extractions were performed without any radiographs. Is this considered to be acceptable, because of the dire circumstances? Then there is the matter of international dental missions, which are even more confusing from an ethical standpoint. Dentists and dental students alike participate in these trips that often take place in exotic destinations with vacation appeal. The clients or patients seen in these circumstances are at an even greater disadvantage than their American counterparts because there is no safety net system for them to turn to. It is a wonderful thing to provide dental services to these patients, but the downside is that there is seldom adequate follow-up provided and very little regulation of these makeshift clinics.

As students, the ethical considerations of charity care are as complicated as the system that has created such extreme neediness in certain populations. Whatever the “right” answers are to these questions, what does seem perfectly clear is that it will require a coordinated effort among many professionals and agencies within and outside dentistry to provide a more inclusive, comprehensive system of care. The goal should be to eliminate the need for charity care.

As student leaders, we encourage our peers and community practitioner participants to reflect about these issues. Now is the time, as we develop into dental professionals, to engage ourselves in the challenges and solutions to access to care. We challenge our peers to strive toward making access to critical health services more equitable.
### SCOPE and Community Campus Partnership Projects

Annual Outreach Activities & Projects, University of the Pacific Arthur A. Dugoni School of Dentistry

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**Spring Quarter**

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Mission of Mercy

Mark Humenik, DDS, FACD

Abstract
Some dentists prefer solo charity work, but there is much to be said for collaboration within the profession in reaching out to those who are dentally underserved. Mission of Mercy (MOM) programs are regularly organized across the country for this purpose. This article describes the structure, reach, and personal satisfaction to be gained from such missions.

“Do good work; treat the patients well.” That was my response to a young dental associate who recently asked how he might thank me for my help and guidance. It is a principle that has guided me through dental school, advanced training, and private practice. And now, like a growing number of my dental colleagues, I can fully express this conviction, in its purest sense, by caring for the underserved.

As dental professionals, we strive to provide assistance and promote healing. We also recognize that the access-to-care issues are critical. Thanks to the initiative and enthusiasm of practicing dental professionals successfully partnering with like-minded friends of dentistry, there has never been a better time to make a significant contribution. Volunteer opportunities are increasing in both number and scope in an effort to reach and treat more patients. With minimal time and financial commitment, those keen to share their skills will gain immeasurable rewards. Also, by volunteering in our field, we combine our eagerness to give back with our greatest strength, our expertise.

As the president of America’s Dentists Care Foundation (ADCF) board of directors (the nonprofit parent organization of Mission of Mercy), I have had the privilege of witnessing the growing participation of dental professionals and dental societies to develop, promote, and host successful Mission of Mercy events. Since the first event was held in Virginia in 2000, Mission of Mercy clinics have improved and expanded every year. The first ADA-sponsored event was held in conjunction with the 2013 meeting in New Orleans, and the next clinic is scheduled to take place this fall in San Antonio. At the conclusion of 2014, the Mission of Mercy family will include 26 states.

Each Mission of Mercy event, or “MOM,” is a two-day dental clinic providing approximately $1 million in charitable dental treatment for 1,600 or more people. Our patients seek assistance because they lack access to dental care. This issue occurs due to limited or nonexistent financial resources, no dental insurance, or the lack of a dental home. All ages are welcome, although pediatric services account for under 15% of event patient treatment—parents will prioritize their children’s needs, and more state-funded programs are available to serve them. A MOM event is hosted by the state dental society and its foundation in partnership with ADCF. The benefit of a state partnering with ADCF is that the infrastructure and support are in place.
place to host a large, high-profile, very productive clinic on a weekend.

A typical MOM event features a 100-chair portable dental clinic, complete with central compressed air, vacuum and water, instruments, and sterilization. ADCF provides, services, and maintains the equipment in addition to offering guidance and technical support prior to and throughout every event. Dental treatment at a MOM event includes cleanings, basic restorative services, oral surgery, and limited endodontics. Oftentimes an on-site lab provides treatment partials and in some states, prefabricated full dentures. Patient educators and assistance from local social service organizations reinforce and support clinical treatment.

Patients are seen on a first-come, first-served basis and are not required to show proof of need or citizenship. Every patient receives at least one treatment after passing a preliminary medical screening (i.e., blood pressure/blood glucose). The goals of a MOM event are:

- Provide free, critical dental care with a high priority on treating patients in pain and with infection.
- Raise public awareness of the barriers to dental care faced by individuals with limited financial resources.
- Challenge patients, policymakers, and dental professionals to work together to make viable and bipartisan “healthy choices” that will improve the oral health of United States citizens.

What is necessary to host a MOM?

It is important that a passionate group of individuals guide and advance the program in active collaboration with dedicated state dental society or foundation staff. Approval and support at the state level is critical to establish a “MOM headquarters” and to ensure the tax-deductible status of all donations. In addition, strong support from the local host community and local dental society for pre-event assistance, on-site assistance, and follow-up care are required.

A MOM event is typically scheduled 12-18 months in advance. This allows the member states adequate time to obtain funding (approximately $150,000 in financial and in-kind donations), seek and secure an appropriate venue, coordinate volunteers, and work with ADCF staff to assess and configure clinic needs. Staffing for a standard MOM event is significant: approximately 250 dentists (general and specialists), 100 hygienists, and 650-700 lay volunteers are required.

Nationwide, Mission of Mercy events have had a positive impact, treating over 146,000 patients and providing $84 million in free dental care since 2000. For every donated dollar, dentists and other MOM volunteers provide $6-8 of care. It has been observed that following MOM events, dental emergency room

It is impossible for an individual to successfully volunteer without a network of support.
As dental professionals we strive to provide assistance and promote healing. We also recognize that the access-to-care issues are critical.

visits are seen to decrease, often by as much as 40-50%.

A free, bustling clinic allows us to heighten political awareness by inviting legislators, community leaders, and the media to witness the “human face” of our dental access problem. A MOM clinic can prompt productive discussions that we hope and believe will lead to better solutions to meet the rising demand for oral healthcare services for those individuals with limited financial resources.

Collaboration is intrinsic to ADCF and Mission of Mercy. The philosophy behind MOM and ADCF is “see one, do one, teach one.” It is a terrific model for growth and illustrates a culture that mandates collective sharing. State dental societies and program directors are encouraged to share clinic protocols, volunteer recruitment suggestions, fundraising methods, promotion techniques, etc. Guests visiting another state’s MOM events are enthusiastically welcomed and are encouraged to remain in close contact to ensure that ideas are shared, questions and concerns are addressed by those with greater experience, and assistance is made available upon request. The same is true with ADCF. Home-office personnel as well as foundation board members welcome e-mails, phone calls, and opportunities to volunteer on-site.

