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Dentistry Goes
to Court

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and leadership in dentistry**

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Dentistry Goes to Court

- 4 U.S. Supreme Court Clarifies Role of State Dental Boards in North Carolina Case
David W. Chambers, EdM, MBA, PhD, FACD
- 12 The Boundary between Professional Standards and Commercial Claims
Andrew Bigart, JD
- 17 Saving Dental Medicaid Coverage for Adults in Ohio
David J. Owsiany, JD, FACD
- 23 Nuances in the Legal Aspects of Dental Advertising
Mert N. Aksu DDS, JD, MHSA, FACD and Pamela Zarkowski, JD, MPH, FACD

Gies Ethics Project: Justifiable Criticism

- 32 What Dentists Do When They Recognize Faulty Treatment: To Tattle or Build a Moral Community?
David W. Chambers, EdM, MBA, PhD, FACD
- 44 Study #1: Justifiable Criticism Ethics Case
- 48 Study #2: Justifiable Criticism Scenarios
- 54 Study #3: The Way Justifiable Criticism Looks
- 60 Study #4: Components of Justifiable Criticism
- 64 Study #5: How Patients View Justifiable Criticism

Issues in Dental Ethics

- 67 Ethical Challenges in Forensic Dentistry and the Need for Enhanced Education
Steven Daws and Hassan Khan

Departments

- 2 From the Editor
Boards Should Be Based on Multiple Tests Using Patients



Cover image: Ornate Supreme Court in Lansing, Michigan.

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From the Editor

Boards Should Be Based on Multiple Tests Using Patients

For almost 50 years I have argued that candidates for licensure should demonstrate their competence on patients before being allowed to practice. A paper-and-pencil exercise or station exam is inadequate. My dissatisfaction with a single encounter, narrow technique test on patients out of context is also well known. Both one-shot and head knowledge exams are simultaneously unreliable and invalid. It is quite within the realm of possibility that dental therapists could qualify under either alternative.

A recent American Student Dental Association (ASDA) whitepaper summarizes these shortcomings.¹

Just one example involves a turf war about 15 years ago between the California Dental Board and Western Regional Examining Board (WREB). To show which was tougher (better at protecting the public), in the year where candidates could take either exam, the pass rate fell by 14% across all five dental schools in the state but immediately returned to equilibrium when California dropped out. Some candidates took both exams so it was possible to compare two performances of the same procedures separated by a few days. On the clinical periodontal performance, the correlation between the two tests for the same candidates was negative 0.04. There is no way to know which was right.

I was invited to a conference cosponsored by the American Dental Association (ADA), the American Dental Education Association (ADEA), and the testing community in Chicago in 2003. It was no surprise to find that an outside expert had been hired by the examiners. As I have a master's degree in testing from Harvard, the two of us hit it off just fine. We volleyed generalities for a bit until the expert asked how often the candidates were tested and what the failure rate was. Appropriately, he announced that it would be virtually impossible to determine the validity of a one-off test under such circumstances.

Those in the examining community seemed discouraged so I admitted that dental schools had made mistakes in the past and graduated some students who should not have practiced dentistry. Every year across the country a small number of practitioners have their licenses revoked or are placed on probation. In every case, these are individuals who graduated from dental school (not all in the United States) and who passed the one-shot initial licensure hurdle or alternative. For the past several months I have been reading disciplinary reports on dentists from four states. There are deaths, overtreatment, fraud, drugs, sexually aberrant behavior, and assaults. I have yet to run across a single disciplined license for an overhang, open margin, or anything else that would constitute a failure on an initial licensure examination.

There was a time when an independent examination of the near totality of dental knowledge and skill could be done in an afternoon. Throughout much of the nineteenth century there were no dental schools, but there were examiners. During the first quarter of the twentieth century, dental education was short—mostly lectures and demonstrations—and unstandardized, and schools were not accredited or otherwise held to common standards. Boards were necessary under such circumstances.

A high-water mark was reached in the 1940s, 50s, and 60s. The professional literature of that period showed educators and examiners sitting side by side working out a common way to elevate the profession. The American College of Dentists took the lead on some of these issues with standing committees on denturists, scope of practice of hygienists, and continuing education.

I have not been able to figure out why that era of cooperation came to an end. Some of the potential factors might include: (a) the steady decline of membership in the ADA from about 95% in 1960 to 65% today; (b) the explosion of effective and less technique-sensitive therapies; (c) prevention, the use of auxiliaries, and scientific understanding of the course of dental diseases all of which greatly

expanded what it means to “practice” dentistry; or (d) the emergence of third-party examining bodies that have to show a profit.

My disappointment is not with boards of dentistry. They provide a voice for minimal standards in oral health treatment in a world where state agencies are underfunded and slow to pursue regulations, consumer belly-aching, and a small number of greedy folks who passed the one-shot licensure process and have lawyer friends.

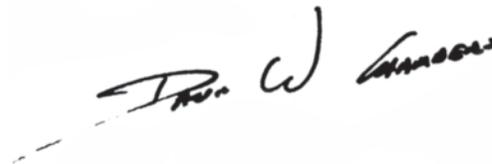
Although boards must retain responsibility for ensuring standards, they have the authority to delegate some of this work to others, consistent with state statutes. For example, boards delegate background checks for criminal activity to law enforcement agencies. They delegate certification in the theoretical areas of dentistry to the Commission on National Dental Board Examinations (NBDE).

Most states have chosen to delegate one-shot, narrow scope initial licensure testing to financially independent examination agencies. There are many reasons why it would be better to delegate this function to the dental schools. That is already being done in some states by the GPR mechanism. It could easily be done generally at the DDS/DMD level. Students would be required to present evidence of their competence to independently manage and treat a family of patients to the standard of care across the full range of dental skills. This would include a battery of test case patient treatments including those the examining agencies

use, except that they would come from a pool of patients in the normal comprehensive treatment sequence and there would be lots of them. To guarantee independence, examiners would be faculty members who can demonstrate calibration against standards developed by the state board.

This is known as the portfolio evaluation system, or the California system. It is now in place in several states. The system is more valid than alternatives because it is possible to test dental skill in a realistic, continuous, and comprehensive setting. The system is reliable because there are multiple measures of the core competencies.

Finally portfolios address the ethical concerns so prominent today. Professionalism on this score is a matter of who accepts the risk for patient treatment performed by non-licensed individuals, especially long-term risk. Testing agencies have refused to do so, thus transferring the risk to candidates. Treatment of patients by dental students does not constitute moral distress because schools are willing to assume the legal and professional responsibility.



¹ www.asdanet.org/docs/advocate/asda_white-paper_licensure_web_final.pdf?sfvrsn=6

Both one-shot and head knowledge exams are simultaneously unreliable and invalid.

The portfolio evaluation system is more valid than any alternatives because it is possible to test dental skill in a realistic, continuous, and comprehensive setting. The system is reliable because there are multiple measures of the core competencies.

U.S. Supreme Court Clarifies Role of State Dental Boards in North Carolina Case

David W. Chambers, EdM, MBA,
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Abstract

In 2015 the United States Supreme Court upheld an administrative law judge ruling in favor of the Federal Trade Commission (FTC) and a sustaining opinion by the U.S. Fourth Court of Appeals stating that the North Carolina Board of Dental Examiners had exceeded its authority in attempting to prevent the practice of teeth whitening by individuals who are not dentists. The decision was based on denying that the dental board could so act based on the "state action doctrine" because the board was not under the direct and effective supervision of the State of North Carolina. The decision has been widely interpreted as involving other matters of the relationship between the profession and the public's health and safety.

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Early in 2015, the United States Supreme Court ruled on an appeal by the North Carolina Board of Dental Examiners in the matter of the board's actions taken with the intent to limit the demonstration and sale of tooth whitening services in malls. The FTC had rendered a judgment against the dental board on the grounds of inappropriate restraint of trade. The U.S. Fourth District Court subsequently upheld the FTC ruling in an appeal by the dental board. The decision by the nation's highest court has been difficult for many in the dental community to understand and it has stimulated ripples through the health professions regulation community generally. It is not the intent of this paper to defend or criticize the ruling. There is significant need, however, for analyzing it in an effort to realize what the court decided and what issues of importance to dentistry were never on the table to begin with.

What Is Justice?

I am not a lawyer. But there is that thing about "ignorance of the law (or how it works) is not an excuse." Fortunately all of what I know about the law comes from reading and watching crime shows on TV rather than from direct experience. There is also the old joke questioning how

much lawyers really know about their craft since half of them lose their cases.

Kidding aside, understanding how the legal system works is vital to every professional, individually and collectively. We are a nation under the rule of law...thank goodness. But anyone who thinks that is black and white and simple is mistaken. Virtually everything done in a dental office, and much of oral health that is out of dentists' hands are regulated by law. This begins with licensure and carries down to equipment certification and CE hours and even frivolous suits motivated by the personal motives and billions of dollars of healthcare fraud.

Roughly, there are three phases of the law: (a) creating laws and regulations; (b) interpreting them; and (c) enforcement. Legislatures, assisted by lobbyists, take care of the first, and courts and federal and state administrative agencies have some discretion in interpretation. Enforcement is a function of authorized public agencies or professional organizations, such as is the case with 4.C in the ADA Code of Professional Conduct. The profession is active on behalf of members and the public in all three areas. All phases of all law are for the public good.

When I was a kid, I thought there was right and wrong and that courts were where it was decided who was really right. How could the U.S. Supreme Court possibly decide cases with split decisions if that were true? I also imagined that some parties were

winners and others losers. To the contrary, courts are not even supposed to care who you are; they do not decide matters based on whether this person or the other is right. Rather, courts apply laws to categories of individuals and render decisions relative to the category (Sullivan et al, 2007). If it is claimed that a practitioner falls into the category of committing professional negligence, and it is determined that the practitioner does in fact fall into this category, he or she is treated as anyone similarly situated would be treated.

In the American system, this is a two-part process. The judge determines whether the claimed category is relevant and thus what laws apply. The jury determines matters of fact. Television has sensitized us to focus on the jury verdict regarding whether twelve men and women thought something happened or not. This may get a bit grey with matters of fact, such as whether the person acted with malicious intent or forethought. Only those with direct knowledge can have legitimate opinions about the facts. Almost everyone with an interest at stake in the outcome may participate (through the amicus brief process for example) in trying to influence the interpretation of what the behavior means and which laws are applicable. The real action is often in deciding which categories are in play. Does the plaintiff have standing in the jurisdiction? What is the burden of

proof needed? Which precedents are applicable? What sanctions could be attached? And most importantly, which laws apply? The North Carolina dental board case was not about the facts of the matter; it was of interpretation. Naturally those who thought the U.S. Supreme Court was wrong base this opinion on alternative framing of the issues.

The cases in this theme issue are not about the facts or the laws. Those matters are relatively easy to determine. They are about interpretation. Multiple points of view tend to flourish in areas of great personal advantage and disadvantage by parties differently situated. And they often retain their contradictory justifiability in the face of matters of fact.

This paper and the others in this theme issue are all appellate cases. These are non-juried reviews of interpretation of the law rather than fact. Because they are a rethinking of previous court decisions, it is obvious that multiple parties will be coming forward to suggest alternative interpretations. The real battle is not who is “right” but who is most successful in framing matters as they define the public interest. Dentistry, like every other group, is affected by such decisions. There is a double obligation to understand the legal basis for practice and to influence it positively.

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North Carolina State Board of Dental Examiners v. Federal Trade Commission

On February 25, 2015, the United States Supreme Court, by a six-to-three margin, upheld the decisions of an administrative law judge, the Fourth Circuit Court, and the FTC that the North Carolina State Board of Dental Examiners had exceeded its authority in ordering teeth whitening establishments not owned by dentists to cease and desist operation. The decision stated: “If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked. The judgment of the Court of Appeals for the Fourth Circuit is affirmed.” (See page 9 for the syllabus of this ruling.) The full decision is available online.¹

The court’s action was what is known as a “broad interpretation,” one that goes beyond particulars and sets precedent for boards in all states and other professions. North Carolina’s Attorney General was not a strong backer of the dental board in this matter (Parker, 2015), and several other professions attempted to dissuade the North Carolina board from its appeal, fearing a broad interpretation might limit their freedom. The decision continues to be the subject of webinars and

The decision stated: “If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked. The judgment of the Court of Appeals for the Fourth Circuit is affirmed.”

conferences. The relationship between professional boards and other branches of state governments turned out to be the pivotal point of the court’s judgment.

Alternative Interpretations

While the implementation of this ruling will take place over many years, reaction has been prompt and diverse. Most of the responses can be better understood by knowing how groups framed the question than by what the court said in its opinion. Alec Parker (2105) has written an excellent summary of the particulars and timeline of the case from the perspective of North Carolina dentistry.

The North Carolina dental practice act is silent on whether the demonstration and sale of teeth whitening procedures other than by a dentist or under the supervision of a dentist constitutes the practice of dentistry. The board argued, notwithstanding, that such a characterization could be inferred and that it constituted a hazard to public health. The U.S. Supreme Court weighed the anecdotal reports provided by the board in their appeal but said it could not evaluate that in the absence of data comparing reported side effects from whitening provided by dentists or in products sold over-the-counter in drug stores (DeFriese, 2015).

What is not in question is the fact that barring nondentists from demonstrating and selling teeth whitening systems constitutes anticompetitive behavior. The FTC was the defendant in the Supreme Court case. It has been the policy of state and federal governments to oppose anticompetitive practices on the grounds that competition lowers costs and improves quality and innovation. Federal guidelines regarding interpreting anti-trust laws were issued in 1998 as *Promoting Competition, Protecting Consumers*.²

But the matter is not as straightforward as it may appear. The American commercial landscape is rife with anticompetitive rulings—all justified on the grounds of the public good. Obviously there is a barrier that prohibits unlicensed quacks from competing with dentists. Anyone who wants to can say what they think your house is worth, but banks will only accept the opinions of licensed appraisers for their highly-regulated lending practices. Patents protect drug developers. But mergers of large companies may be blocked on the grounds of creating monopolies in restraint of trade.

The deciding point is the interest of the public. When restrictive regulations benefit or protect the safety of the public, they are favored. When such restrictions increase cost, lower safety or choice, or otherwise harm the public, they are opposed. The North Carolina dental board argued that mall teeth whitening operations harmed the public; the FTC argued to the contrary. The board went further, however, and asserted that they, the board, were empowered to make that determination. Many in the professional communities were surprised that the United States Supreme Court did not accept this argument.

Some have cast the North Carolina case in terms of self-serving interests rather than restraint of trade. If, it is argued, a body is comprised of only or predominantly those types of individuals who will realize an economic advantage from adjusting the market, this is seen as constituting a conflict of interest when done so in the name of the state. Some have interpreted the high court's decision as requiring changes in the composition of professional boards to preclude a dominant membership by the profession being regulated. While the 2015 Supreme Court opinion mentioned that possibility, its decision was not based on the numerical dominance of any group and certainly did not require that a specific number, proportion, or type of board member other than those of the profession overseen be represented. Neither was there language in the court decision regarding how board members are selected. Some states, including Nebraska and New York, have already

begun using "health professions" boards composed of members from and overseeing several related disciplines, such as medicine, dentistry, pharmacy, optometry, and nursing.

The North Carolina board also argued that unless it is allowed an autonomous voice it will be difficult to recruit professionals willing to serve on behalf of the public interest. The board was arguing in effect that dentists may be unwilling to serve unless they can be completely in charge. This drew a bit of moral scolding from the court: The justices noted that the preamble of the ADA Principles of Ethics and Code of Professional Conduct calls "upon dentists to follow high ethical standards including honesty, compassion, kindness, integrity, fairness, and charity."

Perhaps the loudest cry of "foul" comes from those who see the professional expertise of dentists being hobbled. "Who knows better than dentists what is in the best interests of the public's oral health, and especially what appropriate safety measures should be in place? Dentists' training, experience treating a large segment of the public, and the professional service motive of those willing to take leadership positions with no personal reward should stand as sufficient guarantees for dental boards determining how oral health should be achieved." The court did not dispute this position. It allowed that dental boards may have a predominant role to play, but not an exclusive one, and that a board must play that role as an agent of the state and not an agent of the profession. It has been wisely said that all members of professional boards are public members, even when some are also professionals.

Grounds for the Decision

The North Carolina Dental Board appealed the FTC position on the basis of the "state action doctrine." This precedent from a case involving a commission of California raisin growers, known as *Parker v. Brown* or simply the "Parker precedent," was decided by the U.S. Supreme Court in 1943 and held that state agencies are exempt from FTC antitrust standards provided they can demonstrate that they are state-created agencies acting pursuant to a clearly articulated and affirmatively expressed state policy when displacing competition and that their conduct is actively supervised by the state. Six of the nine justices were of the opinion that the action of the North Carolina dental board failed to meet the standard of clearly articulated existing policy and active supervision by the state.

The relationship between professional boards and other branches of state governments turned out to be the pivotal point of the court's decision.

The United States Supreme Court ruled in the case of the North Carolina State Board of Dental Examiners that they were not acting as a representative of the state, through existing laws and regulations supervised by the state government—presumably the office of the Attorney General—in restricting the activities of teeth whitening programs outside of dental offices. Quoting the decision: “The Court holds today that a state board on which a controlling number of decision makers are active market participants in the occupation the board regulates must satisfy...active supervision requirements in order to invoke state-action antitrust immunity.”

So what was changed by the court ruling on the dental board in North Carolina? Nothing really. The nation’s highest court simply reaffirmed that the board, and presumably all health boards in all states, are agencies of the state and not agencies of the profession. They always were. They operate under rules established by state legislatures and managed by the appropriate administrative branch of government. Board members are selected by rules established by state statute and implement practice acts that they may help frame and interpret. But they cannot do so independently. They act, like every other component of state government, in coordination with the entire state government system. For example, the court took clear exception to the North Carolina dental board’s issuing cease and desist orders to whitening vendors in the name of the board

and on the board’s stationery. The reported, somewhat cool, attitude of the North Carolina Attorney General’s office is understandable on this interpretation. The dental board was functioning too independently.

What this Means for Dentistry’s Role in Protecting the Public

There is a justifiable tension in this case for many dentists, especially among the leaders in dentistry. Many say, “I can understand that interpretation but it still does not seem right to me.” There is an inherent tension between dentistry as a commercial activity and dentistry as a profession. A license is a privilege to engage in a commercial activity in the public’s interest. Professionals are ready to go beyond the minimal requirements of state law, and they should. This does not change the fact, however, that the commercial practice of dentistry is regulated by the state and that state dental boards are authorized by statute to guide, interpret, and enforce laws of the state through the mechanism of the state’s commercial apparatus. Even for the best of reasons, they cannot do so outside of their role as agents of the state. Or at least that is what the U.S. Supreme Court said.

The response by the profession to the North Carolina case might proceed along two lines: First there is the political or commercial response. Although it might be wise on other grounds such as promoting dentistry as a part of overall health or efficiency, it is unnecessary to surrender controlling membership on dental boards. What is required is the establishment of a state action doctrine. This involves demonstration of active state supervision of a board’s actions,

including review by supervisors who have no market interest in the action, who review the effect of the action, not just its procedural grounds, and who have the power to reverse or modify the actions. The role of dentistry in proposing rules and regulations through the legislative process that promote the oral health of the public and opposing efforts by others to weaken these protections remains a responsibility of the profession.

The second response is professional rather than commercial. Individually and collectively dentists should do all in their power to advance oral health by the way they practice. The recent Supreme Court decision left that imperative untouched. ■

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COURT DECISION SYLLABUS

The full report of the decision can be seen online. This includes, in addition to what is reproduced below, the majority opinion written by Justice Kennedy and the minor opinion authored by Justice Alito.

SUPREME COURT OF THE UNITED STATES

Syllabus

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS *v.* FEDERAL TRADE COMMISSION

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 13–534. Argued October 14, 2014—Decided February 25, 2015

North Carolina’s Dental Practice Act (Act) provides that the North Carolina State Board of Dental Examiners (Board) is “the agency of the State for the regulation of the practice of dentistry.” The Board’s principal duty is to create, administer, and enforce a licensing system for dentists; and six of its eight members must be licensed, practicing dentists.

The Act does not specify that teeth whitening is “the practice of dentistry.” Nonetheless, after dentists complained to the Board that nondentists were charging lower prices for such services than dentists did, the Board issued at least 47 official cease-and-desist letters to nondentist teeth whitening service providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime. This and other related Board actions led nondentists to cease offering teeth whitening services in North Carolina.

The Federal Trade Commission (FTC) filed an administrative complaint, alleging that the Board’s concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition under the Federal Trade Commission Act. An Administrative Law Judge (ALJ) denied the Board’s motion to dismiss on the ground of state-action immunity. The FTC sustained that ruling, reasoning that even if the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board must be actively supervised by the State to claim immunity, which it was not. After a hearing on the merits, the ALJ determined that the Board had unreasonably restrained trade in violation of antitrust law. The FTC again sustained the ALJ, and the Fourth Circuit affirmed the FTC in all respects.

Held: Because a controlling number of the Board’s decision makers are active market participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met.

- (a) Federal antitrust law is a central safeguard for the Nation’s free market structures. However, requiring States to conform to the mandates of the Sherman Act at the expense of other values a State may deem fundamental would impose an impermissible burden on the States’ power to regulate. Therefore, beginning with *Parker v. Brown*, 317 U.S. 341, this Court interpreted the antitrust laws to confer immunity on the anticompetitive conduct of States acting in their sovereign capacity.
- (b) The Board’s actions are not cloaked with Parker immunity. A nonsovereign actor controlled by active market participants — such as the Board — enjoys Parker immunity only if “ ‘the challenged restraint ...[is] clearly articulated and affirmatively expressed as state policy,’ and ... ‘the policy ...[is] actively supervised by the State.’ ” *FTC v. Phoebe Putney Health System, Inc.*, 568 U.S. ___, ___ (quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105). Here, the Board did not receive active supervision of its anticompetitive conduct.

(1) An entity may not invoke *Parker* immunity unless its actions are an exercise of the State’s sovereign power. See *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 374. Thus, where a State delegates control over a market to a nonsovereign actor the Sherman Act confers immunity only if the State accepts political accountability for the anticompetitive conduct it permits and controls. Limits on state-action immunity are most essential when a State seeks to delegate its regulatory power to active market participants, for dual allegiances are not always apparent to an actor and prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. Accordingly, *Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State’s own. *Midcal*’s two-part test provides a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for entities purporting to act under state authority might diverge from the State’s considered definition of the public good and engage in private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this. Cite as: 574 U.S. ____ (2015) harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity. Pp. 6–10.

(2) There are instances in which an actor can be excused from *Midcal*’s active supervision requirement. Municipalities, which are electorally accountable, have general regulatory powers, and have no private price-fixing agenda, are subject exclusively to the clear articulation requirement. See *Hallie v. Eau Claire*, 471 U.S. 34, 35. That *Hallie* excused municipalities from *Midcal*’s supervision rule for these reasons, however, all but confirms the rule’s applicability to actors controlled by active market participants. Further, in light of *Omni*’s holding that an otherwise immune entity will not lose immunity based on ad hoc and ex post questioning of its motives for making particular decisions, 499 U.S. , at 374, it is all the more necessary to ensure the conditions for granting immunity are met in the first place, see *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633, and *Phoebe Putney, supra*, at _____. The clear lesson of precedent is that *Midcal*’s active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity — public or private—controlled by active market participants.

(3) The Board’s argument that entities designated by the States as agencies are exempt from *Midcal*’s second requirement cannot be reconciled with the Court’s repeated conclusion that the need for supervision turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade. State agencies controlled by active market participants pose the very risk of self-dealing *Midcal*’s supervision requirement was created to address. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 791. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants’ confusing their own interests with the State’s policy goals. While *Hallie* stated “it is likely that active state supervision would also not be required” for agencies, 471 U.S. , at 46, n. 10, the entity there was more like prototypical state agencies, not specialized boards dominated by active market participants. The latter are similar to private trade associations vested by States with regulatory authority, which must satisfy *Midcal*’s active supervision standard. 445 U.S. , at 105–106. The similarities between agencies controlled by active market participants and such associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie, supra*, at 39. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. Thus, the Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.

(4) The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. But this holding is not inconsistent with the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State. Further, this case does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. Of course, States may provide for the defense and indemnification of agency members in the event of litigation, and they can also ensure *Parker* immunity is available by adopting clear policies to displace competition and providing active supervision. Arguments against the wisdom of applying the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity must be rejected, see *Patrick v. Burget*, 486 U.S. 94, 105–106, particularly in light of the risks licensing boards dominated by market participants may pose to the free market.

(5) The Board does not contend in this Court that its anticompetitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis. The Act delegates control over the practice of dentistry to the Board, but says nothing about teeth whitening. In acting to expel the dentists' competitors from the market, the Board relied on cease-and-desist letters threatening criminal liability, instead of other powers at its disposal that would have invoked oversight by a politically accountable official. Whether or not the Board exceeded its powers under North Carolina law, there is no evidence of any decision by the State to initiate or concur with the Board's actions against the nondentists. P. 17.

(c) Here, where there are no specific supervisory systems to be reviewed, it suffices to note that the inquiry regarding active supervision is flexible and context-dependent. The question is whether the State's review mechanisms provide "realistic assurance" that a nonsovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick*, 486 U.S. , 100–101. The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, see *id.*, at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state supervision is not an adequate substitute for a decision by the State," *Ticor*, *supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case.

The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked. The judgment of the Court of Appeals for the Fourth Circuit is affirmed.

It is so ordered.

The Boundary between Professional Standards and Commercial Claims

Andrew Bigart, JD

Abstract

Nearly 20 years ago, the United States Supreme Court held in favor of the California Dental Association (CDA) in a case in which the Federal Trade Commission (FTC) alleged that CDA's code of ethics impermissibly restricted price and quality competition by dentists under federal antitrust laws. While the decision was a big win for CDA, it should not be misinterpreted as providing *carte blanche* for all trade and professional associations when it comes to codes of ethics and other membership restrictions. To the contrary, the decision affirmed the FTC's jurisdiction over trade and professional associations and acknowledged that codes of ethics can present significant antitrust risks if they limit competition between members.

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The FTC continues to scrutinize trade and professional associations for anticompetitive conduct. Over the past several years, the FTC has brought at least seven enforcement actions targeting codes of ethics or other membership restrictions that prohibit or dissuade members from competing aggressively in the market. These enforcement actions underscore a lesson worth repeating—codes of ethics and membership restrictions present antitrust risks if not implemented and managed carefully.

What's the Big Deal with Codes of Ethics?

The federal antitrust laws, principally the Sherman Act (15 U.S.C. § 1 *et seq.*) and Federal Trade Commission Act (15 U.S.C. §§ 41 *et seq.*), prohibit unreasonable restraints of trade. Some conduct, like price-fixing, is almost always presumed unreasonable under the antitrust laws. Most other conduct is analyzed under the “rule of reason,” which examines the totality of the circumstances and balances the procompetitive benefits of the conduct against the potential anticompetitive harm to determine the likely overall effect on competition. Most trade and professional association conduct is analyzed under the rule of reason, although conduct that directly impacts competition or pricing in the market may trigger *per se* scrutiny.

The issue addressed by the Supreme Court in *California Dental* was the distinction between the *per se* and rule of reason tests, with a particular focus

on the manner in which the rule of reason test is applied. In the underlying administrative complaint, the FTC alleged that CDA placed unreasonable restraints on members' truthful and nondeceptive advertising of the price, quality, and availability of dental services. While the FTC recognized the right of CDA and its members to restrict misleading or deceptive advertising, the FTC argued that CDA went too far by prohibiting members from advertising (a) using terms such as “low,” “reasonable,” or “affordable” in advertising (regardless of truth); (b) using terms about quality of services; and (c) offering discounts, unless such discounts are accompanied by five detailed disclosures. In an administrative decision, the FTC held that the CDA's price advertising restrictions *per se* violated the antitrust laws and that both the price and nonprice advertising restrictions were unlawful under a “quick look” rule of reason assessment.

The Ninth Circuit, on appeal, disagreed with the FTC's *per se* conclusion for the price advertising restrictions, but upheld the FTC's quick look rule of reason analysis. The United States Supreme Court reversed the Ninth Circuit's decision (and the FTC's before it) for condemning CDA's code of ethics without a sufficient factual inquiry into the competitive effects of the advertising restrictions, including potential procompetitive benefits. The court concluded that

where the anticompetitive effects of a restraint are less than certain, the rule of reason requires a thorough market analysis. On this basis, the court remanded the case to the Ninth Circuit for further consideration of the facts. On remand, the Ninth Circuit concluded that the FTC had not met its burden of showing that the restrictions caused a “net harm to competition” in the California dental service market and vacated and remanded the FTC’s judgment with instructions to dismiss the case. In doing so, however, the FTC cautioned against interpreting its dropping of the case as “an indication of any lessening of our keen interest in the activities of trade or professional associations that harm competition.”

Continued Scrutiny of Codes of Ethics for Antitrust Risks

Now, almost twenty years after the *California Dental* decision, the FTC has lived up to its warning and shown a renewed interest in challenging trade and professional association codes of ethics that potentially limit competition between members. The CDA decision, after all, does not immunize trade and professional associations from antitrust scrutiny. To the contrary, the court recognized the antitrust risks inherent in codes of ethics and similar restrictions, while also recognizing that such restrictions may offer procompetitive benefits in some cases. In other words, codes of ethics continue to present risks for

trade and professional associations if not structured to minimize risks under the antitrust laws.

Starting in 2014, with a complaint against the Music Teachers National Association, Inc., the FTC has brought at least seven enforcement actions against associations for encouraging their members not to compete (usually through a code of ethics or similar document). In the *Music Teachers* case, for example, the FTC challenged a code of ethics that restricted members from soliciting clients from rival music teachers. As explained by the FTC in announcing the enforcement action, “Competing for customers, cutting prices, and recruiting employees are hallmarks of vigorous competition. Agreements among competitors not to engage in these activities injure consumers by increasing prices and reducing quality and choice.”

Most recently, in May 2017, the FTC announced a similar action against the American Guild of Organists (AGO), an association with 15,000 organists and choral conductors in more than 300 chapters across the United States and abroad. According to the FTC’s complaint, AGO maintained a code of ethics that prohibited members from soliciting positions held by someone else, and required members to obtain the approval from an incumbent before accepting a job at the incumbent’s

These enforcement actions underscore a lesson worth repeating—codes of ethics and membership restrictions present antitrust risks if not implemented and managed carefully.

The commercial or economic considerations of members should play no role in the development, application, or enforcement of a code of ethics.

venue. According to the FTC, these restrictions likely raised prices for consumers as well as the organizations that employed organists.

These actions demonstrate that the FTC remains keenly focused on trade and professional association codes of ethics. While CDA may have won its battle with the FTC, any trade or professional association with a code of ethics should keep the following best practices in mind for purposes of minimizing potential antitrust risks:

- A mandatory code of ethics presents more antitrust risks than a voluntary code of ethics or aspirational best practices or guidelines. Before adopting mandatory requirements, associations should review the proposed standards carefully for provisions that may impact competition among members.
- While advertising restrictions related to deceptive or untruthful advertising are unlikely to violate the antitrust laws, restrictions that target truthful advertising may present significant antitrust concerns.
- An association's code of ethics should be clear, reasonable, and based on objective standards. Standards should never be vague or ambiguous, and the association should not be arbitrary or capricious in enforcing them.
- An association's code of ethics should be no more stringent or rigid than necessary to ensure that minimum acceptable levels of conduct are met.

The commercial or economic considerations of members should play no role in the development, application, or enforcement of a code of ethics. A code of ethics should never be designed or administered for purposes of raising, lowering or

stabilizing prices, excluding competitors from a market, or limiting the supply or output of products or services.

Due process should be built into any enforcement of a code of ethics. This generally requires an association provide a member or applicant with notice of the alleged violations, a meaningful opportunity to respond, and the right to appeal an adverse decision to a higher-level decision-making body within the association. This process should be administered without subjectivity, favoritism, or discrimination. The rules for enforcing the code must be followed consistently by those administering the standards.

An association should maintain strict confidentiality with respect to all adverse allegations, complaints, actions, and proceedings that arise in connection with the process.

Codes of ethics and other membership standards play an important role in protecting consumers and ensuring high standards in different professions and industries. When done right, a code of ethics benefits an association, its members, and the public at large. Done wrong, however, a code of ethics can present significant antitrust risks for an association. Nearly 20 years ago CDA escaped several years of litigation with a favorable Supreme Court ruling. More recently, however, the FTC has brought several enforcement actions against associations alleged to have stifled competition through unreasonable codes of ethics. Given the potential costs of litigation and corresponding reputational harm, any association with a code of ethics should take steps to ensure that the code does not expose the association or its members to antitrust risks. ■

CALIFORNIA DENTAL ASSOCIATION v. FEDERAL TRADE COMMISSION

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 97–1625. Argued January 13, 1999—Decided May 24, 1999

Syllabus

The full decision can be viewed at <https://supreme.justia.com/cases/federal/us/526/756/case.html>, including the unanimous opinion written by Justice Souter with a partial dissent by Justice Breyer.)

Petitioner California Dental Association (CDA), a nonprofit association of local dental societies to which about three-quarters of the State’s dentists belong, provides desirable insurance and preferential financing arrangements for its members, and engages in lobbying, litigation, marketing, and public relations for members’ benefit. Members agree to abide by the CDA’s Code of Ethics, which, *inter alia*, prohibits false or misleading advertising. The CDA has issued interpretive advisory opinions and guidelines relating to advertising. Respondent Federal Trade Commission brought a complaint, alleging that the CDA violated § 5 of the Federal Trade Commission Act (Act), 15 U.S.C. § 45, in applying its guidelines so as to restrict two types of truthful, nondeceptive advertising: price advertising, particularly discounted fees, and advertising relating to the quality of dental services. An Administrative Law Judge (ALJ) held the Commission to have jurisdiction over the CDA and found a § 5 violation. As relevant here, the Commission held that the advertising restrictions violated the Act under an abbreviated rule-of-reason analysis. In affirming, the Ninth Circuit sustained the Commission’s jurisdiction and concluded that an abbreviated or “quick look” rule-of-reason analysis was proper in this case.

Held:

1. The Commission’s jurisdiction extends to an association that, like the CDA, provides substantial economic benefit to its for-profit members. The Act gives the Commission authority over a “corporatio[n],” U. S. C. § 45(a)(2), “organized to carry on business for its own profit or that of its members,” § 44. The Commission’s claim that the Act gives it jurisdiction over nonprofit associations whose activities provide substantial economic benefits to their for-profit members is clearly the better reading of the Act, which does not require that a supporting organization must devote itself entirely to its members’ profits or say anything about how much of the entity’s activities must go to raising the members’ bottom lines. There is thus no apparent reason to let the Act’s application turn on meeting some threshold percentage of activity for this purpose or even a softer formulation calling for a substantial part of the entity’s total activities to be aimed at its members’ pecuniary benefit. The Act does not cover all membership organizations of profit-making corporations without more. However, the economic benefits conferred upon CDA’s profit-seeking professionals plainly fall within the object of enhancing its members’ “profit,” which is the Act’s jurisdictional touchstone. The Act’s logic and purpose comport with this result, and its legislative history is not inconsistent with this interpretation.
2. Where any anticompetitive effects of given restraints are far from intuitively obvious, the rule of reason demands a more thorough enquiry into the consequences of those restraints than the abbreviated analysis the Ninth Circuit performed in this case.
 - (a) An abbreviated or “quick-look” analysis is appropriate when an observer with even a rudimentary understanding of economics could conclude that the arrangements in question have an anticompetitive effect on customers and markets. See, *e. g.*, *National Collegiate Athletic Assn. v. Board of Regents of Univ. of Okla.*, 468 U. S. 85. This case fails to present a situation in which the likelihood of anticompetitive effects is comparably obvious, for the CDA’s advertising restrictions might plausibly be thought to have a net procompetitive effect or possibly no effect at all on competition.

(b) The discount and nondiscount advertising restrictions are, on their face, designed to avoid false or deceptive advertising in a market characterized by striking disparities between the information available to the professional and the patient. The existence of significant challenges to informed decision making by the customer for professional services suggests that advertising restrictions arguably protecting patients from misleading or irrelevant advertising call for more than cursory treatment. In applying cursory review, the Ninth Circuit brushed over the professional context and described no anticompetitive effects from the discount advertising bar. The CDA's price advertising rule appears to reflect the prediction that any costs to competition associated with eliminating across-the-board advertising will be outweighed by gains to consumer information created by discount advertising that is exact, accurate, and more easily verifiable. This view may or may not be correct, but it is not implausible; and neither a court nor the Commission may initially dismiss it as presumptively wrong. The CDA's plausible explanation for its nonprice advertising restrictions, namely that restricting unverifiable quality claims would have a procompetitive effect by preventing misleading or false claims that distort the market, likewise rules out the Ninth Circuit's use of abbreviated rule-of-reason analysis for those restrictions. The obvious anticompetitive effect that triggers such analysis has not been shown.

(c) Saying that the Ninth Circuit's conclusion required a more extended examination of the possible factual underpinnings than it received is not necessarily to call for the fullest market analysis. Not every case attacking a restraint not obviously anticompetitive is a candidate for plenary market examination. There is generally no categorical line between restraints giving rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment. What is required is an enquiry meet for the case, looking to a restraint's circumstances, details, and logic. Here, a less quick look was required for the initial assessment of the CDA's advertising restrictions.

128 F.3d 720, vacated and remanded.

Saving Dental Medicaid Coverage for Adults in Ohio

David J. Owsiany, JD, FACD

Abstract

This paper describes the role of organized dentistry in supporting state actions in the public good through the amicus brief mechanism. The Ohio Dental Association was successful in defending the use of tobacco settlement funds for general health purposes rather than the more narrow intent of smoking cessation programs.