The esprit de corps that resonates through Mission of Mercy is also an essential component of organized dentistry, dental societies, and study clubs. Through our involvement in these groups, we benefit from and are enriched by the friendships that develop, the knowledge and insights that are shared, and the support that is offered when challenges arise. In addition we are afforded opportunities to develop common goals and celebrate individual and group successes. Participating in a MOM experience provides the opportunity to give back through our profession in a meaningful way.

Dental friends have remarked that, though they may have volunteered in their communities, at church and school functions, and at larger, nationally organized events, no experience quite compares to a MOM event. The difference lies in the pleasure of using their skills creatively while working side-by-side with colleagues outside the comfort of private practice. Many have conveyed that they have never felt a stronger sense of solidarity within dentistry or more pride in their fellow caregivers. Great satisfaction comes from committing to one another and contributing to the team’s common vision to transform lives.

A Mission of Mercy event absolutely transforms lives in a direct and tangible way. Inevitably one of the first patients in line will present with active infection involving a front tooth or missing front teeth. These individuals are always self-conscious and confide that they are embarrassed to apply for jobs. Later in the “clinic day,” following treatment, the dental team is able to deliver a transitional partial that restores the patient’s smile and dignity and provides a confidence boost that will allow him or her to seek employment. Nothing compares to the joy shared by the patient and many caregivers. It is really remarkable!

Amelia Earhart observed that, “a single act of kindness throws out roots in all directions, and the roots spring up and make new trees,” thus illustrating the power and expansive nature of volunteerism. When we choose to actively contribute to and promote our cause to staff, patients in our practices,
family, and friends, our enthusiasm has the capacity to influence and inspire. Many a dental office has committed, as a team, to participate at a MOM event and have found that in addition to accomplishing a great deal of good work and good will in a weekend, they have gained a better appreciation of their colleagues’ talents, improved their communication techniques, and returned to the office as a stronger unit.

As critical as practitioners are to the success of a MOM event, the support roles undertaken by general volunteers are invaluable. Dental supply representatives, technicians, plumbers, electricians, local and national business associates, friends of dentistry, family, and personal friends step up and embrace incredible challenges to set up, maintain, and dismantle a clinic. For their dedicated efforts, this enthusiastic group earns the gratitude of both the patients and clinicians.

It is impossible for an individual to successfully volunteer without a network of support. Time away from practice and family shifts our concerns to others who willingly commit themselves to our cause. I contend that every individual close to the on-site volunteer, personally or professionally, contributes as an active member of the volunteer team. At a minimum, the “at-home” team offers necessary personal support, accepts increased responsibilities at home or office, and often is involved in fundraising and securing necessary supplies and equipment. I always respond to every gesture of support with, “Thanks for being part of this mission!”

For me there is no experience more thrilling than watching the clinic hum with an energetic, productive rhythm as dental students, hygienists, assistants, and general volunteers, together with younger and more senior dentists work in concert to treat deserving people. Our patients benefit enormously and so does every volunteer.

The countless “MOM Moments” we experience through volunteering are deeply satisfying. However, we recognize that regardless of an event’s success or how worthwhile the experience is for its participants (patients and volunteers), we are limited by the nature of our clinic. We are equipped only to deliver critical care, and a MOM clinic is not intended to function as a patient’s dental home. A great need remains to be filled and until better programs are in place to offer complete treatment to individuals with limited financial resources, MOM and other outreach ventures are crucial.

As a skilled team of dental professionals sharing our expertise, we send a genuine and explicit message to the general public and our state and national politicians that our attempts to provide access to care are diligent and innovative.

I guarantee that a MOM experience will enrich you and invigorate your career commitment. If the challenge of a lead role sounds too ambitious, I encourage you to volunteer on-site at a MOM event. Your involvement (as a clinic set-up or tear down volunteer or as a two-day, one-day, or half-day treatment provider) is always genuinely appreciated. If a time conflict prevents your clinical participation, I ask that you consider making a financial donation in support of an event at www.adcfmom.org or through your state dental society.

By the simple gesture of offering your skills, enthusiasm, and support, you will positively impact other lives, as well as your own.

No experience quite compares to a MOM event. The difference lies in the pleasure of using their skills creatively, while working side-by-side with colleagues outside the comfort of private practice.
Do dentists have a moral duty to provide charity care? That is a valid question. We can go further: Does anyone have a moral duty to provide charity? Maybe people do not have an obligation to give charitably. But turn the question around. If someone has the means to give, perhaps they should. We believe the answer is yes—especially when it comes to healthcare services. Helping those in need is central to the mission of healthcare providers. We do not mean they must donate money. While we do believe they should if they have the means, we are referring specifically to volunteering time and talents.

Across the country, there are so many people in so many communities who have no access to quality dental care. In Atlanta, hundreds of thousands of people cannot afford a dentist. Yes, they have many other needs as well, such as affordable housing, food and clothes, and transportation. And there are many worthwhile charities that offer support in those areas. But unlike an organization such as Habitat for Humanity, where volunteers do not need to have a certain level of education to build a house, dentistry is specific. It can be provided only by a limited number of highly trained individuals in any community. Perhaps the privilege dentists have earned places them in a different position with respect to helping others.
supporters who share the challenge of treating this population but recognize our limitations. Once our volunteer dentists restore stable oral health, we have reached our primary goal of offering a helping hand to individuals. But they still have other needs, and using a patient-centric approach, we try to help them navigate and advocate for those needs. To do this we have two social workers to help patients with mental health and social services concerns and then identify resources for primary health, vision services, and other needs including food, shelter, energy assistance, job training and placement, clothing, substance abuse and recovery, domestic violence, and the like. If dental health is truly a part of overall health, it should not be offered in isolation.

The clinic itself is part of Jewish Family & Career Services (JF&CS), an organization that provides programs, services, and support to the entire community, regardless of race, religion, or age. JF&CS depends on both donors and volunteers to operate.