Amicus—or “friend of the court”—briefs are usually filed by an individual or organization with a strong interest in the subject matter of a lawsuit but who is not a party to the lawsuit or directly involved with the litigation. Many associations are active in filing amicus briefs in appellate cases, especially if the underlying issues involved in the litigation have the potential to impact the association’s membership or the profession represented by the association. According to the Public Health Law Center,¹ amicus briefs have become powerful and effective in developing public policy, including health policy, through the courts.

Several years ago, the Ohio Dental Association (ODA) took the lead in the drafting and filing of an amicus brief with the Ohio Supreme Court in a case involving the state’s budget, tobacco settlement funds, and dental coverage for adults in Ohio’s Medicaid program. The outcome of that case continues to have a positive impact on the oral health of hundreds of thousands of low-income Ohioans.

Background

The case had its origin in the Master Settlement Agreement between the major tobacco companies and the states signed in 1998, in which the tobacco companies agreed to transfer more than \$200 billion to the states over a 25-year period. Nothing in the agreement specified how the states were to use the money. Pursuant to

statutes passed by the Ohio General Assembly and signed into law by then-Governor Bob Taft, the state used tobacco settlement funds for various purposes, including education technology, biomedical research, law enforcement, education facilities, and tobacco use prevention and cessation activities.

Because the federal government does not mandate that states provide comprehensive dental care for adults in the Medicaid program, coverage for adults is considered “optional.” Other so-called optional Medicaid services include optometric, chiropractic, podiatric, and psychological care. Most states have now eliminated or severely limited their optional Medicaid services, including dental coverage for adults. For more than a decade before Ohio’s tobacco litigation, the ODA was the lead entity successfully advocating before the Ohio legislature for dental coverage for adults.

During the Great Recession, as Ohio’s economy began to struggle and unemployment rose, the Ohio General Assembly passed a statute directing money that was formerly placed in the tobacco cessation endowment fund to a series of other programs. Specifically, in 2008, the General Assembly passed a law directing approximately \$230 million of the tobacco settlement funds into jobs stimulus programs and \$40 million for anti-tobacco programs.

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In 2009, Ohio's economy worsened and state tax revenues shrank while demand for social services grew as hundreds of thousands of Ohio workers lost their jobs and health and dental benefits. With Ohio's economy in a free fall, the General Assembly passed the state budget for fiscal years 2010–2011. In signing the state budget into law, Ted Strickland, who was governor at the time, announced that a portion of money formerly contained in the tobacco cessation endowment fund and redirected for jobs stimulus programs would instead be used for necessary social services and Medicaid coverage. Included in the expenditure was approximately \$129 million for optional Medicaid services, such as dental coverage for adults.

State Budget Challenged in Court

The Washington, D.C.-based American Legacy Foundation, which expected to receive approximately \$190 million from the settlement funds for tobacco use prevention efforts in Ohio, filed a lawsuit challenging the state's expenditure of the tobacco settlement funds. In August 2009, the trial court ruled in favor of the Legacy Foundation and invalidated the state's attempt to use the disputed funds for anything other than tobacco use prevention efforts. The court's ruling effectively put the funding for optional Medicaid services in jeopardy.

The state of Ohio immediately appealed and the ODA led a coalition of healthcare organizations, including the Ohio Association of Community Health Centers and the Ohio Optometric Association, in filing an amicus brief with the appellate court. The ODA's brief supported the state's

position that budgeting decisions are to be made by the legislature and the governor, not the courts. On December 31, 2009, the Court of Appeals reversed the trial court's decision and ruled in favor of the state, agreeing with the ODA's position that the General Assembly and governor have broad authority to determine the state's budgetary priorities.

Appeal to the Ohio Supreme Court

While the Court of Appeals' decision was positive from the ODA's perspective, the future of the dental Medicaid program remained in limbo because the Legacy Foundation appealed the case to the Ohio Supreme Court. The ODA again filed an amicus brief—this time with Ohio's highest court—in support of the state's position. The ODA's brief acknowledged that in an "ideal world" unlimited funding would be available for tobacco use prevention and important health programs such as optional Medicaid services but in the "real world" where hard decisions about the allocation of limited resources must be made, our system of government calls for such decisions to be made by the representatives of the people in the legislative branch. The ODA argued that "the General Assembly's decision to fund various health services programs," including adult dental services, "is a considered and prudent allocation of scarce state funds."

The brief explained that "the General Assembly was aware of the adverse consequences of cutting such funding," which included:

- "Cutting off critical health services to Ohio's poor and medically underserved populations;"
- "Penalizing providers of Medicaid optional services who generously serve such populations and

hindering their ability to do so in the future;" and,

- "Costing the state millions more dollars in emergency room costs and lost federal matching funds."

The ODA's brief concluded that the Ohio Constitution and Supreme Court precedent made clear that "allocating state funds to competing uses is exclusively a legislative function" that should not be disturbed by the courts.

In December 2010, several months after hearing the oral arguments and receiving all of the briefs, including the amicus brief, the court issued a unanimous decision in the *Board of Trustees of the Tobacco Use Prevention and Control Foundation v. Boyce* case upholding the state's use of the tobacco settlement funds for optional Medicaid services.

Did the ODA's Involvement Have an Impact?

While research indicates that amicus briefs can have significant influence on courts, it is impossible to definitively know the impact the arguments had in the tobacco case. However, in closely reviewing the decision, it is clear that the ODA's were winning arguments in the eyes of the court.

The brief discussed the negative real world impact on Ohioans if the court ruled against the state and eliminated funding for adult dental Medicaid and other state priorities. The ODA also made the case that these funding decisions are policy judgments that should be made by the legislature, not the courts. The Ohio Supreme Court agreed.

For example, the ODA argued that under the Ohio Constitution the General Assembly has broad lawmaking power in passing legislation, including the state budget.

Specifically, the brief stated that “the Ohio Constitution provides that the General Assembly’s legislative power is plenary; the General Assembly can pass any law so long as it is not constitutionally prohibited.” The Supreme Court completely agreed with this position, using strikingly similar wording. The court’s written opinion stated that “the General Assembly has plenary power to enact legislation; it is limited only by the Ohio Constitution and the Constitution of the United States.”

In its brief, the ODA also argued that the actions of a previous General Assembly to direct tobacco settlement funds to tobacco use prevention efforts could not bind a future General Assembly, thereby preventing it from redirecting unused funds to new priorities, such as dental Medicaid. The ODA’s brief specifically stated: “the Ohio Constitution prohibits one General Assembly from binding a later General Assembly.” Again, the Ohio Supreme Court completely agreed, using similar language. The court held: “Although the General Assembly’s plenary legislative power is expansive, it is not all-inclusive. It does not include the ability to bind future General Assemblies.”

The ODA also argued in our brief that the General Assembly had statutorily created a custodial account for the purpose of tobacco cessation and prevention programs. Years later, in the face of a severe economic downturn, the General Assembly determined that the funds remaining in the custodial account were needed for other purposes, including funding for optional Medicaid services. In doing so, the ODA argued that the General Assembly properly exercised its constitutional legislative power.

On April 14, 2010, while the case was pending before the Ohio Supreme Court, the *Columbus Dispatch*

Today, according to the Kaiser Foundation, Ohio is one of only 15 states that provide comprehensive dental coverage for adults in their Medicaid programs.

published an op-ed reiterating the arguments made in the ODA brief including “the General Assembly retains its powers to legislate with regard to custodial funds unless the funds have expressly been rendered unreachable through a constitutional amendment, which was not the case here.” In its written opinion, the Ohio Supreme Court again agreed with the ODA’s position, specifically holding: “Several states have passed constitutional amendments preventing the reallocation of funds that were allocated from the proceeds of the MSA [master settlement agreement] to tobacco-use and prevention. The Ohio Constitution, however, has not been amended to prevent the reallocation of tobacco settlement proceeds.”

The *Columbus Dispatch* op-ed summarized the ODA’s main argument that it is not the court’s role to determine whether the General Assembly’s policy decisions related to the state budget were wise or not. The case, instead, was about whether the General Assembly acted in a manner that is consistent with the Ohio Constitution. Specifically, “this case is not about whether the General Assembly made the ‘right’

decisions in setting the state’s priorities. It is about who is charged with making such decisions. Under the Ohio Constitution, policy decisions related to the state budget are to be made by the legislature.”

The Ohio Supreme Court agreed, stating in the concluding paragraph of its written opinion: “it is not for us to judge the wisdom of the General Assembly but to determine whether the exercise of its power comports with or violates the Ohio Constitution.”

Conclusion

Today, according to the Kaiser Foundation, Ohio is one of only 15 states that provide comprehensive dental coverage for adults in their Medicaid programs. This is in large part because of the Ohio Supreme Court’s decision in the tobacco litigation and the efforts of the Ohio Dental Association through its advocacy at the Ohio Statehouse—and in the courts. ■

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**BOARD OF TRUSTEES OF THE TOBACCO USE PREVENTION AND CONTROL FOUNDATION;
AMERICAN LEGACY FOUNDATION ET AL., APPELLANTS, v. BOYCE, TREASURER, ET AL., APPELLEES.**

(No. 2010-0118 — Submitted July 6, 2010 — Decided December 22, 2010.)

APPEAL from the Court of Appeals for Franklin County

The full decision can be viewed at <https://www.sconet.state.oh.us/rod/docs/pdf/0/2010/2010-Ohio-6207.pdf>

The issue in this case is whether certain sections of 2008 Am.Sub.S.B. No. 192 (“S.B. 192”) and 2008 Sub.H.B. No. 544 (“H.B. 544”) are constitutional. We conclude that the sections are constitutional and affirm the judgment of the court of appeals.

Factual and Procedural Background

In November 1998, the Ohio attorney general entered into a master settlement agreement (“MSA”) with the largest tobacco-product manufacturers in the United States that resolved litigation to recover healthcare expenses incurred by the states as a result of tobacco-related illnesses. Pursuant to the MSA, Ohio was to receive \$10.1 billion in payments through 2025; there was no restriction on how the money could be spent.

In 2000, the General Assembly enacted Am.Sub.S.B. No. 192, 148 Ohio Laws, Part V, 10767, creating R.C. Chapter 183. The new law distributed proceeds from the MSA to eight different funds, including \$235 million to the newly created Tobacco Use Prevention and Cessation Trust Fund. Money from the trust fund was to be appropriated to an endowment fund, which was to “be in the custody of the treasurer of state but not be a part of the state treasury.” Former R.C. 183.08, 148 Ohio Laws, Part V, at 10785. The endowment fund was to fund programs and research related to tobacco-use prevention and cessation. Former R.C. 183.07, 148 Ohio Laws, Part V, at 10784. Former R.C. 183.08 directed that a newly created Tobacco Use Prevention and Control Foundation (“foundation”) would serve as trustee of the endowment fund.

On April 2, 2008, the governor and legislative leaders announced a bipartisan agreement to spend state funds to stimulate the economy. The agreement called for reallocating approximately \$230 million then in the endowment fund to the stimulus package. On April 8, 2008, the General Assembly passed S.B. No. 192, which liquidated the endowment fund. On the same day, the executive director of the foundation, pursuant to a motion passed by the board of the foundation, executed a contract with American Legacy Foundation (“ALF”) to transfer \$190 million from the endowment fund to ALF. The following day, the foundation filed a complaint against the treasurer seeking to enjoin the enforcement of S.B. 192 and asking that the statute be declared unenforceable. The board then rescinded its resolution authorizing the \$190 million transfer to ALF. ALF moved to intervene as a plaintiff in the lawsuit brought by the foundation and filed a complaint requesting a declaration that H.B. 192 be declared unconstitutional and an injunction to stop the state treasurer from transferring the money in the endowment fund to the jobs fund.

On May 6, 2008, the General Assembly enacted H.B. 544, which abolished the foundation and gave the Ohio Department of Health (“ODH”) responsibility for any residual matters, including legal obligations. Section 4 of H.B. 544 directed the state treasurer to liquidate the endowment fund, deposit the lesser of \$40 million or 14.8 percent of the proceeds into the state treasury to the credit of a tobacco-use-prevention fund, and deposit the remaining proceeds from the liquidation (approximately \$190 million) into the state treasury to the credit of a jobs fund. On May 9, 2008, ALF amended its complaint to contest the constitutionality of H.B. 544 as well as S.B. 192.

On May 27, 2008, Robert G. Miller Jr. and David W. Weinmann, former smokers who had participated in the foundation’s cessation programs, filed a complaint for declaratory relief, claiming that the enactment of R.C. Chapter 183 and the transfer of money into the endowment fund had created a trust that the General Assembly did not have the power to change. Miller and Weinmann claimed that they were beneficiaries of the trust because they were participants in programs funded by the foundation, and they sought a judgment declaring that (1) H.B. 544 is unconstitutional under the Contract Clauses of Section

10, Article I of the Constitution of the United States and Section 28, Article II of the Ohio Constitution and (2) H.B. 544 illegally attempts to appropriate nontreasury funds in breach of an irrevocable trust. Their action was consolidated with ALF's lawsuit in May 2008.

On August 11, 2009, the trial court entered judgment against ALF, finding that the contract between it and the foundation was invalid. The court also entered final judgment for Miller and Weinmann on their claims, finding that the endowment fund was an irrevocable trust and that the portions of H.B. 544 that transferred money from the endowment fund violated the Retroactivity Clause of Section 28, Article II of the Ohio Constitution and the Contract Clauses of the United States and Ohio Constitutions. Accordingly, the trial court permanently enjoined the state of Ohio, the treasurer, the attorney general, and ODH ("appellees") from enforcing any provision of H.B. 544 and S.B. 192 that related to the endowment fund.

On appeal, the court of appeals held that the endowment fund was not an irrevocable charitable trust and that appellees had no vested rights that could be violated. *Tobacco Use Prevention & Control Found. Bd. of Trustees v. Boyce*, 185 Ohio App.3d 707, 2009-Ohio-6993, 925 N.E.2d 641, ¶ 41-46. The court reasoned that the appellants offered no authority supporting the proposition that custodial funds, once created, cannot be abolished or transferred by the General Assembly. *Id.* at ¶ 34 (a custodial account is an account that is in the custody of the treasurer of the state but that is not part of the state treasury. R.C. 113.05(B). For an example, see former R.C. 183.08(A)). The court also affirmed the decision of the trial court that the contract between ALF and the foundation was invalid, stating that the resolution approving the contract had been improperly discussed only in executive session, in violation of R.C. 121.22, Ohio's Open Meetings Act, and thus the executive director had no authority to enter into the contract with ALF. *Id.* at ¶ 27.

We accepted the discretionary appeal of Miller, Weinmann, and ALF ("appellants").

Analysis

The General Assembly has plenary power to enact legislation; it is limited only by the Ohio Constitution and the Constitution of the United States. Section 1, Article II, Ohio Constitution. See *Williams v. Scudder* (1921), 102 Ohio St. 305, 307, 131 N.E. 481. "[B]efore any legislative power, as expressed in a statute, can be held invalid, it must appear that such power is clearly denied by some constitutional provision." *Id.* See *Lehman v. McBride* (1863), 15 Ohio St. 573, 592 (when the power of the General Assembly to enact a law is questioned, the proper inquiry is whether the law is clearly prohibited by the Constitution). Our inquiry, then, is whether the portions of H.B. 544 and S.B. 192 liquidating the endowment fund and placing the money in the jobs fund are clearly prohibited by the Ohio Constitution.

The General Assembly's legislative power enables it to "pass any law unless it is specifically prohibited by the state or federal Constitutions." *State ex rel. Jackman v. Cuyahoga Cty. Court of Common Pleas* (1967), 9 Ohio St.2d 159, 162, 38 O.O.2d 404, 224 N.E.2d 906. See *State ex rel. Poe v. Jones* (1894), 51 Ohio St. 492, 504, 37 N.E. 945 ("whatever limitation is placed upon the exercise of that plenary grant of [legislative] power must be found in a clear prohibition by the constitution"). No constitutional amendment was adopted in Ohio restricting the use of the tobacco settlement money. In the absence of a constitutional provision, the General Assembly had the power to change the use of the settlement money by enacting H.B. 544 and S.B. 192.

The *Retroactivity Clause* Section 28, Article II of the Ohio Constitution states that "[t]he general assembly shall have no power to pass retroactive laws." In *Van Fossen v. Babcock & Wilcox Co.* (1988), 36 Ohio St.3d 100, 522 N.E.2d 489, paragraph one of the syllabus, this court stated, "The issue of whether a statute may constitutionally be applied retrospectively does not arise unless there has been a prior determination that the General Assembly specified that the statute so apply." See *Smith v. Smith*, 109 Ohio St.3d 285, 2006-Ohio-2419, 847 N.E.2d 414, at ¶ 6, quoting *Bielat v. Bielat*, 87 Ohio St.3d 350, 353, 721 N.E.2d 28 ("To determine whether a law is unconstitutionally retroactive, we must first 'determine whether the General Assembly expressly intended the statute to apply retroactively'"). Appellants argue that Section 4 of H.B. 544 clearly indicates that the act is retrospective in its application. However, the language of Section 4 does not indicate that the General Assembly expressly intended the act to apply retroactively. Instead, the language demonstrates the General Assembly's intention that the act be applied prospectively: "Notwithstanding any provision of law to the contrary, on the effective date of this section, the Treasurer of State shall liquidate the Tobacco Use Prevention and Control Foundation Endowment Fund created by section 183.08 of the Revised Code in a prudent manner. The Treasurer of State shall deposit into the state treasury to the

credit of the Tobacco Use Prevention Fund (Fund 5BX0), which is created in section 3701.841 of the Revised Code, the lesser of \$40 million or 14.8 per cent of the proceeds from liquidation. The Treasurer of State shall deposit the remaining proceeds from liquidation into the state treasury to the credit of the Jobs Fund (Fund 5Z30), which is hereby created.”

On its face, the statute applies only from the date of its enactment, not to acts, events, or cases that predate its enactment. *Van Fossen*, 36 Ohio St.3d at 105, 522 N.E.2d 489. In *E. Liverpool v. Columbiana Cty. Budget Comm.*, 114 Ohio St.3d 133, 2007-Ohio-3759, 870 N.E.2d 705, ¶ 31, we stated that “when the application of a statute to the case before us involves only a prospective operation, we will not entertain a retroactivity claim under Section 28, Article II. *State v. Hawkins* (1999), 87 Ohio St.3d 311, 314, 720 N.E.2d 521. That doctrine bars East Liverpool’s retroactivity claim.”