**Ethical Standards in Charity Clinical Care**

The American Dental Association spells out what it expects from its members in its *Principles of Ethics and Code of Professional Conduct*:

Since dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

Giving back is important but where ethics enters into the equation is in giving the same level of quality as in private practice. Dentists have an obligation to do good, high-quality work—no matter where they are doing it and who the patient is. We might even place volunteer work on a higher ethical level, because one is not getting compensated for doing it. For dentists who volunteer their time through pro bono treatment or even at Mission of Mercy-type of events, it can be challenging to maintain that level of commitment.

One of the great things about BMDC is our ability to provide ideal treatment, which is not always possible for charity patients treated in a private office. We do not frequently have patients who ask why they need this root canal or that other procedure. They have confidence that because with no cost involved, they are getting what they actually need. Special, once-a-year charity events have their place—principally to sensitize patients and practitioners regarding the need for care. Charity clinics in fixed locations...
Perhaps the best response to that is for excessive or unreasonable requests. The underserved and this may lead to a practitioner who provides care for professional’s business. People might hear services can interfere with a profession episodically or in remote areas. Local It can appear easier to do charity in one’s neighborhood. Reluctance to Do Charity in One’s Neighborhood

It can appear easier to do charity episodically or in remote areas. Local services can interfere with a professional’s business. People might hear of a practitioner who provides care for the underserved and this may lead to excessive or unreasonable requests. Perhaps the best response to that is for large-hearted dentists to pool resources. BMDC, for example, serves as a screening and coordination mechanism for patients. We provide a venue for dentists to focus on what they are good at—delivering treatment. We take those difficult or awkward situations they might face out of their hands.

Another barrier to private-office charity care might be the potential for liability. Community clinics have surmounted that by using the laws of the state to offer our providers sovereign immunity coverage.

Multiple Standards of Care

The question of quality of care received in private fee-for-service offices and community clinics depends entirely on how the question is framed. One sense of quality has to do with the standards for the treatment that is delivered. The issues here are informed consent, sterilization, technique and materials, freedom from iatrogenic effects, and service life of the procedure. Community clinics have an advantage over health fairs and other occasional events in temporary locations and are on a par with private offices. There should be only one standard for treatment rendered. There is an additional definition of quality of dentistry, and that has to do with whether patients receive the treatment they need. There is a sense in which patients who cannot afford fee-for-service dental care experience a lower quality of oral health. Community dental clinics that accept all patients regardless of ability to pay play a critical role in meeting this standard of quality.

While the need for public oral health varies from state to state, there always will be patients without access. That remains true in the general medical field as well, and laws like the Affordable Care Act (ACA) are intended to help close the gap for those who cannot afford medical care. The oral health field will not change any time soon. Nationally, the ACA does not require oral health. In some states, there is public access for it.

Our ability as dentists to literally heal the community is enormous. By addressing people’s dental needs, we are not just addressing their medical needs. We are doing something much greater. By helping them physically, we are helping them emotionally, and they are more likely to end up in a better place. If they are unemployed, they may be able to reenter the workforce or focus their energy on improving their lives in other ways and contributing to society.

Ben Massell’s legacy is built on getting people back on their feet, giving them back their dignity, and helping them to improve their lives. For more than a century, we have been changing thousands of lives every year. We have evolved into a training center for students and residents, and we are fostering a commitment by this next generation to quality volunteer work. Public health is a critical piece of the overall education of the next generation of dental professionals.

The decision to volunteer or not is an individual one. What we have found overwhelmingly is a generosity and compassion from most dentists. Is there a moral obligation? We are uncertain. Neither of us is that authority. But what we do know is that many dentists do believe there is. Many come to us looking for a way to give back to their community. That is a good thing, because if they did not want to give back, where would we be? And more important, where would our patients be?
Abstract

Federally Qualified Health Centers serve, on a “cost-to-provide-care basis,” low-income and other patients who cannot use private pay facilities. This is a safety-net care system that is much more comprehensive and less expensive than emergency room visits. The existence of an FQHC in a community partially removes the pressure on fee-for-service providers to make arrangements for treating dentally disadvantaged individuals. Increases in federal spending for dental services have recently outpaced declines in out-of-pocket private pay spending and sluggish improvements in insurance coverage.

An FQHC is a Federally Qualified Health Center. FQHCs are the “safety-net” facilities for underserved communities. “Medically underserved population” refers to those in urban or rural areas designated as having a shortage of personal health services. This includes the homeless, migrant workers, and patients with the inability to pay for their own health care. FQHC facilities can be community health centers, Indian Health Services, or programs serving migrant workers and the homeless population. The main purpose of an FQHC is to provide primary care services. These facilities receive enhanced reimbursement from Medicare and Medicaid in exchange for providing services to the low-income population.

This low-income population is generally medically underserved, meaning having no insurance or insurance of limited value, where there are few providers that are willing to take patients’ coverage. When the dental services ceased to exist for adults in California in July 2009, patients often sought care at FQHC clinics. More often than not, this treatment was done in the emergency department of hospitals or in primary-care physician offices.

There are certain required primary health services that must be provided by an FQHC clinic. These services include:

1. Health services related to family medicine for all age groups
2. Diagnostic laboratory and radiology services
3. Preventive health services including prenatal and perinatal services, cancer screening, well-child services, and immunizations
4. Dental screenings to determine the need for dental care, and delivery of preventive dental services
5. Emergency medical services
6. Pharmaceutical services
7. Hospital and specialty care

Additional health services, which include behavioral and mental health, recuperative care, environmental health services, and others, are also provided in several of these community clinics. A reduced-cost program must be in place for non-emergency services that the facility is not required to provide.

There are benefits associated with being an FQHC provider. These include receiving cost-based reimbursement for services provided under Medicare, reimbursement under state-approved payment for services provided under Medicaid, medical malpractice coverage through the Federal Tort Claims Act, eligibility to purchase prescription and nonprescription medication for outpatients at a reduced cost, access to national health services, access to vaccines for children program, and eligibility for various other federal grants and programs.