The doctrine bars appellants’ claim in this case. We have also stated that the “retroactivity clause nullifies those new laws that ‘reach back and create new burdens, new duties, new obligations, or new liabilities not existing at the time [the statute becomes effective].’ *Miller v. Hixson* (1901), 64 Ohio St. 39, 51, 59 N.E. 749, 752.” Bielat, 87 Ohio St.3d at 352-353, 721 N.E.2d 28. In *Van Fossen*, this court stated that the constitutional limitation against retroactive laws “ ‘include[s] a prohibition against laws which commenced on the date of enactment and which operated in futuro, but which, in doing so, divested rights, particularly property rights, which had been vested anterior to the time of enactment of the laws.’ ” 36 Ohio St.3d at 105, 522 N.E.2d 489, quoting Smead, *The Rule Against Retroactive Legislation: A Basic Principle of Jurisprudence* (1936), 20 Minn.L.Rev. 775, 781-782. In *E. Liverpool*, after stating that the law operated prospectively, this court addressed East Liverpool’s contention “that the statute ‘permitted the retrospective extinguishment of East Liverpool’s preexisting legal right under former R.C. 5747.53 and 5747.63.’ ” 114 Ohio St.3d 133, 2007-Ohio-3759, 870 N.E.2d 705, at ¶ 33. Accordingly, we now address appellants’ claim that H.B. 544 extinguished their preexisting property rights.

Conclusion

We affirm the judgment of the court of appeals.

Judgment affirmed.

Nuances in the Legal Aspects of Dental Advertising

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Abstract

The behavior of individual dentists can blur the line between professional standards and commercial interests. This is especially true in the case of advertising claims. State dental boards have the authority and responsibility to enforce the standards the often cross the line between free speech protected by the First Amendment and protection of the public as defined in state practice acts. The process can be complex.

Many changes to the standards for advertising in the dental profession have occurred over the last 40 years. While most of the changes impacting dental advertising are related to constitutionally protected rights under the First and Fourteenth Amendments, which protect freedom of speech and equal protection of the laws, increasingly, attacks on the legality of advertising has focused on the “truthfulness” of such ads. Most recently there have been a number of cases that have challenged the standing of dentists to proclaim “specialty” status for those specialties not recognized by the American Dental Association. The trend is that states are being restricted from prohibiting dentists from proclaiming specialty status when such specialty represents a specialized body of knowledge and attainment of the status includes a program of study and “board examination” to demonstrate competence as a specialist.

A number of legal cases have tested the freedom of dentists to advertise and the abilities of state dental boards to regulate advertisement. In general, the legal arguments defending the advertisements have been narrowly crafted around the Constitutional protections designating advertisements as “commercial speech.” This status affords the advertisements protections from the First Amendment and the Fourteenth Amendment, and the “Equal Protections Clause” prohibiting states from applying state standards under the individual state’s dental

practice act. However, misleading and “uninformative” advertising do not receive Constitutional protections as commercial speech. State dental boards generally will “step in” when a complaint against a licensed dentist contains allegations of “false or misleading” claims, and such action is consistent with the state dental boards’ responsibility of protecting the public.

In addition, the American College of Dentists Ethics Handbook¹ and American Dental Association Principles of Ethics and Code of Professional Conduct² both contain language regarding prohibitions on false or misleading advertising and provide some guidance to the practicing dentist to help define acceptable language for advertisements. The ADA code in section 5.F.2 provides examples of false or misleading advertisements and included in the list of examples is statements which contain a material, objective representation, whether express or implied that the services are superior in quality to those of other dentists.

A Test of Enforcing Actions against Advertising

An example of the complexity of such matters as they involve individual dentists concerns an Indiana dentist named Irfan Atcha. In 2012, in response to complaints about Dr. Atcha’s advertising, the State Attorney General

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reached a settlement, that was later rejected by the Indiana State Board of Dentistry. Dr. Atcha claimed that “general dentists typically have little or no knowledge of the sedation process” and that “oral surgeons, periodontists, and prosthodontists may do more harm than good; that specialists have no knowledge or understanding about the restorative end (tooth placement) of the [implant] procedure; and that certain implant procedures are too advanced for most dentists, oral surgeons and periodontists.” Atcha sought and won relief from the board’s decision from a trial judge in Marion County, Indiana in 2013. Subsequently, the board appealed the decision to the District Court for Northern Indiana and at about the same time Atcha filed with the Court of Appeals for personal damages. The Appeals court dismissed Atcha’s claim on the grounds that no damage had been finally determined since there was an outstanding appeal. The court further dismissed the case with prejudice, meaning that the matter could not be reopened. Subsequently, the District Court overturned the lower court’s decision, saying that Atcha’s advertising claims were not protected free speech but upheld the lower court’s opinion that requiring the listing of all involved dentists was an unnecessary burden. Since then, it appears that Dr. Atcha’s disciplinary record with Indiana has been expunged and he practices in Illinois.

The facts are as follows: shortly after purchasing a practice, Dr. Atcha, began an extensive advertising campaign marketing his expertise in modern implant and sedation techniques. Among other claims, he advertised that his procedures are

“too advanced for most dentists, oral surgeons, and periodontists.” He also promoted himself as the “only licensed and certified advanced trained dentist to perform the IV sedation and dental care on his patients.” In response to several complaints, the State of Indiana Attorney General filed a complaint with the Indiana Board of Dentistry stating:

- Count I: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-14(a) and (b) in that Respondent has failed to list all dentists in his practice on his advertisements.
- Count II: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-18(k) in that Respondent has used words that express or imply specialization in implant dentistry, that do not state the services are being provided by a general dentist, and are false or misleading.
- Count III: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-18(m) in that Respondent has advertised superior services, better materials, or more skillful care available in his office in a deceptive manner.
- Count IV: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-18(n) in that Respondent has advertised guarantees or warranties that are deceptive and utilized testimonials or endorsements in a misleading manner.

During the Court of Appeals review, the State raised three issues on appeal: “(a) whether Dr. Atcha’s advertisements were false or misleading and, therefore, not entitled to First Amendment protection; (b) whether the regulations restricting advertise-

ment of dental specialties and superior materials or services are constitutional restrictions on speech; and (c) whether the regulation requiring dentists to include the names of all dentists associated with their practice in every advertisement is constitutionally compelled speech.”

At approximately the same time that Atcha’s action against the Indiana board for personal damages was being dismissed, the United States Supreme Court ruled in the case of the *North Carolina Board of Dental Examiners v. the FTC* that the board lacked status to enforce prohibitions of teeth whitening by nondentists. It is unclear whether that decision might have influenced the Atcha case. The U.S. Supreme Court decision was not mentioned by Atcha’s lawyers. It is also unclear whether absent standing under the state action doctrine makes board members liable for personal injury actions or whether the Indiana board was acting independently of the state Attorney General.

There were many lessons to be learned in the case of Dr. Irfan Atcha. The Constitutional protections only exist when advertising is not false, misleading, or deceptive. And absent a compelling state reason for the protection of the public, overly onerous requirements that all dentists located at a specific practice location be listed in any advertisement for that practice are prohibited. It is significant to note that in this instance, the law and the codes of ethics are in alignment. ■

Online Sources

- 1 www.acd.org/ethicshandbook.htm
- 2 www.ada.org/~media/ADA/Member_Center/Files/2016_ADA_Code_Of_Ethics.pdf?la=en
- 3 <https://casetext.com/case/atcha-v-indiana>

FIGURE 1. Timeline for Atcha Advertising Case

March 2012

Initiator: Indiana State Attorney General Office
Request: State filed a complaint with the Indiana State Board of Dentistry containing four counts
Decider: Attorney General reaches agreement with Atcha
Action: Settlement is rejected by the State Board of Dentistry
Grounds: State Dental Practice Act

October 4, 2013

Initiator: Indiana State Attorney General Office
Request: State filed a complaint with the Indiana State Board of Dentistry containing four counts
Decider: Indiana State Board of Dentistry
Action: License placed on indefinite probation and a \$3000 fine (\$1000 per violation)
Grounds: Purview of State Board
Reference: www.in.gov/judiciary/opinions/pdf/01201601nhv.pdf

December 2014

Initiator: Atcha
Request: Appeal of State Board of Dentistry Decision
Decider: Marion Superior Court
Action: Reversed the Indiana State Board's order
Grounds: First Amendment protection of commercial speech
Reference: Order, Marion County, Cause No. 49D03-1312-MI-044739

Early 2015

Initiator: Atcha
Request: Complaint against the State of Indiana for malicious prosecution
Decider: William C. Lee, Judge United States District Court
Action: Case dismissed without opportunity to refile
Grounds: An action for personal injury cannot be taken until the injury has occurred
Reference: <https://casetext.com/case/atcha-v-indiana>

April 2, 2015

Initiator: Indiana Professional Licensing Agency
Request: Appeal of Marion County trial judge decision
Decider: Indiana Court of Appeals
Action: Affirm false advertising; disallow requirement to list all dentists
Grounds: Court precedent
Reference: www.in.gov/judiciary/opinions/pdf/01201601nhv.pdf

 IN THE COURT OF APPEALS OF INDIANA

 INDIANA PROFESSIONAL LICENSING AGENCY
 AND INDIANA STATE BOARD OF DENTISTRY

Appellant Respondents

v.

IRFAN A. ATCHA, DDS

Appellee-Petitioner

January 20, 2016

Court of Appeals Case No.

49A02-1504-MI-197

Appeal from the Marion Superior Court

The Honorable Gary L. Miller

Trial Court Cause No.

 49D03-1312-MI-44739

Case Summary

Dr. Atcha, a Dyer dentist, began an extensive advertising campaign marketing his expertise in modern implant and sedation techniques. Among other claims, he touted that his procedures are “too advanced for most dentists, oral surgeons, and periodontists.” He also promoted himself as the “only licensed and certified advanced trained dentist to perform the IV sedation and dental care on his patients.” Undoubtedly to encourage potential clients to receive dental implants from him, he used pictures to show that dentures combined with dental adhesives are poisonous.

After a number of complaints from fellow dentists, the Indiana Professional Licensing Agency and the Indiana State Board of Dentistry found when advertising his practice Dr. Atcha made false and misleading claims of (1) dental specialty and (2) better materials or superior services. He also was found to have violated regulations compelling him to disclose every dentist within his practice in his advertisements. Upon his appeal to the Marion Superior Court, the court found all three dental advertising regulations unconstitutional. We reverse in part and affirm in part.

Although protected by the First Amendment, commercial speech receives less protection than other forms of expression. In particular, the State retains the authority to prohibit or restrict false and misleading commercial speech. Here, the State properly restricted Atcha’s false and misleading claims implying he had a particular dental specialty and could provide better materials or superior service than other dentists. However, we conclude that the State may not compel a dentist to list on his advertisements every dentist in his practice. Finding no reasonable relationship between compelling the disclosure of all associated dentists and preventing deception, we agree with the trial court that the regulation does not satisfy First Amendment protections for commercial speech. Therefore, we affirm the trial court in part and reverse in part.

Facts and Procedural History

Dr. Irfan Atcha has held a license to practice dentistry in Illinois since 1996. He obtained a dentistry license for Indiana in 2006, purchased an existing practice, and began practicing dentistry in Dyer, Indiana. Shortly after taking over the practice in Dyer, Dr. Atcha began an extensive advertising campaign that included radio, television, billboards, phone books, newspapers, direct mailing, social magazines, and online media.

The gist of Dr. Atcha’s voluminous advertising is that he uses modern implant and sedation techniques, which might be particularly helpful to consumers who need prosthetic teeth. However, some of his advertising claims went beyond that simple message. Dr. Atcha implied that he is able to perform implant procedures that are “too advanced for most dentists, oral surgeons and periodontists[.]” Appellant’s App. p. 189. He claimed his cosmetic dentures “consistently fool other dentists[.]” *Id.* at 186. Dr. Atcha implied that there is a lack of accountability and responsibility in corporate dental implant centers. *Id.* at 189. He claimed that oral surgeons, periodontists, and prosthodontists “make you feel like they’re experts in dental implants, but they can do more harm than good.” *Id.* at 255. In the same advertisement, Dr. Atcha claimed that “[t]he

specialist only worries about what he needs to do and has no knowledge or understanding about the restorative end (tooth placement) of the procedure, so the restorative dentist's hands are tied." *Id.* He claimed that "general dentists typically have little or no knowledge of the sedation process." *Id.* at 191. Dr. Atcha advertised that he is the "only licensed and certified advanced trained dentist to perform the IV sedation and the dental care on his patients." *Id.* Finally, under the heading "NO ONE should die with their teeth in a glass!" Dr. Atcha used pictures to indicate that dentures combined with denture adhesives are poison. *Id.* at 252.

Dr. Atcha's advertisements drew complaints from other dentists and, as a result, the State filed a complaint with the Indiana State Board of Dentistry containing four counts:

Count I: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-14(a) and (b) in that Respondent has failed to list all dentists in his practice on his advertisements.

Count II: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that

Respondent has knowingly violated 828 IAC 1-1-18(k) in that Respondent has used words that express or imply specialization in implant dentistry, that do not state the services are being provided by a general dentist, and are false or misleading.

Count III: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-18(m) in that Respondent has advertised superior services, better materials, or more skillful care available in his office in a deceptive manner.

Count IV: Respondent violated Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated 828 IAC 1-1-18(n) in that Respondent has advertised guarantees or warranties that are deceptive and utilized testimonials or endorsements in a misleading manner.

Dr. Atcha and the State reached a settlement agreement and presented it to the Board on February 1, 2013. But the Board rejected the proposed settlement after a hearing.

Thereafter, the Board held another hearing on October 4, 2013, and issued its findings of fact, ultimate findings of fact, conclusions of law, and order on November 15, 2013. The Board ultimately found that Dr. Atcha knowingly violated three regulations: 1) 828 IAC 1-1-14(a) and (b) in that he failed to list all dentists in his practice on his advertisements; 2) 828 IAC 1-1-18(k) in that he used words that express or imply specialization in implant dentistry, that do not state the services are being provided by a general dentist, and are false or misleading; 3) 828 IAC 1-1-18(m) in that he has advertised superior services, better materials, or more skillful care available in his office in a deceptive manner, and that Section 18(m) would not have been violated if the advertisements were not in fact deceptive.

The regulations that the Board found Dr. Atcha violated read, in pertinent part, as follows:

1) 828 IAC 1-1-14:

(a) Any advertisement for dental treatment shall include the names of the licensed dentists associated with such treatment or treatment facility or employed by the treatment facility or another dentist.

(b) Advertisements listed in telephone directories, or other such advertisements which are listed once a year, must include the names of the licensed dentists associated with the treatment or treatment facility or employed by the treatment facility or another dentist as of the date the contract is made to run the advertisement.

2) 828 IAC 1-1-18(k):

A dentist who is not considered a specialist by this section and who wishes to announce the services available in his or her practice may announce the availability of those services so long as he or she avoids any communications that express or imply specialization. The dentist shall also state that the services are being provided by a general dentist. No dentist shall announce available services in any way that would be false or misleading in any material respect.

3) 828 IAC 1-1-18(m):

An advertisement indicating that superior services, better materials, or more skillful care are available in a particular office or by a group of practitioners may be deceptive.

Dr. Atcha was subject to disciplinary sanctions for the three regulatory violations pursuant to Indiana Code section 25-1-9-4(a)(3). The Board ordered, among other things, Atcha's license placed on indefinite probation and a \$3000 fine (\$1000 per violation).

Dr. Atcha appealed to the trial court, contending, among other allegations, that the Board's Order violated his right to free speech guaranteed under the United States and Indiana Constitutions. The trial court reached only the First Amendment question. It found that the regulations violated Dr. Atcha's First Amendment rights and reversed the Board's Order. The State now appeals.

Discussion and Decision

The legislature has granted courts limited power to review the action of state government agencies taken pursuant to the Administrative Orders and Procedures Act ("AOPA"). See *Ind. Educ. Employment Relations Bd. v. Nettle Creek Classroom Teachers Ass'n*, 26 N.E.3d 47, 53 (Ind. Ct. App. 2015); *State Bd. of Registration for Prof'l Eng'rs v. Eberenz*, 723 N.E.2d 422, 430 (Ind. 2000). Under the AOPA, a court may only set aside an agency action that is:

- 1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
- 2) contrary to constitutional right, power, privilege, or immunity;
- 3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
- 4) without observance of procedure required by law; or
- 5) unsupported by substantial evidence.

Ind. Code § 4-21.5-5-14(d).

The State raises three issues on appeal: (1) whether Dr. Atcha's advertisements were false or misleading and, therefore, not entitled to First Amendment protection; (2) whether the regulations restricting advertisement of dental specialties and superior materials or services are constitutional restrictions on speech; and (3) whether the regulation requiring dentists to include the names of all dentists associated with their practice in every advertisement is constitutional compelled speech.

At the outset, the First Amendment, as applied to the States through the Fourteenth Amendment, protects commercial speech from unwarranted governmental regulation. *Wallace v. Brown Cnty.* Area Plan Comm'n, 689 N.E.2d 491, 493 (Ind. Ct. App. 1998). The protection for commercial speech is based on the informational function of advertising. See *Va. State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 765 (1976). In a predominantly free-enterprise economy, resources are allocated through numerous private economic decisions. *Id.* "It is a matter of public interest that those decisions, in the aggregate, be intelligent and well informed. To this end, the free flow of commercial information is indispensable." *Id.*

However, the Constitution "affords a lesser protection to commercial speech than to other constitutionally guaranteed expression." *United States v. Edge Broad. Co.*, 509 U.S. 418, 426 (1993). Moreover, regulations that compel disclosures in advertising receive less protection than regulations that restrict or prohibit commercial speech. See *Milavetz, Gallop & Milavetz, P.A. v. United States*, 559 U.S. 229, 249-50 (2010). Here, the Board found that Dr. Atcha violated 828 IAC 1-1-18(k) and (m), regulations which primarily restrict speech, and 828 IAC 1-1-14, which compels speech. We divide our analysis into two categories—regulations restricting the content of advertising and regulations compelling disclosure in advertising.

Restrictions on Dentists' Advertising

Both parties agree that the appropriate test for whether restrictions on commercial speech comport with the First Amendment is the test outlined in *Central Hudson Gas & Electric Corp. v. Public Service Comm'n of New York*, 447 U.S. 557 (1980). *Central Hudson* sets forth a four-part test that begins by assessing whether the expression being restricted is entitled to First Amendment protection. *Id.* 566. If the expression is entitled to protection, the regulation of that expression must be narrowly tailored to directly advance a substantial government interest. *Id.*

At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

If the statements are false and misleading, the remainder of the four-part analysis of the *Central Hudson* test need not be completed. This is because only truthful advertising related to lawful activities is entitled to First Amendment protection. *In re R.M.J.*, 455 U.S. 191, 203 (1982).

The State first argues that Dr. Atcha’s advertising is false and misleading and, therefore, not entitled to any constitutional protection. Alternatively, the State contends that regulations 828 IAC 1-1-18(k) and (m) meet the standards set out in *Central Hudson*, and that Dr. Atcha’s advertisements violate the regulations. Dr. Atcha, in addition to denying that his advertising is false or misleading, contends that the two regulations violate the First Amendment by failing the remaining four-part *Central Hudson* test. Additionally, Dr. Atcha argues that the regulations are vague and overbroad. We will address Section 18(k) and Section 18(m) separately, beginning by applying the *Central Hudson* standard to each regulation as written, then to the facts of this case, and, finally, examining Dr. Atcha’s overbreadth and vagueness challenges.