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The main purpose of an FQHC is to enhance the provision of primary care services in underserved urban and rural communities. These facilities receive enhanced reimbursement from Medicare and Medicaid in exchange for providing services to the low income population.
Operation

An FQHC facility offers comprehensive health care much the same as a closed panel health system or Health Maintenance Organization (HMO) does. The standard of care offered is usually high, as there are several quality measures in place that are constantly being reviewed, monitored, and enhanced. Continued reimbursement for services provided is dependent on the quality and extent of care being administered. FQHC facilities do not treat patients other than low-income patients that qualify for financial assistance in regard to their medical care. Providers, both medical and dental, are either employees of the FQHC or on contract with it. They do not bill their “pro fee” to any patient for the services they provide, as all billing is done by the FQHC facility. In such a system, private patients are not obligated to take on the financial burden of allowing the provider the opportunity to treat low income patients. Between 2008 and 2001 the amount of money entering dentistry from private pay fell by almost 7% in constant dollars. At the same time insurance contributions rose by 2.6%, but the amount of cash entering the dental market from federal sources grew by 36% and now stands at about 10% of all funding.

Since FQHCs are an all-inclusive health system, low income patients, attached to an FQHC, have the benefit of receiving all of their health services within the same facility. This can be considered a benefit not available to the private-paying public. An important thing to note is that patients treated in an FQHC are patients that the private medical and dental providers do not usually want to treat due to low reimbursement for services provided. To give an example, when San Mateo Medical Center opened the dental clinic at Coastside, the dental-practice community was concerned about the clinic, until they realized that no private-paying patients could be seen there, and that the patients that would be treated there were patients for whom they were trying to find placement. One must realize that patients that go to these facilities have little access to health care anywhere else.

Presently there are approximately 118 FQHC clinics in California. Many, but not all, of these clinics offer comprehensive dental services. In the end, it is important to note that these federally funded health centers care for all patients, even if they have no health insurance. They are the “safety net” for all patients in need of medical and dental care. Without these clinics low-income, noninsured and underinsured patients would have nowhere to go for their healthcare needs.
The Potential for Telehealth Technologies to Facilitate Charity Care

Creating Virtual Dental Homes

The traditional office and clinic-based oral health delivery system is failing to reach an increasingly large segment of the United States population. The disparities in access and the resulting health disparities have been well documented in the 2000 Report of the U.S. Surgeon General, and in the 2011 reports Advancing Oral Health in America and Improving Access to Oral Health Care for Vulnerable and Underserved Populations by the Institute of Medicine of the National Academies of Science. One solution being used is charity care where teams of dentists provide screening and limited care to individuals who self-select to attend a one-time event without follow-up. While these programs do help the targeted population by eliminating the most advanced disease, often through extraction of teeth, there is limited ability to create and foster a system of ongoing preventive activities and follow-up monitoring and care.

Welcome to a Connected World

Recent advances in the use of telehealth technologies may allow dental care for those who do not regularly see their own dentist to include pre-visit and post visit triage, prevention, and monitoring activities. The last decade has brought rapid expansion in the availability of internet connectivity and the development of telehealth systems that can be used to facilitate care for those in greatest need.

Telehealth technologies could dramatically alter the delivery of care by facilitating engagement with the target population prior to and after an in-person visit. If a team of health workers already working with groups of at-risk individuals could be identified and provided training, perhaps through online videoconferencing and other distance education methodology, this local team could gather health records to be used by the visiting team for pre-visit triage and planning. The local team could also be empowered to begin preventive education and intervention programs with supervision and coaching from the visiting team.

If oral health records could be reviewed prior to a visit, this could allow the visiting team to better prioritize the work that needs to be done. It might be possible to provide instructions and coaching so that some procedures that would have otherwise been performed by the visiting team can be performed by local workers prior to the visit. Such a system could also allow the visiting team to spend less time on diagnostic and preventive procedures, concentrating...
Recent advances in the use of telehealth technologies may allow dental care for those who do not regularly see their own dentist to include pre-visit and post-visit triage, prevention, and monitoring activities.

The Virtual Dental Home
With the advent of teams connected by telehealth systems, a fragmented or one-time delivery of care could be transformed into a "dental home" or "health home" for the target population. There has been considerable interest and an expanding body of literature on improving health care provided to underserved populations through a "medical home" or "health home" model (American Academy of Pediatrics, 2007; Edwards, 2004). In general the health home model encompasses systems that provide:

- Care management over time
- Health promotion activities
- Access to technical medical services when needed
- In pediatric medical home models, there is also an emphasis on early intervention services

There is a system of oral health delivery currently operating in the United States that could serve as a model for a connected charity-care system. The Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry (Pacific) has created a Virtual Dental Home in sites throughout California (Glassman et al, 2012). Pacific is using this model to deliver oral health services in locations where people live, work, play, go to school, and receive social services. The individuals receiving these services range from children in Head Start Centers and elementary schools to older or disabled adults in residential care settings or nursing homes.

The Virtual Dental Home is a community-based oral health delivery system in which people receive preventive and early intervention therapeutic services in community settings where they live or receive educational, social, or general health services. It uses allied dental personnel who work in a team lead by geographically distant dentists and can keep many people healthy in community settings by providing education, triage, case management, preventive procedures, and early intervention therapeutic services. The system promotes collaboration between dentists in dental offices and clinics and these community-based allied dental personnel. This project redefines the use of the term "dental home" to include the entire geographically distributed, collaborative, telehealth-facilitated
system of care. The Virtual Dental Home provides all the ingredients of the health home, keeps dentists at the head of the distributed team, and most importantly, it brings much-needed services to individuals who might otherwise receive no care.

Equipped with portable imaging equipment and an Internet-based dental record system, the allied dental personnel collect electronic dental records including radiographs, photographs, charts of dental findings, and dental and medical histories, and upload the information to a secure Web site where the records are reviewed by a collaborating dentist. The dentist reviews the patient’s information and creates a plan for dental treatment. The allied dental personnel then carry out the aspects of the plan under general supervision of the dentist that can be conducted in the community setting. These services include:

- Health promotion and prevention education
- Dental disease risk assessment
- Preventive procedures, such as application of fluoride varnish or dental sealants, and for dental hygienists, dental prophylaxis, and periodontal scaling
- Placing carious teeth in a holding pattern using interim therapeutic restorations (ITR) to stabilize patients until they can be seen by a dentist for definitive care and tracking and supporting the individual’s need for and compliance with recommendations for additional and follow-up dental services

The accompanying figure is a diagram illustrating the Virtual Dental Home Concept Model that illustrates how the emphasis of the Virtual Dental Home system is the delivery of diagnostic, preventive, and early intervention services by allied dental personnel in community settings under general supervision of dentists who have reviewed patient records and determined a plan of treatment for that patient.

The Virtual Dental Home system of care has been operating in California for more than three years. Over 2,000 patients have been cared for in almost 5,000 visits. The project has clearly demonstrated the ability to connect dentists with allied personnel operating in community settings. The project has also demonstrated the ability of allied dental personnel, after review of records by dentists, to apply prevention, education, and early intervention techniques in populations of people who traditionally do not seek dental care until they have advanced disease.
Scaling the Virtual Dental Home Model

While the Virtual Dental Home system in California has demonstrated the ability to use telehealth technologies to connect providers in geographically distributed sites, there are clearly challenges to be faced in translating this experience to other areas. These challenges include the cost and deployment of equipment, identifying or recruiting teams of local health workers, and creating a system of care that can function on an ongoing basis.

Fortunately, the cost of equipment needed to create telehealth system has been decreasing dramatically. The “technology kit” that is being used in the Virtual Dental Home system in California is under $20,000. While this may be a significant expense in a global charity-care system, the amortized cost over thousands of patient encounters might amount to only a few dollars per visit.

Identifying and recruiting teams of local health workers to participate in a distributed, telehealth system of care may be challenging. As has been the case in the Virtual Dental Home system in California, it would be necessary to train these individuals to use the technology equipment to collect oral health records and transmit them to a cloud-based server. These workers would also need to be trained to provide preventive education and perform basic preventive procedures for the population they are serving. None of these challenges is insurmountable, however.

Finally, if equipment is available and local teams can be recruited and trained, it is still necessary to develop a system for coordinating the activities of the local team with the visiting team. Developing such a system has the potential to transform episodic or one-time visits into an ongoing system of care.

Conclusion

The dramatic increase in broadband connectivity is opening up the possibility for using telehealth-connected teams in improved systems for reaching populations that are not well adapted to the traditional dental care delivery system. The Virtual Dental Home demonstration taking place in California provides a model for the development and deployment of such teams. Teams using telehealth connections to augment oral health care for difficult-to-reach populations can transform episodic or one-time visits into an ongoing system of care with a much greater emphasis on prevention and early intervention techniques and a greater likelihood of improved oral health for the population.

References


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Abstract

Dental ethics is often taught, viewed, and conducted as an intellectual enterprise, uninformed by emotional or other noncognitive factors. Emotional intelligence (EQ) is defined here and distinguished from the cognitive intelligence measured by Intelligence Quotient (IQ). This essay recommends more inclusion of emotional, noncognitive input to the ethical decision process in dental education and dental practice.

Ethics is the systematic study of human conduct examined in the light of moral values and principles. It is the most important competency in dentistry, in business, and in life. Competency in ethics requires an understanding of its accepted principles, and such competency is the obligation of every dental professional.

—Alvin Rosenblum (2001)

This article explores the relationship between the disciplines of applied professional ethics and emotional intelligence (EQ). Although the affective dimensions of applied ethics have been addressed in the professional ethics literature, even as they apply to dental practice (1989 Curriculum Guidelines), the 2010 CODA (accreditation) standards for ethics in dentistry direct the educator’s attention to the cognitive and philosophical and seem to ignore a necessary psychological, noncognitive, emotional component. The paradigm of emotional intelligence presented in the popular press offers a viable way to redirect attention to a need the authors see as critical for effective ethics education and for professional practice.

The authors view professionalism as a social contract requiring altruism, caring, community, commitment to excellence, and service to others. Professionalism includes service over profit. It is not something one can put on and take off like a white coat; it must exist deeply as a part of personality and identity. The goals of ethics are based on a commitment to a purpose higher than our own self-serving ends. As such, it is much more than the absence of unprofessional behavior, or even an understanding of normative principles and decision models.

A challenge the authors (one dentist and one psychologist) faced in integrating professional ethics with emotional intelligence was in defining their own discipline for each other. Having done
that to their satisfaction the task has been
to provide the reader with definitions for
both ethics and emotional intelligence (EQ) and to subsequently clarify the
importance of the relationship between
those two disciplines. We believe that
by highlighting the importance of emotional intelligence as it applies to
professional ethics we will refine the
definition of both, especially as they
pertain to dental education and practice.

Applied Professional Dental Ethics

This analysis necessarily begins with
a bit of a history lesson. As recently as
1980 the literature about ethics in
dentistry was scant. With the exception
of the Journal of Dental Education,
the Journal of the American College of
Dentists, and the occasional editorial,
little was written that had the discipline
of ethics as its focus. Much of the
ey early literature could reasonably be
characterized as a professional “scold.”
Rather than addressing the moral values
and ideals that might guide the dentist’s
interaction—and there may not have been
widespread agreement on these—the
writing focused primarily on negative or
questionable behavior in the profession,
much of which could be categorized as
“dental-professional etiquette.”

In the early 1980s two highly
regarded academicians began to focus
on ethics in the profession of dentistry.
Muriel Bebeau of the University of
Minnesota is a psychologist whose
research interests include the processes
(sensitivity, reasoning, motivation, and
implementation) that give rise to ethical
decision-making and their role as deter-
minants of ethical behavior (Bebeau &
Monson, 2008). David Ozar is professor
of philosophy at Loyola University of
Chicago, formerly director of Loyola’s
Center for Ethics, and author of a popular
dental ethics text (Ozar & Sokel, 1994).
These two non-dentist educators became
the prime movers in what became a
collaboration of interested teachers in
dental schools across the country.

With that collaboration and Dr.
Ozar’s leadership, the Professional Ethics
in Dentistry Network (PEDNET) was
founded in 1986. The organization,
which included a small number of
dental school faculty and a handful of
practicing dentists, ultimately became
the American Society of Dental Ethics,
now a section of the American College
of Dentists. That organization and the
work of Drs. Ozar, “Pat” Odom, and
Bebeau became a stimulus for a growing
body of literature about ethics in the
dental profession. They and a number
of other dental educators have helped to
clarify what the discipline of ethics is
and how it can be taught.