False or Misleading Claims of Specialty

We first apply the *Central Hudson* standard to Section 18(k), which provides in part that “No dentist shall announce available services in any way that would be false or misleading in any material respect.” We read the plain text of the regulation as prohibiting only those advertisements which announce services in a way that is materially false or misleading.

Because we read Section 18(k) to prohibit only false or misleading statements, the regulation affects only expression that does not have First Amendment protection. States retain the ability to prohibit misleading advertising entirely. *In re R.M.J.*, 455 U.S. at 203. “[T]here can be no constitutional objection to the suppression of commercial messages that do not accurately inform the public about lawful activity.” *Central Hudson*, 447 U.S. at 563. Because false and misleading statements are not entitled to First Amendment protection, we need not analyze the remaining prongs of the *Central Hudson* test. The regulation is constitutionally permissible as written.

Turning to the application of Section 18(k) to Dr. Atcha’s advertisements, the State argues that there is substantial evidence that Dr. Atcha announced his services in a way that was false or misleading. We agree.

The record contains examples from Dr. Atcha’s advertisements that claim other dentists are not competent to perform the services that the State licenses them to perform. Dr. Atcha claimed that “general dentists typically have little or no knowledge of the sedation process.” Appellant’s App. p. 191. But the State issues sedation permits to general dentists—indicating that general dentists do, in fact, have sufficient knowledge of the sedation process. *Id.* at 22. Dr. Atcha claimed that oral surgeons, periodontists, and prosthodontists may “do more harm than good”; that specialists have “no knowledge or understanding about the restorative end (tooth placement) of the [implant] procedure”; and that certain implant procedures are “too advanced for most dentists, oral surgeons and periodontists.” *Id.* at 255, 189. Again, the tasks described by Dr. Atcha are tasks that dentists are licensed by the State to perform. Moreover, oral surgeons, prosthodontists, and periodontists are required to obtain advanced certifications from institutions accredited by the American Dental Association. It is misleading to suggest that other general dentists and dental specialists are incapable of competently performing an implant procedure.

Dr. Atcha argues that the State may not rely on the naked assertion that claims of specialty are inherently misleading. However, Dr. Atcha did not merely assert his own expertise; he announced his services in conjunction with the implication that other dentists, who hold the same license he holds and provide the same services he provides, are not competent. General claims that duly licensed professionals, in a well-regulated profession, are incompetent to perform the very procedures for which the State licenses them are, at least, misleading. Therefore, we conclude that there is substantial evidence to support the Board finding that Dr. Atcha violated Section 18(k) by falsely or misleadingly announced his available services.¹

Dr. Atcha responds that Section 18(k) is overbroad and vague. Again, because the regulation prohibits only commercial speech that is false or misleading, it implicates no constitutionally protected conduct. His overbreadth challenge fails. See *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494-95 (1982).

Turning to Dr. Atcha’s vagueness challenge, in general, there are two independent causes to invalidate a statute for vagueness: (1) the statute does not provide notice enabling ordinary people to understand the conduct that it prohibits; and (2) the statute potentially authorizes or encourages arbitrary or discriminatory enforcement. *Tiplick v. State*, No. 49S04-1505-CR-2872, 2015 WL 5837690, at *2 (Ind. Oct. 7, 2015). To determine whether a regulation is vague, the Court begins by examining the facts in the current case because “a plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others.” *Id.* Finally, the Court examines facial vagueness by determining whether the law is vague in all of its applications where, as here, the regulation does not implicate constitutionally protected conduct. *Flipside*, 455 U.S. at 494-95.

As applied to Dr. Atcha, Section 18(k) is not impermissibly vague. The ordinary person would understand that advertising claims such as oral surgeons, periodontists, and prosthodontists may “do more harm than good” and that “general dentists typically have little or no knowledge of the sedation process” are false and misleading and therefore violate the regulation.

Finally, to succeed in a claim that the regulation is vague on its face, Dr. Atcha “must demonstrate that the law is impermissibly vague in all of its applications.” *Id.* at 497. Proof of vagueness in some applications is insufficient to void the regulation. *Id.* at 495. As we have determined that the regulation is not vague as to Dr. Atcha’s advertising, he has not met his burden.

His claim of facial vagueness also fails.

Claims of Superior Services or Better Materials

Next, the Board found that Dr. Atcha violated 828 IAC 1-1-18(m). Section 18(m) provides that “[a]n advertisement indicating that superior services, better materials, or more skillful care are available in a particular office or by a group of practitioners may be deceptive.” The Board made clear in its Ultimate Findings of Fact that this section “would not have been violated if the advertisements were not in fact deceptive.” Appellant’s App. p. 26. We understand the Board’s construction of the regulation to be that it bans only advertisements which claim better services, care, or materials in a way that is deceptive. An interpretation of regulations by the administrative agency charged with enforcing those regulations is entitled to great weight. “Indeed, when a court determines that an administrative agency’s interpretation is reasonable, it should terminate its analysis[.]” *Indiana Dept. of Environmental Management v. Steel Dynamics, Inc.*, 894 N.E.2d 271, 274 (Ind. Ct. App. 2008).

Therefore, we adopt the Board’s construction of Section 18(m).

As explained in the analysis of Section 18(k), the State may bar any advertising claim that is deceptive. Such claims have no First Amendment protection, and we need not go further with the *Central Hudson* analysis. See *In re Keller*, 792 N.E.2d 865, 869 (Ind. 2003) (“[T]he advertisements are more likely to deceive the public than inform it and thus are not protected under the First Amendment’s commercial speech doctrine”). Section 18(m) is a constitutionally permissible restriction on commercial speech.

In applying the regulation to Dr. Atcha, the Board found his advertisement with pictures suggesting dentures and dental adhesives are poisonous to be deceptive. We agree. The State may prohibit advertising claims that dentures are poisonous where the claim is being made by a dentist for the purpose of selling implants.

Dr. Atcha also claims that Section 18(m) is overbroad and vague. His overbreadth claim fails for the same reasons it failed with respect to Section 18(k) above. Specifically, the Board construed the regulation to reach only deceptive commercial speech, which has no First Amendment protection. Therefore, the claim that the regulation is overbroad fails. See *Flipside*, 455 U.S. at 494-95.

His claim of vagueness also fails. An ordinary person would understand that the picture indicating that dentures and dental adhesives are poison is deceptive. It appears to be intended to persuade people with working dentures to undergo an implant procedure which may not be necessary. As with Section 18(k) above, Dr. Atcha clearly violated the proscriptions of Section 18(m) by claiming better services or materials in a deceptive way.

Finally, addressing whether Section 18(m) is vague on its face, we begin by repeating that it does not implicate constitutionally protected conduct under the Board’s construction. Dr. Atcha has not “demonstrate[d] that the law is impermissibly vague in all of its applications.” *Id.* at 497. Therefore, his claim of vagueness fails.

In summary, both Sections 18(k) and 18(m) are constitutional restrictions on dental advertising and there is substantial evidence supporting the Board’s Ultimate Findings of Fact that Dr. Atcha violated 828 IAC 1-1-18(k) and (m). Therefore, we reverse the trial court’s decision with respect to these two regulations.

Compelled Disclosure in Dentists’ Advertising

Next, the State argues that the trial court erred by finding that 828 IAC 1-1-14 violates the First Amendment. 828 IAC 1-1-14 compels dental practices to list every dentist in every advertisement. The analysis of compelled commercial speech differs from the analysis of prohibited speech because of the material difference between restricting what can be said and requiring advertisers “to provide somewhat more information than they might otherwise be inclined to present.” *Zauderer*, 471 U.S.

at 650. Unjustified or unduly burdensome disclosure requirements might offend the First Amendment by chilling protected commercial speech. *Id.* at 651. However, “an advertiser’s rights are adequately protected as long as disclosure requirements are reasonably related to the State’s interest in preventing deception of consumers.” *Id.*

The State relies on *Zauderer* in support of its position that it may compel a dental practice to disclose all of the dentists it employs in every advertisement. In *Zauderer*, however, the issue was a lawyer’s advertisement that said “[i]f there is no recovery, no legal fees are owed by our clients.” *Id.* at 631. *Zauderer*’s advertisement did not include a compulsory disclosure explaining how the contingency fee would be calculated, or notify consumers that they would still be liable for any costs incurred. *Id.* at 633. “[T]he advertisement would suggest that employing appellant would be a no-lose proposition in that his representation in a losing cause would come entirely free of charge.” *Id.* at 652. The Supreme Court found it reasonable to require disclosure of potential liability for costs in contingent-fee advertisements in light of the “self-evident” potential for deception—very few non-lawyers would be aware of the distinction between fees and costs. *Id.* at 653.

Here, the State asserts that a consumer might call Dr. Atcha’s office and expect to make an appointment with Dr. Atcha, but instead be given an appointment with another dentist, who may not have the same credentials as Dr. Atcha. This is distinctly different than the concerns over hidden costs that justified the compulsory disclosures in *Zauderer*. A potential client will learn that he or she has an appointment with a different dentist before any costs are incurred. We do not see a similar, “self-evident” potential for deception in this case.

Without an adequate justification for the compulsory listing of all dentists in advertisements, the State’s additional argument that it is not unduly burdensome for Dr. Atcha to list the other dentists in his practice is unavailing. Finding no justification for the compulsory listing of all dentists in the record, we find 828 IAC 1-1-14 unconstitutional.

We, therefore, reverse the trial court’s decision with respect to 828 IAC 1-118(k) and (m), affirm the trial court’s decision with respect to 828 IAC 1-1-14, and remand to the Board for reassessment of the penalty in light of this decision.

What Dentists Do When They Recognize Faulty Treatment To Tattle or Build a Moral Community?

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Abstract

Justifiable criticism is the obligation to speak out in the face of gross or continuous faulty treatment. The assumption is that dentists are in the best position to recognize practices that damage patients and jeopardize the reputation of the profession and that early and positive intervention by dentists is preferable to later actions taken by lawyers and government enforcement agencies. This report summarizes five studies conducted to characterize how dentists and patients regard justifiable criticism. It is part of the ACD Gies Ethics Project, which is intended to offer perspective on the ethical dimension of dental practice. It is expected that this reflection on how the professional practices will open insight and discussion regarding ways to improve oral health and the professional satisfaction of dentists. This report consists of a summary report and five supplemental papers describing individual studies.

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What one says about the work of one's peers requires careful judgment. This is affected by the nature of the treatment, what one knows about the circumstances, and the motives involved. Dentists X and Y may have different opinions about the appropriate treatment for the patient:

- A. Does it matter to the outcome?
 1. X believes Y is practicing differently, but acceptably
 2. X believes Y is practicing below the standard of care and thus endangering patients
 3. X believes Y is practicing in a fashion that will damage the reputation of the profession
- B. Is there an information barrier?
 1. X has sufficient understanding of the situation to form a defensible position
 2. X needs additional information to make sense of what Y is doing
 3. X believes there is something useful to learn from Y
- C. What motives are involved?
 1. X sees an opportunity to increase business at the expense of Y
 2. X sees an obligation to protect the public or the profession
 3. X believes that all will benefit from understanding what Y is doing

There are three possible courses of action:

Unjustifiable criticism: A1 in combination with C1 while disregarding B

Professional development: A1 in combination with B and C3

Justifiable criticism: A2 or A3 with C2, adjusted for B

This chapter will focus on justifiable criticism.

The Profession's Obligation to the Public

Writers on the professions (Hughes, 1959) are generally agreed that the following characteristics set professionals apart from others who provide services to the public for financial compensation:

1. A body of specialized knowledge and skill requiring years of preparation and continuous updating to remain current
2. Service to the public at large, including helping the public make informed decisions by full disclosure of alternatives and their effects
3. A substantial degree of self-determination regarding standards for education, admittance to the profession, and practice

The second and third characteristics are usually considered to be complementary. They are sometimes referred to as an "implied contract." Professional self-governance is granted by the public in exchange for service. Regulation of oral health care is inserted by third parties into this relationship, as with all other commercial activities, to the extent that the public or special interests groups in the public feel members of

a profession place their own interests above those of the public at large.

Various groups within the profession create, modify, negotiate, and update standards that the public can expect of the profession generally. The ethical dimensions of professional-public relationships are the subject of the ACD Gies Ethics Project.

The voluntary enforcement of the implied contract is a separate ethical issue from the creation of the standards. Because neither the public nor reasonable regulatory monitoring can adequately detect quality professional care, monitoring remains the responsibility of the profession. That is sometimes accomplished by standardized and invasive methods such as insurance standards, initial licensure examination or continuing education hour requirements and OSHA, HIPAA, and other compliance monitoring. Sometimes it is done by law suits initiated by staff, former partners, or patients, or by the threat of them. On very rare occasions, it is done by voluntary peer monitoring and reporting. The latter is commonly spoken of as justifiable criticism.

The Code of Professional Conduct

The American Dental Association Code of Professional Conduct, in the section on Justice states: “C. Justifiable Criticism. Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty

Professional self-governance is granted by the public in exchange for service. Regulation of oral health care is inserted by third parties into this relationship, as with all other commercial activities, to the extent that the public or special interests groups in the public feel members of a profession place their own interests above those of the public at large.

treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services.”

There are two positive obligations in this statement: (a) bring matters of perceived unprofessional conduct to the attention of authorized representatives of the profession and (b) ensure that the patients are informed regarding their oral health condition. This is plain enough.

What is excluded from the statement is also important. Dentists are not expected to pass judgment on their colleagues’ motives or to personally intervene to correct their behavior. Creating doubts in the patient’s mind regarding the treating dentist is specifically interdicted. This is either “unjustifiable criticism” or placing the responsibility for redressing the issue on the patient. By extension, undermining a colleague’s reputation within the profession by

innuendo is equally prohibited, although not specifically mentioned in the code.

The moral expectation is clear: responsible perception of inappropriate treatment is to be reported in a descriptive fashion to those in the profession who have the responsibility for managing such matters. Every member of the American Dental Association is expected to observe this ethical rule as a condition for retaining association membership.

How Do Practitioners Use this Rule?

This rule is not an ethical principle, but an element in the Code of Professional Conduct. An ADA member can be sanctioned for not reporting a colleague who engages in

gross or continuous faulty treatment, although I am unaware that this has ever happened. Neither do I know of any case where a dentist has lost his or her licenses exclusively for failing to report a colleague.

Many dentists are ambivalent about publically commenting on the quality of their colleagues' work. The reactions range from false disparaging comments and suggestions about competence intended to "steal" patients and gossip among colleagues that cause damaged reputations, to complete silence and denial of ever having seen anything reportable. In the other direction one finds "hints that a wise person should know what to do with," to informal professional engagement in hopes of helping a colleague, to very frank discussions with warnings attached, and even reporting to the appropriate group, either within organized dentistry or through the state licensure mechanism. The latter actions initiated by dentists are believed to be fairly rare. Most disciplinary actions against dentists are initiated by staff members and patients.

Should and Will

It does not make any sense to simultaneously endorse an ethical principle and fail to act on it. The most typical way this is done is to endorse the ethical principle in theory but add practical circumstances that excuse one from having to do anything. A dentist peer may demonstrate consistent evidence of substandard treatment, but "who knows the circumstances?" or "You cannot believe everything patients tell you," or "My colleague certainly would not want me poking my nose in his

practice." That is an automatic pass while still wearing the moral mantle. Although it has not been studied in dentistry, there is ample evidence in business that questionable practices on the part of others are tolerated as a form of "protection" for our own minor deviations. Not quite so obvious, but nevertheless a reason for avoiding calling out bad actors, is the cover they provide. If Dr. A cuts corners and engages in questionable practices, it is in his or her best interest to hide behind the cover of others who are behaving more outrageously. Certainly, there is little to be gained by more transparency and an open discussion of where the line should be drawn. Why draw attention to the problem generally?

Whistle Blowing

Research indicates that whistle-blowing is uncommon, that whistle-blowers are admired in the abstract and shunned in practice, and that few who do it once make it a habit (Greenberger et al, 1987). The research also offers insight into what prompts some to alert those outside the group to inappropriate behavior of some in the group.

More common reasons for holding justifiable criticism at arm's length include the belief that becoming involved will be personally costly and is unlikely to make a difference. A prominent pattern is that A is upset by the behavior of B but believes that peers and immediate superiors will do nothing or will make an inadequate response. Repeatedly, this is given as the major reason students are unwilling to report academic dishonesty. Women often say the same about sexual abuse or even rape. The United States has a special program for undocumented persons who report gang activities, drugs, and domestic

violence and assist in the prosecution of bad actors. They are given a U-visa. The program has all but dried up recently.

Similarly, potential whistle-blowers perform a simple calculation: are the social and hassle costs worth the effort? The difficulty with making this calculation is that the costs are typically personal while the benefits accrue to others generally, such as the profession or society. The government has attempted to mitigate this difficulty by offering financial rewards, a percentage of settlement damages, to promote whistle-blowing. This is a cheap trick on the part of authorities and open to abuse, such as the specialized lawyers who hunt down minor infractions of the Americans with Disabilities Act.

Yet another justification for not identifying a colleague as apparently damaging patients, even when the evidence is prima facie strong and there would be more to gain personally than lost by doing so, involves loyalty to the profession. The original ADA code of a century and a half ago was explicit that ethical dentists must charge comparable prices (price fixing) and the current code, in the language immediately following that quoted above in 4.C warns: "Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true." As Robert Jackall notes in his classic study of ethics in business organizations (1988), publically noting a flaw in the behavior of a member of an organization makes one vulnerable to sacrificing the protection of the organization.

A related explanation for not becoming involved in justifiable criticism is deeply psychological. We all have images of what the world

is like. For example most dentists believe, and there is much reason to support this, that they are members of a noble profession where dentists place their patients' interest foremost. This becomes a lens through which the world is seen, and inconvenient counter examples have a diminished chance of being noticed. Further, modifying that generalization can be challenging to one's self-image. Even

Many dentists are ambivalent about publically commenting on the quality of their colleagues' work.

maintaining the generalization but carving out and explaining exceptions is an unwelcome cognitive burden.

It is plain that the normative principle of justifiable criticism is a blunt instrument for correcting problems with dentists being reluctant to take appropriate action to stop colleagues from damaging patients. If principles were enough, there would be no issue to discuss. Even among dentists who publically endorse principles in a code, they can duck out in practice by any of several means. It is easy enough to hold that one has an obligation to take action in the face of recognized patient abuse without being required to take action. Nonmaleficence is a handy counter principle: Do no harm to others, especially one's colleagues, would trump the need to report. Principle underdetermination is another escape. "I must report gross or continuous faulty treatment." "Conceivably, the case in hand has some plausible

explanation." Therefore "I both hold the principle and need not take action."