The 1989 model curriculum
guidelines (mentioned above) resulted
from a tripartite arrangement among
the American Association of Dental
Schools (AADS, now ADEA) the American
College of Dentists (ACD), and the ADA
Counsel on Dental Education (CDE).
Even before the guidelines were published,
the ADA Commission on Dental Accredi-
tation (CODA) revised its standards to
require mandatory instruction in ethics

The paradigm of emotional intelligence presented in the popular press offers a viable way to redirect attention to a need the authors see as critical for effective ethics education and for professional practice.
This action quickly resulted in greater emphasis on the need for formal instruction in ethics as an independent subject in dental schools. A survey of all 56 United States dental schools operating in 2008 indicated that 80% offered formal instruction in dental ethics, with the rest offering ethics instruction integrated with other courses. Reflecting on changes over the past 30 years, Lantz, Bebeau, and Zarkowski (2011) noted that whereas the relatively small amount of time devoted to ethics instruction (an average of 26.5 clock hours) is unchanged over the past 30 years, there was substantial change in what was classified “ethics” instruction. Instead of classifying courses in practice management, jurisprudence, and avoidance of malpractice as constituting ethics instruction, curricula today focus on topics such as the social contract, priority of needs (dentists and those served), obligations and central values, and with normative principles (expressed as virtues such as integrity, trust, justice, and compassion). Most schools include information about ethics codes and many, about 40%, address the guild, agent, commercial, and interactive career models described by Ozar, and reflected in the Professional Role Orientation Inventory, designed by Bebeau, Born, and Ozar (1993). Most schools present models for resolving ethical dilemmas (Rule & Veatch, 2005) along with material on topics such as access to care, managed care, delegation and supervision, standard of care, impaired colleagues, child and elder abuse, advertising, and commercialism.

The shift in content reflects growth in the discipline, yet it appears from these descriptions that the study of ethics is often perceived by dental educators to be a fundamentally cognitive activity. Even when formal ethics education programs include case analysis and discussions, those discussions tend to focus on the decision process: an intellectual task. Rather than broadening the focus to include the affective dimensions of ethical competence, the CODA standard, revised in 2010, directs attention exclusively to the cognitive dimension of decision-making: “Graduates must be competent in the application of the principles of ethical decision making and professional responsibility” (Commission on Dental Accreditation, 2010, p. 25).

There have been efforts on the part of thought leaders in dental ethics to acknowledge the influence of noncognitive elements, to be sure. For example, the interdisciplinary team that formulated the 1989 curriculum guidelines used Rest’s (1983) Four Component Model of Morality as an organizing framework for describing curriculum objectives. Rest’s model includes factors such as awareness of self and others, the capacity to code social situations, and how one’s actions might impact others. It also includes empathy and perspective-taking. Several of these are clearly components of EQ. When describing moral sensitivity, the first of Rest’s components, empathy and affective arousal (anger, apathy, anxiety, empathy, and revulsion), together with recognition of the professional’s ethical duties, are seen as key elements in the interpretive process. To test the importance of moral sensitivity to ethical decision making, Bebeau and her dental colleagues (Bebeau et al., 1983) designed a series of cases (the Dental Ethical Sensitivity Test [DEST]), to see whether the dentist (or student dentist) could diagnose the affective dimensions of an ethical problem—often from ambiguous clues, while simultaneously recognizing what was ethically expected of the dentist.

The DEST has been used to assess ethical sensitivity of dental students (You & Bebeau, 2011) and as a way to assess shortcoming in both ethical sensitivity and ethical implementation of practicing dentists referred for assessment by a licensing board (Bebeau, 2009a; 2009b). Groups tested reveal significant variability both within and between groups. Further, the eight cases of the DEST that are devised to assess ethical sensitivity have been used as a stimulus to teach what we refer to in this article as “emotional intelligence.” DEST cases specifically address ethical considerations in the dentist-patient relationship. Because the cases require respondents to construct a
dialog in response to an unstructured problem and then to respond to a number of open-ended questions, the cases and method lend themselves to self-assessment and peer-assessment, as well as an opportunity to engage the respondent in discussions with dentists who have expertise in professional ethics and emotional intelligence.

In contrast to the DEST, the widely used Defining Issues Test (DIT) (Rest, 1979; Thoma, 2006) measures the cognitive schema that individuals use to make moral decisions—the competence described by the 2010 CODA standards. Although not a measure of EQ, DIT results can be used to show the respondent the extent to which affective responses might override cognitive judgments. For example, if a respondent says “Heinz should steal the drug to save his dying wife,” then argues that community laws must be upheld, this inconsistency between reasoning and judgment may help him or her see the disconnect between affective and cognitive responses. In fact, Bebeau (2009a; 2009b) recommends giving respondents feedback on their DIT profile, including their consistency index, as part of an educational experience. In other words while the DIT indices attempt to explore the relative influence of noncognitive factors in ethical decision-making, there was no attempt on the part of the test developers to directly assess emotional reactivity.

In addition, while the DIT is frequently referred to as a teaching tool. Unfortunately, data from Lantz, Bebeau, and Zarkowski (2011) on the current state of dental education indicate that only 15 or fewer of the 56 dental schools used tests such as the Defining Issues Test, the Dental Ethical Sensitivity Test, or the Professional Role Orientation Inventory (a measure of Rest’s third component) to assess student development.

In sum, a review of the status of ethics education in United States dental schools, together with research findings from the study of ethical sensitivity, supports inclusion of the affective elements of EQ into ethics education. Also arguing for broader inclusion of the affective dimensions of ethical decision making, David Nash (2010) directly addresses emotional intelligence as recently as 2010, saying, “The thesis of this essay is that emotional empathy, as it has evolved in human evolution and developed existentially in the socialization of children, is an important determinant of moral behavior” (p. 575).

To date, the potential influences of noncognitive factors related to EQ have not yet been adequately integrated into dental ethics curricula. The recently revised 2010 CODA standards ignore the broader concerns of ethical development, suggesting that it is sufficient to focus solely on the cognitive or intellectual application of principles.
Defining Ethics

There is, at this point in time, no settled discussion or agreement about the appropriate content of ethics courses, nor is there total agreement on teaching methods or curriculum. There are even disagreements about the very meaning of the term “ethics.” Confusion about the nature of dental ethics has resulted in historic arguments about whether or not ethics can even be taught.

A recent essay by Chambers (2011) in this journal provides a generic definition of ethics. “In its pure form, ethics is the study of right and wrong, good and bad. This is an academic pursuit, largely confined to departments of philosophy in universities.... It is about reflecting on principles and learning to give good reasons for behavior” (p. 42). He goes on to write that “Ethics education is generally understood as training in how to apply principles.” (p. 45). This is, in fact, the competency required by CODA standards. But he distinguished between ethical reasoning as an isolated cognitive skill and morality as the way moral agents act based on the full use of thinking, feeling, and valuing. The problem, as Rest (1983) articulates it, is that to apply principles in real-life settings one must first code the situation as ethical. Having done so and arrived at a defensible reason for action, one must commit to acting in accord with one’s judgment and then effectively act upon it. A moral failing can result from a deficit in any of the four processes.

In contrast to the narrow definition of ethics, the Hastings Center offers a broader definition. They state, “Ethics is the study of right and wrong, good and evil, duty and obligation in human conduct and of reasoning and choice about them.” They define ethics as the discipline of moral philosophy. And in their book Ethics Teaching in Higher Education Daniel Callahan and Sissela Bok (1980) suggest that in teaching ethics, “The emotional side of students must first be elicited or evoked—empathy, feeling, caring, sensibility” (p. 65). Even here though, the cognitive must quickly enter to discern hidden assumptions, to notice consequences of thought and behavior, to see that pain or pleasure do not merely happen.

Defining Emotional Intelligence

Ethical practice necessarily involves ethical behavior, not just case analysis and decision-making. Few can deny the powerful influence emotions and personality have on how we behave and manifest our decisions. Emotional intelligence is therefore a key component in the practice of normative ethics, in which case the authors argue that competency in dental ethics must include an understanding of emotional intelligence. This is obviously not an original idea. While not employing the term “emotional intelligence” directly, Bebeau’s application of Rest’s Four Component Model attempted to both measure effects of emotion on ethical
decision-making and assist participants to explore and develop it.

When discussing intelligence it is most often assumed that the reference being made is to IQ, the intelligence quotient. IQ is a measure of intelligence describing cognitive (thinking) abilities. (Dentists have been known to describe patients in terms of their “dental IQ,” their knowledge of dental facts and concepts.) IQ includes the demonstrated ability to complete math problems, to remember things, to understand abstract concepts, to navigate mazes, to define vocabulary words, to complete designs of blocks, to recite basic scientific facts, and to complete puzzles. Emotional intelligence, a more recent development, describes emotional abilities. The history of EQ is embedded in the history of IQ, which dates from 1905 (Kamin, 1995). At that time Alfred Binet and Theodore Simon published the first intelligence test for children. Subsequently, in 1916, the Binet-Simon test was updated by Lewis Terman, a Stanford psychologist who renamed it the Stanford-Binet IQ Test for Children (Terman, 1916). Psychologist David Wechsler, while working for the United States military in 1939, developed and published the Wechsler Adult Intelligence Scale (WAIS). Over the past 75 years the Wechsler tests (WISC, WAIS, and WPPSI) have become the standard instruments for measuring IQ. Scores on these standardized tests have defined the abstract concept of intelligence for practical applications in professional psychology. Wechsler himself, however, acknowledged that there were dimensions of “intelligence” which had not been addressed in the tests that he had developed. Here is a sample of his thinking about the limitations of intellect (1981): “Intelligence is a function of the personality as a whole and is responsive to other factors besides those included under the concept of cognitive abilities. Evidence...strongly implies the influence of personality traits and other non-intellective components, such as anxiety, persistence, goal awareness, and other conative dispositions” (p. 8). (Conation is an archaic term for the force of drive or will or striving to action. It could be thought of as one’s capacity to make something happen.)

Psychologist Howard Gardner later expanded the study of intelligence (1993) with a theory of multiple intelligences. He identified 14 “problem solving” intelligences which included intrapersonal (within a person) and interpersonal (between people) social skills.

Daniel Goleman, a psychologist building upon the work of Mayer and Salovey (1997), successfully launched the concept of emotional intelligence—EI or EQ—into the American mainstream with his bestselling book Emotional Intelligence (1995). The book and concept were a smash, and Time Magazine put “Emotional Intelligence” on its cover in huge red letters. For a comprehensive critical review of emotional intelligence see Peltier (2010).

Emotional intelligence might be best understood as “the mind of the limbic system,” which at its most primitive level has been informing us as to whether we feel safe or unsafe since the origin of our species. The limbic brain produces emotions in the way that the reptilian brain produces heartbeats or the urge to flee. We cannot help it; we experience powerful emotions that influence our behavior, for better and sometimes for worse. EQ includes the ability to identify, understand, and communicate limbic, emotional experiences.

While there are now several models of emotional intelligence, the most important and useful idea is that noncognitive aspects of life and decision-making are at least as important as the intellectual one, if not more important in the execution of real life. The core component of Goleman’s EQ is a four-part model that includes:

- Self-awareness
- Self-management
- Social awareness (awareness of others)
- Relationship management (management of others)

The relationship between these four factors has been summarized in table form by Cherniss and Goleman (2002).
A Framework of Emotional Competencies

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<tr>
<th>Recognition</th>
<th>Self (Personal Competence)</th>
<th>Other (Social Competence)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Self-awareness</td>
<td>Social-awareness</td>
</tr>
<tr>
<td></td>
<td>• Emotional self-awareness</td>
<td>• Empathy</td>
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<td></td>
<td>• Accurate self-assessment</td>
<td>• Service orientation</td>
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<td></td>
<td>• Self-confidence</td>
<td>• Organizational awareness</td>
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<thead>
<tr>
<th>Regulation</th>
<th>Self-management</th>
<th>Relationship Management</th>
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<tr>
<td></td>
<td>• Emotional self-control</td>
<td>• Developing others</td>
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<td></td>
<td>• Trustworthiness</td>
<td>• Influence</td>
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<td>• Conscientiousness</td>
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<td>• Adaptability</td>
<td>• Conflict management</td>
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<td></td>
<td>• Achievement drive</td>
<td>• Visionary leadership</td>
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<td></td>
<td>• Initiative</td>
<td>• Catalyzing change</td>
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According to Golman and Cherniss, emotional intelligence involves the four facets identified above. However, Bebeau, in a personal communication, reminds us that, “This has no relationship to professional ethics unless one ties it to the responsibilities the professional has to put the interests of other before the self. Unless this is tied to ethical responsibilities, it is nothing more than managing others. The salesman who is able to talk you into purchasing a product may have well-developed emotional intelligence, but that does not make him or her a virtuous professional.”

Wolf (2009) adjusted Goleman’s four-part model to emphasize the importance of understanding of emotions. His model includes:
- Self-awareness (and the ability to communicate and to feel understood)
- Other awareness (awareness of others and the capacity for sympathy and empathy)
- Self-management
- Understanding emotions

There is general agreement that emotional intelligence involves awareness and understanding feelings, management of those feelings, empathy, awareness of the thoughts and feelings of others, and effective responses to other people. While Cherniss and Goleman (2002) place emphasis on management skills, Wolf emphasizes the understanding of emotions.