A more direct analysis could be framed in terms of costs and benefits. If a former associate breaches the terms of a non-competitive clause in the employment contract, the senior dentist will determine whether to take action based on the chances of getting a settlement and its amount, minus the costs of pursuing the matter. If the expected reward is greater than the expected cost, he or she will probably go forward. Something like this direct logic seems to be working in the case of dentists who poach others' patients and risk being a bit pushy in the eyes of patients and colleagues for the chance to increase the bottom line. This is a personal good calculation.

But this analysis fits poorly in the case of justifiable criticism. There is a personal cost in terms of time, reputation, collegial relations, and the possible embarrassment of being wrong. But there is little or no direct personal benefit. The benefit is to the patient and to the profession generally. This is what is known as a "common good" situation rather than one involving a "personal good." The individual pays a personal cost, but the reward is a fractional share of what everyone is entitled to (Fehr & Gächter, 2000). Typically the perceived share of a better reputation of dentistry generally is small and diminishing. An individual may be willing to act in a case where he or she stands to receive all or a significant share of the good coming from the action, but will be reticent to get involved where the benefit is spread evenly across many, including those who bear no personal risk and even a few bad actors. If the individual considering justifiable criticism views the cost of involvement as high or the chances of corrective

action following as low, he or she will likely duck the issue. The determination of personal cost versus collective benefit is likely to dominate the decision to act or not, and this will be independent of judging the ethical nature of the previous treating dentist' actions.

It is probably unfortunate to characterize speaking up to stop gross or faulty treatment as tattling. This report will conclude that it is unwise to require whistle-blowing as an ethical obligation.

Studies of Justifiable Criticism

The work reported here is preliminary and descriptive. The intent is to observe dentists making decisions in a context where there is probably concern that a colleague is delivering gross or continuously faulty treatment. It is important to understand what kinds of treatment are considered faulty, whether the relationship between the treating and reporting dentists matter, the extent to which patterns matter, and who else a reporting dentist might want to involve. There is also something to be learned from patients about their views on whether dentists manage this matter well. The goal of the project is to be descriptive rather than to offer suggestions about changing the kind of behavior typically encountered.

Five studies were conducted. They are summarized in this report, and each is discussed in more formal detail as Studies 1–5.

Study #1: Justifiable Criticism Ethics Case

The first inquiry involved dentists and patient perceptions regarding a written exercise where a dentist is asked for a second opinion about a case involving strong evidence of poor treatment (Chambers, 2015). The case describes failure to diagnose an abscess and periodontal involvement, incomplete information given to the patient, and an extremely high quoted fee. Respondents were asked to indicate on a scale from “Absolutely appropriate” to “No way” their inclination to engage in five alternative behaviors and to indicate from “decisive” to “irrelevant” how important each of seven possible reasons were in supporting their action decisions. Ninety-two dentists and 52 patients completed the survey.

Dentists and patients alike strongly agreed that the patient should be informed of his or her oral health needs because current needs are

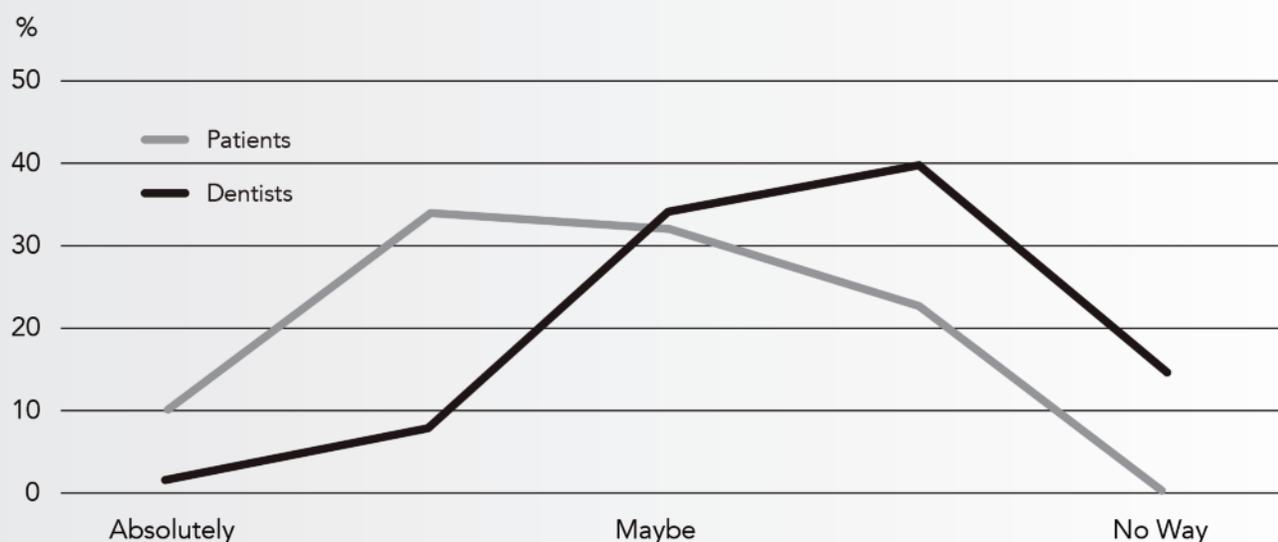
paramount and all patients should be treated equally. Both dentists and patients were more mixed in the opinions regarding involving the treating dentist and the fact that dentists operate independent businesses and that patients personalities may be part of the consideration. Both dentists and patients were twice as likely to strongly favor giving a full explanation to the patient as they were to engage the treating dentist.

There were also significant differences between the views of dentists and patients. The most obvious discrepancy involved whether the matter should be private or more public. Patients were significantly more in favor of the consulting dentist lodging a formal complaint against his or her colleague (see Figure 1). Patients were also significantly more prone to inform their friends informally of their dissatisfaction with the treating dentist than dentists were to mention anything to their colleagues.

A supporting motive for dentists’ reticence to become involved in such matters was their belief that there is a “code” that prohibits criticism of colleagues. The personal interpretations of their treatment carried more weight with patients than they did with dentists.

There were generally weak correlations between preferred actions and reasons offered in justification. The only statistically significant associations turned on the degree of acceptance of the professional “contract” between dentists and the public. Patients were more likely to report their dissatisfaction with the treating dentist if they believed that dentists consider each other as independent rather than part of the same profession. Dentists who placed weight on avoiding unjustifiable criticism were more likely to displace responsibility for resolving matters of inappropriate care on the patient. In both cases, weaker acceptance of the implied social contract for

FIGURE 1. Difference between dentists and patients on expectation that dentist should report substandard care by a colleague.



dentists taking responsibility for their colleague's performance were paired with expectations of greater public engagement.

Study #2: Justifiable Criticism Scenarios

In the second study, 23 dentists were tested individually. Following informed consent, participants were shown five sets of slips of paper and told that short descriptions were written on each. Participants were instructed to assume the role of an endodontist in a community. The scenarios in the patient set were brief descriptions of the presenting condition of various patients, all from the same Dr. X, a general practitioner in the area. The messages on all scenarios are listed in Table 2:1 in Study #2 (page 53). For patients these ranged from "Ms. 2 presents for RCT. There is extensive reconstruction work under way, which you find Dr. X started several months ago. The approach is intriguing: it is not exactly what you would do with the case, but it might work;" and "Mr. 9 presents for RCT. Two new posterior composites have been placed, and they both look well prepped and contoured;" to Mr. 3 presents for Root Canal Therapy (RCT). There are preparations for veneers on the upper anteriors. Many of the teeth were previously unrestored. There is also clear evidence of extensive periodontal involvement in both the maxilla and mandible. The patient reports that this has not been brought to his attention." Other scenarios include "Ms. 14 is being seen on a referral from Dr. X for a confirming diagnosis on treating #18. The radiographs show poorly done root canals on #3, #4, and #5. There is also a clear image of an endo file in the sinus. The patient says the work has

been going on for many months, but is unaware of any complications."

Participants begin the study by drawing at random any of these 14 scenarios. If they choose not to take any action, they draw another scenario from the stack. There were four kinds of alternative responsive actions available to participants. There were five responses that involved engaging the patient, ranging from [2] The patient says "Dr. X hinted that some others who are not as well trained, I mean have not had current and advanced training like he has, might raise questions. He is one of the most professional people I can imagine. He explains everything and I can tell he has my best interests at heart" to [5] the patient says "I think I need to talk to a lawyer. Every single tooth that Dr. X has worked on eventually needed a root canal. I now require my sixth root canal in three years. Are there lawyers that specialize in this sort of thing?"

Alternatively, respondents might wish to communicate with Dr. X by drawing a scenario at random from among the six available. Again, these covered a range from being very open and offering to share breakfast and discuss treatment philosophies to an extreme put-off where the office manager phones and says that Dr. X is too busy to discuss specific cases.

There are five scenarios describing what might happen if a professional colleague is consulted. These range from the benign, "oh, various things happen," to the rather pointed "I have my own doubts about Dr. X but haven't wanted to say anything." The final set of scenarios represented contacting "the appropriate reviewing agency as determined by the local component or constituent society."

By selecting any of these slips at random the participant is imitating an act of reporting justifiable criticism.

At each choice point, before a slip was selected at random from any set, subjects were asked to report what they hope to accomplish and what they would say to the patient, dentist, colleague, or board. Because respondents could choose whom else to involve in the case, including no one, and because the selection of scenarios was random, the path through the exercise was customized and no two subjects encountered the same overall experience. The exercise was concluded when a respondent determined to involve the board or when all 14 patient cases had been seen. At the end of the procedure, each subject was asked whether the exercise seemed realistic. All said yes, and most followed this answer with lengthy descriptions of situations they had personally encountered that were like the path through the exercise they had actually taken.

Among the 23 dentists who participated in the primary study, the number of years of experience ranged from 5 to 46 and the sample included one individual who had served on a peer review committee, six specialists, and a diversity of practice sizes and sizes of communities where respondents had practiced.

The sessions were audio taped and transcribed. Subjects were given an opportunity to review and edit the transcripts. Data analysis consisted of counting choices made

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by respondents and patterns of paths through the exercise and of reporting verbatim comments associated with these choices.

Although nine of 23 subjects in this study ended by referring the treating dentist for formal review, this was a conclusion that participants came to gradually rather than being based on a single instance of gross faulty treatment. Of the 139 initial visits, 42% of them resulted in no action being taken. Respondents were one- and two-thirds times as likely to discuss the matter with the treating

dentist as with the patient. Colleagues were almost never involved and referral for possible disciplinary action was rare, and only occurred based on an average of patient visits and repeated conversations with the treating dentist.

The overall impression is one of dentists referring their colleagues for possible action reluctantly and only following multiple examples and failed attempts to work with the treating dentist to prevent continuous faulty treatment.

There was noticeable individual variation in this general pattern of attempting to build up a constructive relationships between the consulting and treating dentist. Although no consulting dentists went to review quickly, three based their actions on three or fewer patients. The attempt to build a relationship was focused on extensive back-and-forth with the treating dentist, and occasionally with colleagues. At the opposite extreme were four consulting dentists who attempted, sometimes very briefly, to build a relationship with the treating dentist but ended by running all 14 cases by turning the slips and doing nothing. They had resigned themselves to the treating dentist providing continuous faulty treatment but were unprepared to involve others.

Dental peers were consulted in fewer than 10% of cases, and in four of the nine where participants in the study referred the treating dentist for formal review without ever consulting the patient about his or her condition. The general pattern is that dentists consider potential incidents of continuous faulty treatment as involving primarily themselves and the treating dentist and that third parties are involved only after it has been determined that the treating-consulting relationship had failed.

Study #3: The Way Justifiable Criticism Looks

Dentists orient toward the clinical manifestations of particular cases. It may be more difficult for them to gauge the patient's relationship to their oral condition or the attitude another dentist places on work that has been done. There may also be some difficulties associated with seeing patterns of treatment outcomes. All of these "context" factors are used to frame the meaning of a case. They are needed to judge the competence of another dentist, which is something different from spotting an instance of an open margin or a missed canal.

When a consulting dentist says "I cannot pass judgment based on seeing just this outcome, I was not there," he or she is correct. But that alone does not excuse the consulting dentist from placing the clinical situation in a plausible context and then verifying that interpretation. Nor does it excuse the consulting dentist from engaging both the patient and the treating dentist in a discussion so that all parties understand what is at stake. Identical presenting cases can be judged differently depending on what the patient and treating dentist believe is going on and on what has gone on before.

In the scenario exercise described as Study #2 respondents' reflections as they interpreted the case were recorded and transcribed into almost one hundred pages of text. This corpus was analyzed using the conventional techniques of qualitative research to extract major themes. Such themes were documented by verbatim quotations. This provided a picture of how subjects framed the issue of responding to a colleague's ambiguous

treatment. The purpose of this research was not to count how many dentists responded in certain ways (as in Study #2) but to show how they structured such problematic situations. How did they “see” the problem of possible gross or continuous faulty treatment?

Six major themes emerged. These are extensively documented in Study #3 (page 54). In order to give a general view of how dentists frame cases involving ambiguous treatment by a colleague, the defining nature of each category is presented below followed by a single illustrative quotation.

1. *Alerting the treating dentist is sufficient:* When an action was taken by the consulting dentist it was most often first and entirely a matter of altering the treating dentist to the presence of a condition that might be considered below the standard of care. —“I think he is aware now that I have mentioned the open margin. I trust him.”
2. *Patients are informed tenuously:* Patients were often informed of the existence of a compromising condition, although that information may have been ambiguous, and consulting dentists resisted responding to patients other than regarding the technical nature of their clinical condition. —“Now I’m just going to retreat this [poorly done endo] and not say anything to the patient. If he asks me whether that is because Dr. X did not do it right, I’ll just make up something about new circumstances requiring special additional care.”
3. *Reframing the situation as convenient hypotheticals:* Consulting dentists reframed the presenting case as either so underdefined as to excuse involvement or by imagining additional facts that excused the need to become involved. —“The important thing is to resolve these matters ethically, and to do the right thing. These things need to be handled right and resolved peacefully, I mean without entanglements. I’m not sure specifically what I would do.”
4. *Patterns and general conclusions are avoided:* Individual cases tended to be considered separately; the dominant context was the current clinical situation and elements of comprehensive care and generalizations about the treating dentist were suppressed. —“There’s no line that separates competent from incompetent.”
5. *Responsibility for corrective action rests with the patient:* The consulting dentist was seen as responsible for addressing the referral (if indicated), the treating dentist was responsible for restoring the patient to prior clinical standard, and the patient was responsible for everything else, including action against the treating dentist for general incompetence. —“I would not report this matter myself. I would refer the patient with the complaint to PR.”
6. *There is no sense of general professional responsibility:* There was no “we” in these cases; treating dentist, consulting dentist, and patient had separate interests that were confined to individual treatment and they did not work together for a general resolution of difficulties or a general elevation of the profession.

—“If the guy doesn’t respond [to my feedback], I’d just let it lie. Pretty soon something really bad will happen and then maybe somebody will do something.”

A related part of this study involved asking respondents to match their preferred course of action in the case involving treatment planned veneers on periodontally involved teeth with one of four radiographs showing poor to awful periodontal support. This was done after the respondents had chosen a course of action and was used as a test of the hypothesis that respondents will “imagine” a condition, given a general written description, that warrants their action or makes it easier to defend. In other words they assumed that Dr. X behaved in such a manner as to support the decision that the consulting dentist wanted to make.

The correlation between action chosen and selection of radiographic image that supports that action was $r = 0.512$. This is a statically significant association. Fully one-quarter of the variance is in common, meaning that dentists, to a significant extent, saw courses of action as much as they saw an objective condition and then chose a course of action. This is consistent with the literature in the social psychology of perceptions (Bruner and Goodman, 1947).

Study #4: Components of Justifiable Criticism

A survey study was used to explore the relative contribution of “severity” of gross or continuous faulty treatment and practice experience of Dr. X. Sixty-two clinical faculty members at the University of the Pacific Arthur A. Dugoni School of Dentistry indicated the likelihood of reporting on each of the twelve cases in Study #2 where

there was some ambiguity regarding quality of treatment. They offered these judgments with respect to the work having been performed by a colleague they had known in the community for many years, a new dentist in the community, and a candidate on an initial licensure examination.

There were differences in “reportability” of the twelve cases, and these paralleled the findings in Study #2. There were no differences in tendency to report ambiguous cases performed by new or veteran practitioners, but the same fault observed in a candidate on an initial licensure examination was slightly more likely to be actionable. The largest source of variance came from the consulting dentists themselves (respondents on the survey). The chance of reporting any incident in the set for any treating dentist ranged from 6% to 92%, depending on who observed the case. Respondents were more apt in this study to urge reporting in general than respondents were in Study #2 to say that they would be willing to make a report.

Together, observing dentist and the combination of the types of cases the observing dentist was most concerned with, explained more than half of the likelihood that a case would be reported for potential disciplinary action. The type of incident itself explained only 10% of the variance and the treating dentist only 5%.

Study #5: How Patients View Justifiable Criticism

It is possible for dentists to agree with each other to a very significant extent while patients may be left with an inaccurate understanding or come to a different conclusion about the care received. Quite independent of whether the information they receive would make a material difference in treatment decisions, many patients use the amount and understandability of information as part of their determination of the quality of care they receive. It is a foundation of both law and ethics that patients must be provided with sufficient information to determine, as an autonomous agent when competent to do so, what is done to their bodies and whether they chose to enter into a financial arrangement. Where there are questions about the appropriateness of part of that care, the importance of information for patients increases.

Often, questionable care prompts exactly the opposite strategy—information is withheld or perhaps even shaded. It is appropriate then to inquire how patients feel about justifiable criticism.

Forty-eight patients responded to a questionnaire that listed the 14 ambiguous incidents that have been studied from the dentists’ perspective. They were asked to imagine themselves as a patient in the endodontist’s office (consulting dentist) who, upon examination, discovered the various situations described in the 14 incidents. Patients were asked what information they expected to be given by the consulting dentist and whether they expected the consulting dentist to alert the treating dentist. Much like Study #1, there were similarities between dentists and patients

imagining themselves in these situations and there were differences.

Both dentists and patients agreed substantially on which incidents presented the most danger to the patient, and they favored direct action on the part of the consulting dentist and greater involvement of the original treating dentists in these cases. In fact the correlations reflecting seriousness were highly significant at more than $r = 0.700$ and almost exactly half of dentists and patients favored direct contact with the treating dentist with a view toward explanation or correction of the issue.

But there were also differences with respect to information expected from the consulting dentist and about expectations for the relationship that exists among dentists. Dentists were twice as likely as patients to let an incident pass without involving either the patient or the treating dentist (40% versus 20%). Both dentists and patients wanted the treating dentist involved, but with substantial differences in the extent to which patients were to be informed and involved. Dentists chose to engage patients about 40% of the time, but patients expected to be informed and to participate in decisions about correcting the problem in 80% of the cases. Although consulting dentists in Study #2 contacted both treating dentist and informed patient in about 20% of the cases, it was much more likely that a dentist was consulted and the matter closed than that the patient had the final say.

The perception of dentistry as a profession seems to differ slightly for dentists and patients. Patients in Study #5 gave the clear impression that the specialist was a member of the profession, fully responsible for the care of the patient. If there were problems that the consulting dentist could manage, he or she was expected

to do so. That extended to brokering the proper relationship with the original treating dentist. Even though the specialist was not expected to render all aspects of care, and the general dentists had primary and more general responsibility in that regard, the specialist was seen as a member of the profession with the same overall responsibility for the oral health of the patient. Fully four of five patients expressed the opinion that their issues were the responsibility of the profession and they did not expect that the profession would be segmented in a manner that added to their burden.

Patients were saying, in effect, “I expect the profession to treat my oral health needs and I expect to be well enough informed to participate in that process. Further, I expect that each member of the profession will advocate on my behalf. All types of dentists share that obligation by virtue of being a dentist.” Only two participants in the survey mentioned their view that dentists look out for each other more than for patients.

The pattern of responses on Study #2 is consistent with the view that many dentists consider justifiable criticism to be a matter of the relationship among dentists and that should good faith efforts in that direction prove insufficient, at least one has done one’s duty. It may be recalled from Study #1 that patients were significantly more likely to expect that dentists will police their colleagues and are more willing to take their concerns to the street informally. Dentists and patients appear to have a different interpretation of the definition of dentistry and the extent

to which professional responsibility can be segmented. Although these conclusions pass muster by fine-grained statistical tests, their effect are an order of magnitude that should be noticeable to all.

Discussion

The overall picture painted by these five studies suggests that dentists do not frame the issue of justifiable criticism of colleagues’ gross or continuous faulty treatment as a matter of detecting colleagues who are off base and reporting them through professional channels. The role of whistle-blower does not come naturally to dentists. Instead, a more nuanced process appears to be in play. Some dentists assume that their colleagues are practicing to professional standards regardless of evidence to the contrary; others respond to indications that there is a problem with a colleague’s competence or judgment by intervening with the dentist in hopes of bringing about an improvement. Most tend to shield the patient from awareness of professional issues and regard correcting problems as the patient’s responsibility. Contacting an agency in organized dentistry to report gross or continuous faulty treatment seems to occur as a last resort after personal intervention has proven unsuccessful.

Judging Clinical Situations Rather than the Process that May Be Responsible for It

Of the three alternatives tested in the survey study, individual standards of the potentially reporting dentist account for significantly more of the variation than do either the objective nature of the mistreatment or the professional status of the treating dentist. Three quarters of the variance

Some dentists assume that their colleagues are practicing to professional standards regardless of evidence to the contrary; others respond to indications that there is a problem with a colleague’s competence or judgment by intervening with the dentist in hopes of bringing about an improvement.

were associated with personal standards of the consulting dentist. About half of this is attributable to personal opinions regarding how faulty each type of problem is and half to personal willingness to see situations as needing intervention.

Coupled with a range of personal standards for what is acceptable care and the extent to which one wishes to become involved, is an understanding that there is no bright objective line for faulty treatment that can be determined by looking at a single case out of context. Dentists are often aware that the meaning of a clinical condition depends on what has gone before, but they are reluctant to inquire about that. The preferred role

Most tend to shield the patient from awareness of professional issues and regard correcting problems as the patient's responsibility. Contacting an agency in organized dentistry to report gross or continuous faulty treatment seems to occur as a last resort after personal intervention has proven unsuccessful.

is that of diagnosing a clinical condition as though it were a new presenting case.

A single bad outcome, of the type studied here, was never considered adequate evidence in itself to justify a judgment of incompetence. Almost every individual instance was regarded as treatable.

Although it will be argued shortly that the reaction of the treating dentist, and perhaps the patient, are critical to an incident eventually being reported, the sheer frequency of incidents seems to matter little.

There appears to be a personal severity buffer that allows dentists to make adjustments between fact and action. The perception study demonstrated that subjects "saw" cases as less serious if they intended not to become involved. Many participants in Study #2 were incapable of recognizing patterns of treatment, preferring to isolate the case as a unique example to be managed clinically, often by the consulting dentist. We literally shade our perception of the world to better agree with our preferred behavior habits. There is a small literature in decision science indicating that this is typical of many who are unable to combine new with exiting information (Chambers, in press).

Involvement in a Thin Relationship

No case was referred for review without involving a consultation with Dr. X. Further, an uncooperative response from Dr. X was strongly predictive of pursuing action. The data are consistent with a four-stage hypothesis.

1. *First*, the case is considered clinically as a single incident that the consulting dentist can either treat or not.
2. *Second*, if the patient is dissatisfied with the care provided by the treating dentist, that is largely the patient's problem.
3. *Third*, if the consulting dentist chooses to engage the treating dentist, simply alerting him or her is considered to be the appropriate response.
4. *Fourth*, if the treating dentist adopts a posture of resistance to feedback, the consulting dentist either reports the treating dentist or seeks to avoid future contact.

Passing over faulty work by Dr. X necessitates no defense of one's own standards. Attempting to bring about a reconciliation (or the assumption that this would happen) is undertaken with at least the possibility that Dr. X will see the better position of the judging dentist. When that fails, the judging dentist appeals the matter. This view is supported by the fact that

colleagues are almost never consulted; the matter is kept confidential for as long as possible.

The relationship with the patient is also somewhat complex. In many cases, the dentist did inform the patient of his or her condition. But often this was indirect, as in "What has Dr. X told you about this case?." There was a preference for distancing oneself from problematic cases. When patients asked for support, the consulting dentist most typically referred the patient back to Dr. X, often without clearly defining what the problem was and almost never with an explanation as to what might occur if the matter were not corrected. Issues of legal action were left entirely to the patient. The most typical intent in talking with patients was to determine the extent of involvement or liability of the specialist. In no case did the dentist assume the role of advocating for the patient's best interests or long-term oral health. There was no discernable pattern of dentist behavior contingent on information from the patient. Distancing or treatment per expectation were the only actions.

Changing the Code?

The ADA code on justifiable criticism of gross or continuous faulty treatment lays out two specific requirements: (a) inform the patient of his or her current condition and (b) report the treating dentist to the appropriate organizations. The five studies reported here suggest that these may be difficult obligations for not a small proportion of practicing dentists. Certainly, the latter is not a role most readily embrace. More to the point, this research suggests that dentists actually frame such matters differently from the way they are stated in the Code of Professional Conduct. Dentists, at least those in these current studies, ask themselves when they see unexpected treatment:

- Can this possibly be interpreted as within the envelope of plausible outcomes or approaches based on random distribution in typical practice?
- What does the patient know about this and does the patient attitude limit possible resolutions?
- Can I afford to ignore the problem in hopes it is a self-correcting aberration or that someone else will manage it?
- How does the treating dentist respond to my guidance? If the treating dentist resists my help, I will consider approaching a formal third party.

It is probably unwise to honor this code requirement in the breach or mount a campaign to increase awareness and enforcement. To my knowledge, no ADA members have been sanctioned for failing to report gross or continuous faulty treatment by a colleague. A better strategy might be to rewrite the code. Some potential elements might be:

- No patient will leave a dental office without knowledge of his or her oral condition, alternatives for addressing the problem, and an understanding of the consequences of not addressing the issue.
- Colleagues of all patients seen on referral will be informed of information given to patients during referral examinations.
- Colleagues should understand and accept each other's treatment philosophies.
- No disciplinary action (and certainly no third-party disparaging remarks) should be made without first consulting the treating dentist.
- All dentists are to some extent responsible for the care provided by their colleagues.

Conclusions

1. Dentists prefer to manage perceived discrepancies with their colleagues confidentially so as not to have to defend their own standards to others.
2. To the extent that the public perceives the profession to be lax in self-monitoring of its avowed standards, it will seek formal regulation by outside parties to level the playing field.
3. Announcing higher standards without enforcement will lead to cynicism and fragmentation of the profession.
4. The public wants to be better informed about the decisions it is offered with regard to oral health.
5. The extent and nature of engagement with one's colleagues in maintaining standards in the profession is a personal matter among dentists and great variations exist, including some who will not engage under any circumstances. ■

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Study #1

Justifiable Criticism Ethics Case

Purpose

This study was undertaken to compare dentists' and patients' attitudes toward a case involving potential justifiable criticism. A written case was presented involving two dentists and a patient whose treatment by one of the dentists was ambiguous in terms of meeting quality standards. A group of dentists and a group of patients were asked to report the appropriateness of several alternative actions a consulting dentist might take in the case and to indicate the importance of alternative reasons for the action. This single case was part of a larger study, the results have been published separately as Chambers, D. W. Do patients and dentists see ethics the same way? *Journal of the American College of Dentists*, 2015, 82 (2), 31-47. This supplemental report describes only the single case having to do with justifiable criticism.

Materials and Methods

The case involving justifiable criticism is shown below.

Third Opinion

There are three dentists in this case: Dr. B did the initial work and has seen the patient once subsequently, Dr. C declined to give a second opinion, and Dr. A, who is being seen for a "third opinion."

Dr. A has been practicing in a small community for many years and has seen the work of many of his colleagues. He is proud of his colleagues' dentistry, with one exception. Dr. B always seemed to be shaky technically, but recently he has begun doing large, expensive, full-mouth reconstruction esthetic cases.

Mrs. X, a well-respected member of the community but not a patient, has made an appointment for "another opinion." Mrs. X has her anterior bridge in a paper towel. She said it "came off" in Dr. C's office where she had gone because she wanted to verify Dr. B's suggested approach to fixing it and because now her teeth are beginning to "really hurt." The bridge had been placed about six weeks earlier by Dr. B and when Mrs. X went back because "the bridge seemed to be loose," he concluded that it would have to be replaced with a different design because of the patient's "bad

biting habits." Dr. C had said that professionally he could not comment on the case because he had not done the work and suggested that Mrs. X see Dr. A.

Dr. A notices immediately that there is swelling in the tissue around one of the abutment teeth consistent with an abscess and that part of the tooth has fractured with the bridge. [One of the anchor teeth had broken off where it was connected with bridge and had developed an infection in addition to being loose in its connection with the bone.] This is apparently the result of overpreparation [cutting down the tooth too much when the bridge was made], and the tooth may be lost. There is untreated periodontal disease in the mouth, with pockets in the 6–8 mm range. [Gum disease of this advanced stage can cause teeth to become loose and be lost.]

The patient is concerned because she has already paid Dr. B \$22,000 and he says that the required repair work will cost another \$15,000 or more. Mrs. X seems to be unclear about the nature and extent of her problem and whether it is best to proceed as Dr. B has suggested.

Figure 1:1. **Potential actions and reasons when flawed care is recognized.**

What should Dr. A do? (*More than one response might be appropriate.*)

Absolutely	Probably	50:50	Doubtful	No Way	
<input type="checkbox"/>	Contact Dr. B to get his or her side of the story				
<input type="checkbox"/>	Lodge a formal complaint with the dental society or dental board				
<input type="checkbox"/>	Suggest that the patient return to Dr. B for a better explanation (<i>without getting involved</i>)				
<input type="checkbox"/>	Inform the patient of her present condition, as you see it				
<input type="checkbox"/>	Suggest indirectly to colleagues, but so it can be guessed who is involved, that a colleague is not up to par				

Rate the importance of each of these contributing factors as you weigh what to do.

Decisive	Important	Not Clear	Untrustworthy	Irrelevant	
<input type="checkbox"/>	Patient's recollection of what was done, when				
<input type="checkbox"/>	Professional code against unjustifiable colleague criticism				
<input type="checkbox"/>	Dentists are independent, their practices are their business				
<input type="checkbox"/>	Current health needs of the patient				
<input type="checkbox"/>	Complexity and uncertainty of interpersonal relationships				
<input type="checkbox"/>	Patient personality and motives				
<input type="checkbox"/>	Dentists have obligation to all patients and profession generally				

The scenario was presented in written format to section officers of the American College of Dentists and to members of two church congregations in Sonoma, California.

Usable responses were obtained from 92 dentists and 52 patients.

Patients were significantly more likely to favor the consulting dentist reporting the treating dentist to the appropriate authorities. They were also significantly more likely to take the matter into their own hands and advise their acquaintances about concerns over the care they had received than were dentists to share their concern with colleagues.

Results

The primary issues of concern in this study were differences between patients and dentists and strength of connection between preferred actions and reasons given in justification.

Third Opinion (Justifiable criticism): Strong indications of faulty restorative work, undiagnosed periodontal problems, and overcharging the patient.

The most conspicuous difference between patients and dentists was the stronger expectation by patients that the consulting dentist would make the matter of perceived gross or faulty treatment public. Patients were significantly more likely to favor the consulting dentist reporting the treating dentist to the appropriate authorities. They were also significantly more likely to take the matter into their own hands and advise their acquaintances about concerns over the care they had received than were dentists to share their concern with colleagues. The sharing of concerns was phrased with some circumspection and did not involve direct mention of the treating dentist by name.

There were also differences between patients and dentists in the reasons cited in justification of their actions. Patients placed greater weight on the interpretation of their experiences and less on the element of the code that prohibits unjustifiable criticism of colleagues than did dentists.

Correlation coefficients were calculated relating actions patients and dentists favored and reasons they gave for those actions. In only two cases (of a possible 70) were the correlations significant enough to account for 10% of the variance ($p < .05$). Patients who felt that dentists are independent of each other were more likely to expect that the consulting practitioner will not render an opinion and were more willing to share their discontent with friends in the community. This relationship can be summarized as the patients who questioned the social contract that dentists will police themselves were more apt to take matters into their own hands. The most significant association between reason and action ($p < .05$) for dentists was the belief that there is a code that prohibits dentists from commenting disparagingly about a colleagues' work and choosing to send the patient back to the treating dentist without comment. This relationship can be summarized as some dentists prefer to transfer responsibility for managing problems to the patient, again consistent with a soft interpretation of the professional contract with society.

FIGURE 1:2. Patient and dentist responses and reasons when recognizing flawed care.

Actions	Mean	SD	% Absolutely → % No Way					
Patient	3.06	1.18	46	33	8	8	6	Contact dentist who did the work to get his or her side of the story
Dentist	2.93	1.27	44	30	8	11	7	
Patient	2.32#	.96	11	34	32	23	0	Lodge a formal complaint with the dental society or dental board
Dentist	1.44	.93	2	8	35	40	15	
Patient	1.83	1.32	11	28	15	28	19	Suggest patient return to first dentist, do nothing else
Dentist	1.92	1.29	17	18	19	35	12	
Patient	3.80	.45	82	16	2	0	0	Inform the patient of her present condition, as you see it
Dentist	3.80	.48	84	13	3	0	0	
Patient	1.18#	1.30#	7	14	11	27	41	Suggest indirectly to colleagues unnamed dentist not up to par
Dentist	.29	.53	0	0	4	21	75	

Reasons	Mean	SD	% Decisive → % Irrelevant					
Patient	2.96*	.52*	12	73	15	0	0	Patient's recollection of what was done and when
Dentist	2.69	.85	10	62	17	8	52	
Patient	2.26*	1.07	11	32	38	11	9	Professional code against unjustifiable colleague criticism
Dentist	2.64	1.06	20	45	20	10	5	
Patient	1.22	1.20	2	18	18	24	38	Dentists are independent, their practices are their business
Dentist	.92	1.08	1	11	14	26	48	
Patient	3.78	.42	78	22	0	0	0	Current health needs of the patient
Dentist	3.69	.46	69	31	0	0	0	
Patient	1.82	1.17	5	27	32	18	18	Complexity and uncertainty of interpersonal relationships
Dentist	2.00	1.16	7	32	32	16	15	
Patient	1.78	1.16	2	28	30	20	20	Patient personality and motives
Dentist	2.05	1.06	3	35	36	13	13	
Patient	3.65	.52	67	31	2	0	0	Dentists have obligation to all patients and profession generally
Dentist	3.56	.52	57	42	1	0	0	

Higher mean values are toward the "Absolutely" or "Decisive" end of the scale.

*Statistically significant differences between patients and dentists are indicated as * for $p < .01$ and # for $p < .001$.*

Study #2

Justifiable Criticism Scenarios

Purpose

Judgment of a colleague's work is a process unfolding over time based on an accumulation of multiple inputs rather than a response to a single encounter. The nature of the questionable work, the reaction of the patient, possibly input from colleagues, and certainly the response of the treating dentist all have potential for shaping a consulting dentist's approach to justifiable criticism. To better understand justifiable criticism, then, it is necessary to explore potential paths as such a relationship unfolds over time. It is also desirable to simulate more naturally the events in such a relationship and to capture the consulting dentist's thoughts during the process. It is also desirable to place the respondent in research in a position that more nearly resembles what it is like to be a consulting dentist rather than judging from a privileged and detached position as is common in surveys.

Respondents in this study were placed in a realistic "game" situation where different episodes and information were revealed sequentially and interleaved with the consulting

dentist's own responses. The sequence of decisions made by the consulting dentist were of interest, and the responding dentists' thoughts were videotaped.

Materials and Methods

Subjects were tested individually. Following informed consent, participants were shown five sets of slips of paper and told that short descriptions were written on each. The stacks were shuffled in front of the participants. Participants were instructed to assume the role of an endodontist in a community. The scenarios in the patient set were brief descriptions of the presenting condition of various patients from Dr. X, a general practitioner in the area. The messages on all scenarios are listed in Table 1. For patients these ranged from "Ms. 2 presents for RCT. There is extensive reconstruction work under way, which you find Dr. X started several months ago. The approach is intriguing: it is not exactly what you would do with the case, but it might work;" and "Mr. 9 presents for RCT. Two new posterior composites have been placed, and they both look well prepped and contoured;" to "Mr. 3 presents for RCT. There are preparations for veneers on the upper anteriors. Many of the teeth were previously unrestored. There is also clear evidence of periodontal involvement in both the maxilla and mandible. The patient reports that this has not been brought to his attention;" and "Ms. 14

is being seen on a referral from Dr. X for a confirming diagnosis on treating #18. The radiographs show poorly done root canals on #3, #4, and #5. There is also a clear image of an endo file in the sinus. The patient says the work has been going on for many months, but is unaware of any complications."

Participants begin the study by drawing at random any of these 14 scenarios. If they chose not to take any action, they drew another scenario from the stack. There were four kinds of responsive action available to participants. There were five responses for patients, ranging from "The patient says 'Dr. X hinted that some others who are not as well trained, I mean have not had current and advanced training like he has, might raise questions. He is one of the most professional people I can imagine. He explains everything and I can tell he has my best interests at heart,'" to "The patient says 'I think I need to talk to a lawyer. Every single tooth that Dr. X has worked on eventually needed a root canal. I now require my sixth root canal in three years. Are there lawyers that specialize in this sort of thing?'"

Alternatively, respondents might wish to communicate with Dr. X by drawing a scenario at random from among the six available. Again, these covered a range from being very open and offering to share breakfast and discuss treatment philosophies to an

extreme put-off where the office managers phones and says that Dr. X is too busy to discuss specific cases.