The implications of these ideas for dental ethics are profound. Emotions, both conscious and unconscious, often play an important role in ethical decision-making. Reflecting on the facts after problem identification, questions of whose interests are at stake, and reflection on ultimate decisions can all be impacted by feelings. Our feelings can help us distinguish between right and wrong as well as influence us to rationalize and act otherwise. Rationalization occurs when we make a decision and subsequently marshal support for it.
Emotional reactions are certainly an important component of real-life ethical decision-making.

The application of the normative principles found in the ADA’s *Principles of Ethics and Code of Conduct* is an important starting point, but it is not enough. Emotional, non-rational forces have a powerful influence on human decision-making. The most obvious examples include the fear involved with doing the right thing (especially when it runs against majority opinion or a boss’s scowl) or the embarrassment that accompanies admission of an error. You can know the right thing to do but experience powerful feelings that prevent you from actually doing what is right. These feelings rarely make it into discussions of dental ethics, and an embrace of emotional intelligence might open the door to them. Try to recall a formal discussion of a case where decision-makers considered the weight of emotional factors such as fear (and lack of assertiveness) or embarrassment or even revenge. A proper ethical deliberation should include an assessment of the emotional components of the situation, as they are just as important in the end as the cognitive analysis.

Imagine yourself (or someone else) saying or doing something that does not feel right. What feelings are evoked when you imagine such a circumstance? How do you know what “feels” right or not right? Answering these questions requires emotional intelligence. You must first be able to identify qualities of emotional experience, then translate them in a way that guides action, then apply them to the task at hand. Some feelings must be taken more seriously than others. For example, a vague and abiding sense of discomfort—difficult to shake—should be taken more seriously than a sense of embarrassment.

Understanding our own emotional reactions can help to keep us honest. If ethical behavior were determined solely by ideas of right and wrong—which are themselves based on cognitive beliefs and philosophical principles—then EQ would provide little if any value in determining what is ethical. However, knowing “the right thing to do” does not necessarily determine whether one acts ethically or not. Dentists often note that “I know what the right thing is; it’s just hard to do under the circumstances.” Emotions can influence behavior by trumping ideology, influencing one to violate valued ethical principles, or by causing internal conflict and cognitive dissonance. In those circumstances EQ can provide an internal feedback mechanism, an emotion-based early warning system which can inform us when a contemplated action threatens to violate an ethical code or principle, providing invaluable information, perhaps challenging one’s integrity with regard to abiding by an ethical principle.

For example, a dentist might yearn to help a patient by charging a reduced price for a procedure while billing the insurance company for the full fee (waiver of co-payment). If dentists are aware of their emotions, they might notice an uneasy feeling or some anxiety or even a vague sensation of dread about that idea. Some people call this feeling “conscience.”

The feeling can be understood as an emotional signal that the dentist is about to engage in unethical behavior, even though the process of decision-making or rationalization had previously indicated that the behavior was “okay.” Ignoring an emotional signal subjects the dentist to the possibility of proceeding with what is sensed as an unethical act concurrent with the conflicting intention of “doing the right thing.” This creates a type of cognitive dissonance, a state that psychological research has shown to be difficult to bear. Once the signals the conscience is sending are noticed, the dentist has the opportunity to take another look at the situation and to reevaluate. The inclusion of emotional information into the decision process is an essential component of ethical action.

Since emotional intelligence includes both awareness and understanding of emotional experience, it can provide valuable information for addressing those conscious and subconscious contributors to potentially unethical actions. It can affect judgment when a feeling is present and can help determine
whether or not a feeling should even be allowed to influence a particular decision.

There are other advantages to development of emotional intelligence. A case in point is the alleged high incidence of suicide and divorce rates among dentists. (The actual suicide rate of dentists, or of any group of professionals is impossible to accurately determine, for various reasons.) Dentistry is a challenging profession and practitioners experience considerable stress and strain over the days, weeks, and years of practice. Many dentists would benefit from developing greater emotional intelligence to allow for better understanding and integration of emotions to prevent an escalation of emotional pressure and the associated problems and dangers, which may manifest in other non-professional domains of their lives. The reality in ethics is evident when we see public disclosures of practitioners’ wrongdoing. There is a lot at stake for both dentists and patients. Just as a rope comprises interwoven strands, emotional intelligence is a strand within dental ethics, and its presence or absence will continue to influence attitudes, decisions, and actions of oral healthcare providers. The good news is that EQ—unlike IQ which typically remains relatively stable throughout adult life—can be nurtured and developed. We can get “emotionally smarter” and become more able to identify, understand, express, and regulate emotional experience and increase our capacity for sympathy, empathy, and intimacy in chosen relationships.

**Conclusions**

At the time of the most recent CODA revision, many believed as Charles Bertolami did, that dental ethics course content is typically inadequate, “because it does not foster an introspective basis for true behavioral change.” He argued (2004) that dental education in ethics is boring and ineffective because it focuses on principles and ethics codes rather than on self-awareness of a student’s own existing moral instincts. He suggested implementing a precurriculum very early in the dental educational experience to address the disconnect between knowledge and action.

The integration of emotional intelligence into mainstream ethical conversations has significant potential to enhance moral decision-making in dental practice. Additionally, the use of the Dental Ethical Sensitivity Test and the Defining Issues Test appear to be valuable means of assessing the effectiveness of teaching that addresses both ethics and emotional intelligence. A validated, self-scoring, short test for all four of Rest’s components in moral action has been prepared by the American College of Dentists and is available at www.dentalethics.org/pead/exercise-A3.htm. The authors believe it is incumbent upon those invested in achieving and maintaining high ethical
standards in the profession to explore emotional intelligence and to consider how to best include it within the dental school curriculum.

References


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 recently volumes of *JACD*. These can be found on the ACD Web page 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.

Letters from readers concerning any material appearing in this journal are welcome at dchambers@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. [The editor reserves the right to refer submitted letters to the editorial board for review.]

This journal has a regular section devoted to papers in ethical and professional aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of the 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.
Communication Policy

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

Objectives of the American College of Dentists

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

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;

B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;

C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;

D. To encourage, stimulate, and promote research;

E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;

H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.