There are five scenarios describing what might happen if a professional colleague is consulted. These range from the benign, “Oh, various things happen,” to the rather pointed “I have my own doubts about Dr. X but haven’t wanted to say anything.”

The final set of scenarios represented “the appropriate reviewing agency as determined by the local component or constituent society.” By selecting any of these slips at random the participant is imitating an act of reporting justifiable criticism. The slips are quite similar and essentially describe what will happen and ask whether the participant wants to continue.

At each choice point, before a slip is selected at random from any set, subjects are asked to report what they hope to accomplish and what they will say to the patient, dentist, colleague, or board. Because respondents can choose whom else to involve in the case, including no one, and because the selection of scenarios is random, the path through the exercise is individualized and no two subjects encounter the same overall experience. The exercise was concluded when a respondent determined to involve the board or when all 14 patient treatment scenarios had been seen. At the end of the procedure, each subject was asked whether the exercise seemed realistic. All said yes, and most followed this answer with lengthy

descriptions of situations they had personally encountered that were like the path through the exercise they had actually taken.

Twenty-three dentists participated in this study. The number of years of experience ranged from 5 to 46 and the sample included an individual who had served on a peer review committee, six specialists, and a diversity of practice sizes and sizes of communities where each had practiced.

The sessions were audio taped and transcribed. Subjects reviewed and were given an opportunity to add to and edit the transcripts (one did). Data analysis consisted of counting choices made by respondents and patterns of paths through the exercise and of reporting verbatim comments associated with these choices.

Instruction to Participants: Informed Consent

You are invited to participate in a study of the way dentists reach ethical positions. This is a new approach to this field because you will be given small amounts of information and then asked to make choices or to seek additional information. In this way, the project is more natural than most ethical cases used in teaching that provide all the information at once.

Your participation is entirely voluntary and you may stop at any

This suggests that, although some conditions were more likely to stimulate inquiry, none in-and-of-themselves were especially likely to lead to peer review.

point. Although you will be asked to provide general opinion and demographic information, your name and any uniquely identifying information will not be recorded or used in any fashion. Results will be reported as averages for various groups and will not be available individually.

In the exercise, you are to play the part of the only endodontist in a community. You receive referrals on a regular basis from almost all the dentists in the community and naturally you form opinions about their work.

In the exercise you are asked to focus on the referrals from Dr. X. Each patient who comes to you from Dr. X is described on a card—labeled an

Incident-Card. The cards are arranged randomly so that when you select an Incident-Card, you will receive information about a particular patient.

After reading the description of the patient on an Incident-Card, you have your choice of consulting any source (Dentist-Card to interaction with Dr. X, Patient-Card to interact with the patient, Colleague-Card to interact with a peer, or Report-Card to interact with an agency appropriate for considering an investigation into the conduct of Dr. X). You may also draw a new Incident-Card to see a new patient, presumably sometime later. If you select any option other than a new patient visit, the experimenter will ask you in advance to state what you would say when approaching to source and to reflect on the information you find once you have selected from among the set of random possible responses in each case.

You are not required to consult any sources and some may be ignored. When you do not want to consult an external source, you will draw an additional Incident-Card.

Incident-Cards

[1] Ms. 1 presents for RCT. During the initial assessment a huge overhang is noticed on #2. You ask a few questions and find that the work was done by Dr. X at the recent appointment where the referral to you was made. The patient is not aware of any irregularity.

[2] Ms. 2 presents for RCT. There is extensive reconstruction work underway, which you find Dr. X started

several months ago. The approach is intriguing; it is not exactly what you would do with the case, but it might work.

[3] Mr. 3 presents for RCT. There are preparations for veneers on the upper anteriors. Many of the teeth were previously unrestored. There is also clear evidence of periodontal involvement in both the maxilla and mandible. The patient reports that this has not been brought to his attention.

[4] Mrs. 4 presents for RCT. Although there is considerable occlusal wear throughout the mouth, there is not obvious decay or periodontal issues. Many of the severely worn teeth are scheduled for restorations to open the vertical dimension.

[5] Mrs. 5 presents for RCT on #3, on referral from Dr. X. Upon testing, you conclude that #3 is vital. You test other teeth as well and all test normal. The patient is vague about symptoms.

[6] Ms. 6 presents for RCT. Initial access has been completed by Dr. X, but the access is much larger than necessary and has severely impacted the structural integrity of the tooth. The patient is uncertain about how you have become involved.

[7] Mr. 7 presents for RCT. A recent restoration, which the patient says was “just placed” by Dr. X, has a conspicuous open margin and now the tooth is very sensitive to cold.

[8] Mr. 8 presents for RCT. The patient says he thinks the pain is caused by the new crown that Dr. X placed and wonders why a root canal is necessary. “I never had the pain until Dr. X did the work. My whole mouth feels funny and when I bite it doesn’t feel right.” The bite is noticeably high.

[9] Mr. 9 presents for RCT. Two new posterior composites have been

placed, and they both look well prepped and contoured.

[10] Your brother, Mr. 10, a community leader and businessman with a reputation for integrity, mentions at a rotary Club meeting that his wife had been treated by Dr. X and that three times within a short period of time, a temporary crown had fallen off and that the staff in Dr. X’s office blamed his wife for the failure. Your sister-in-law is tired of return visits that are unpleasant and do not seem to be effective.

[11] Mr. 11 received endodontics and a new crown on a lower molar from Dr. X about six months ago. The tooth has never stopped hurting. Dr. X wants you to retreat the case. Your radiographs reveal very poorly shaped and under-filled canals. Additionally, you strongly suspect a missed canal.

[12] Mr. 12 has been referred to you for retreatment of a root canal done by Dr. X three years ago. It has reinfected. Your x-rays reveal the tooth was previously perforated and the patient is unaware of any mishaps or untoward events associated with this past root canal.

[13] Ms. 13 has been referred by Dr. X. There are two recently placed large amalgams and both of them show clear evidence of having been nicked and then smoothed on the adjacent teeth.

[14] Ms. 14 is being seen on a referral from Dr. X for a confirming diagnosis on treating #18. The radiographs show poorly done root canals on #3, #4, and #5. There is also a clear image of an endo file in the sinus. The patient says the work has been “going on for many months,” but is unaware of any complications.

Dentist-Cards (Dr. X)

[1] Dr. X says “I would be happy to talk with you about my approach to dentistry. I realize that there are differences in treatment, based mostly on where and when one went to school. But it would be a good thing for us to get to know each other better so we could harmonize our treatments.”

[2] Dr. X seems vague. “You know how it is. There are bound to be a few patients from time to time who misunderstand what they have been told. I think I have even had a few recently who are shopping for reasons to threaten lawsuits just to get free care.”

[3] Dr. X says “I really doubt that there would be much for us to talk about. Dentistry is a profession where we each follow our own training and standards. And as I understand the ADA ethics code, dentists are supposed to refrain from judging each other’s work or turning patients against their previous dentist.”

[4] Dr. X says “I have been thinking of calling you. I had a patient who implied that you had made some disparaging remarks about my treatment. As you know that is unethical. I suppose in the end, we might all be better served if I just did all the endo cases myself or if I referred them to someone whose treatment philosophy was more similar to my own.”

[5] Dr. X says “I resent the fact that my patient has asked you for a second opinion about the work I have begun on them. I have thirty years of practice experience in this community and all my patients are extremely satisfied with my work.”

[6] You call to Dr. X is returned later in the day by a staff member who says that Dr. X is extremely busy at present. It really would not be convenient to discuss particular cases. But he would

be happy to offer advice on your diagnoses if you could provide detailed documentation.

[7] You have a pleasant phone conversation with Dr. X. You begin with some generalities and assurances that all dentists want to do the professional thing. He agrees with this line of reasoning. When you try to become specific, he reaffirms your general remarks. He thanks you for taking an interest in the quality of dental care in the community.

Patient-Cards

[1] The patient says “Well, I am glad you mentioned the treatment Dr. X is providing. He seems a little pushy, but when I ask for explanations he gets evasive—you know, sort of talking technical. You’re a dentist, what do you think?”

[2] The patient says “Dr. X hinted that some others who are not as well trained, I mean have not had current and advanced training like he has, might raise questions. He is one of the most professional people I can imagine. He explains everything and I can tell he has my best interests at heart.”

[3] The patient makes a specific request “Could you help me change dentists? I have no confidence in Dr. X anymore.”

[4] The patient says “I have some real doubts about the need for all this work Dr. X has started. Some of my friends think I should pursue legal action. I don’t know whether I am just getting the runaround from this guy or whether the whole profession is covering each other’s backsides or whether they even care about patients. Do you think Dr. X is competent?”

[5] The patient says “I think I need to talk to a lawyer. Every single tooth that Dr. X has worked on eventually needed a root canal. I now require my sixth root canal in three years. Are there lawyers that specialize in this sort of thing?”

Colleague-Cards (Peer)

[1] The colleague says “The whole area of justifiable criticism is very tricky, especially in a small town like ours. Of course you don’t want patients being exposed to situations that compromise their health. At the same time you don’t want to impugn the reputation of a colleague any more than you would want your own reputation called into question. Whatever you do needs to be done with discretion and tact.”

[2] The colleague says “I have noticed a few problems with Dr. X’s work myself. I haven’t wanted to say anything without having more backup, but I saw a case that was a complete botch. I have even heard suggestions that he might be under investigation.”

[3] From the ADA Code of Professional Conduct: 4.C. Justifiable Criticism. Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

[4] Your colleague says “I just saw a patient who is under the care of Dr. X. The patient has temporary crowns on at least 15 teeth which are continually

loosening. The two temporary crowns I recently recemented showed grossly overprepared teeth. This is a large case that I feel is too complex for Dr. X. We practice in the same locality and I know his skills are not strong and woefully inadequate to treat this patient.”

Report-Cards (Disciplinary action)

[1] You will be contacted by a member of the committee or one of the agents and asked to make a statement about the dentist in question and to provide details of the conditions and circumstances you observed. You may be called as a witness in order to confirm these remarks if we proceed with an action. Are you prepared to do this?

[2] You will be contacted by a member of the committee or one of the agents and asked to make a statement about the dentist in question and to provide details of the conditions and circumstances you observed. You will not be called as a witness in order to confirm these remarks if we proceed with an action. Are you prepared to do this?

[3] You will be contacted by a member of the committee or one of the agents and asked to make a statement about the dentist in question and to provide details of the conditions and circumstances you observed. We will ask you to determine where there may be violations of the standard of care in Dr. X's work. We are also interested in your opinions on negligence and abandonment.

Results

As shown in Table 2:1, 42% of the visits were passed, without comment. (The proportion would have been larger had not each session stopped after all 14 situations were examined.) Six percent of visits were ultimately referred to peer review. Three cases were found where the first patient resulted in peer review referral, however, there were no cases where this was the first decision. All reported cases involved prior contact with the treating dentist. There were no cases of “gross” faulty treatment. Peer review was ultimately sought by nine of the respondents. This reflected a “pattern of faulty treatment” since the triggering incident was different for each of the nine reporting respondents. This suggests that, although some conditions were more likely to stimulate inquiry, none in-and-of-themselves were especially likely to lead to peer review.

The first six columns are from the 23 subjects in vignette study. The “dentist survey” column is from the 74 dentists who indicated the probability that an incident should be reported. The last four columns are from the 46 lay individuals who reported their preferences as patients. “Pass” means that the incident is passed without comment; “Dentist” means that the consulting dentist at some time consulted the treating dentist with regard to that incident. “Patient” means that the consulting dentists contacted the treating dentist. “Peer” means the consulting dentist spoke with a professional colleague. Percentages combining these classes may exceed 1.0 where multiple actions are taken in response to an incident. For patients, “pass” means no comment expected, “inform” means

that the consulting dentist was expected to alert the patient to a condition needing attention and perhaps provide that care, “back” means that the patient expected the consulting dentist to inform the patient he or she should return to the treating dentist. “Tell” indicates an expectation that the consulting dentist would inform the treating dentist about the case. “Report” indicates that the incident was involved with a report for possible disciplinary action. This does not indicate the likelihood that the particular incident triggered.

The first response, other than drawing a new case and letting the current one pass without comment, was mostly likely to be in contact with Dr. X. There were no cases where peers were consulted initially, and in only 13 cases among the 139 situations were they consulted later in the process. When Dr. X was contacted regarding a concern, 55% of these resulted in the matter being dropped at that point while 21% lead to further conversations with the patient. When the patient was engaged first, Dr. X was also contacted (57% of the time) and the matter was closed 43% of the time.

The average number of visits reviewed by judges was 7.23. Three subjects reviewed exactly one patient (referring to peer review in each case) and six saw all 14 of the treating dentist's patients, without making referral. There were no cases where peer review was invoked without first contacting Dr. X on at least one of the cases.

Table 2:1. Responses to ambiguous incidents.

Incident	Vignette Study						Dentist Survey	Patients			
	N	Pass %	Dentist %	Patient %	Peer %	Report %		Pass %	Inform %	Back %	Tell %
Good composite	10	90	10	10	0	0	–	71	14	14	0
Case in progress	11	64	36	16	46	18	–	100	0	0	11
Big reconstruction	11	73	27	9	18	18	19	63	13	25	11
Nicked near tooth	6	83	17	0	0	0	26	17	50	33	11
Missed vital tooth	10	50	40	40	0	0	31	0	0	100	89
High crown	14	29	57	43	7	0	32	0	13	75	88
Excessive access	8	38	63	38	0	0	34	0	71	29	67
Overhang	15	33	60	20	20	13	39	11	0	89	44
Complaining friend	10	30	50	30	0	10	44	17	17	67	44
Open margin	10	10	90	20	0	0	47	0	14	86	78
Veneers on perio	13	31	85	46	15	8	51	0	0	100	78
Faulty endo care	8	25	38	38	0	0	54	0	86	14	77
Perforation	10	30	50	30	0	0	54	0	71	29	44
Endo file in sinus	6	0	100	67	17	17	66	0	63	38	67
Averages	9.92	41.8	51.9	30.5	8.8	6.0	41.4	19.9	29.4	52.0	50.5

Table 2:2. Paths following contact with Dr. X.

Visit	N	Ignore %	Patient %	Peer %	Report %	Ult Report %
Vague	9	100	0	0	0	0
Let's talk	10	90	10	10	0	10
Accused of alienation	12	83	8	8	0	8
Distancing	7	71	29	0	0	14
Aggressive accusation	14	50	14	21	14	14
Generalities	10	50	20	20	10	20
Staff put-off	7	33	67	0	0	14
Averages	9.86	55.3	21.1	8.4	3.4	11.4

Table 2:3. Paths following contact with patient.

Visit	N	Ignore %	Dr. X %	Peer %	Report %	Ult Report %
Aggressively defends X	9	67	22	11	0	11
Wants to change dentist	7	57	43	0	0	0
Wants a lawyer	5	40	40	10	0	20
Asks for judgment on X	10	30	60	10	0	10
Dentist not responsive	10	20	60	10	10	10
Averages	8.20	42.8	57.0	8.2	2.0	12.2

Study #3

The Way Justifiable Criticism Looks

Purpose

The analysis of Study #2 offered some insight into what dentists do when confronted with alternative ways of gathering information and taking action in the face of treatment of ambiguous quality performed by a colleague. Questions remain to be explored, however, regarding how the consulting dentist frames the situation. A single objective situation—a radiograph for example—can be interpreted in various ways depending on personal factors, context, and even on what actions would be required if classified this way or that. In Study #3, dentists respond to the interpretation of presenting situations, not the situations themselves. Questions can be asked whether there are any patterns in the interpretation of cases of possible gross or faulty treatment by a colleague.

Materials and Methods

Two sources of data were used to investigate how dentists interpret ambiguous outcomes attributable to colleagues. The primary source was the reflections of 23 dentists as they worked their way through an exercise where information was provided by the patient visit, the treating dentist,

the patient, and sometimes by colleagues. Respondents were videotaped during the exercise, which normally lasted from 20 to 40 minutes. The audio portion of the interaction was transcribed verbatim and verified by each participant. This generated 88 pages of written text.

Following standard technique for qualitative research, the corpus of text was read and reread to generate common themes. With this preliminary structure in hand, each sentence, or identifiable thought, was coded as belonging to one or more of the theme categories. The thought segments were grouped under themes and clear definitions of the central idea were created. The corpus was reviewed once again and elements reclassified if necessary.

The second source of information regarding interpretation was a separate study using a single case where veneers were indicated for upper anterior teeth that were periodontally involved. One could say, depending on how the case was read, that such a treatment would be risky but acceptable, if it is assumed that the extent of involvement is minimal. Alternatively, participants in the video study often volunteered that it would be automatic malpractice. Most likely this difference in opinion would be influenced to some extent by how one “saw the case.”

A set of four radiographs was selected according to this criteria. The radiograph in Figure 3:1 was judged by a panel of dental school

faculty members to be a 50:50 case – probably half of practitioners would attempt this procedure. The radiograph on the right was selected to represent a situation where no ethical and competent practitioner would attempt the procedure. The two images in the middle represented mid-points along this continuum.

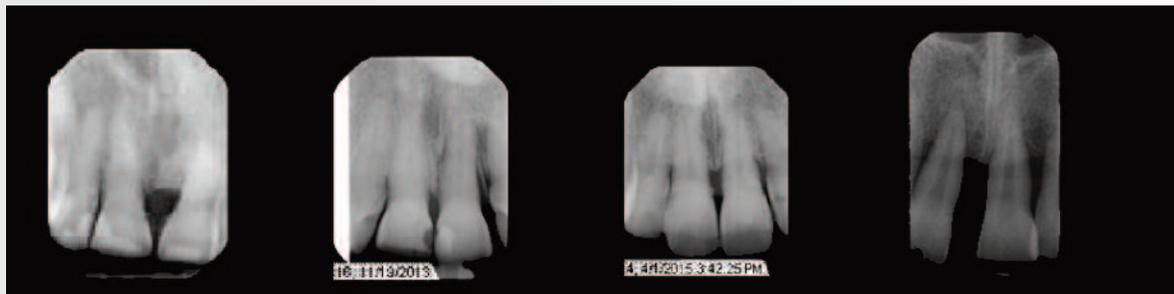
Thirty-seven new subjects were invited to respond to a modified version of the visit describing a patient for whom veneers were indicated on periodontally involved teeth. They indicated only whether this was considered (a) risky but appropriate; (b) whether the patient should be alerted and cautioned; (c) whether this should be brought to the attention of the treating dentist; or (d) whether this should be part of a referral for potential disciplinary action. Next they were shown the four radiographs and asked to select the one that best matched the image they had in their mind when responding to the question about which action they might consider.

Results

Reflections of Consulting Dentists

The major theme to emerge from the reflections of subjects playing the role of consulting dentist in this exercise was the effort to narrow one’s responsibility to objective commentary on isolated clinical examples. Questions of how the

FIGURE 3:1. **Extent of periodontal involvement in teeth targets for veneers.**



problem was to be fixed and who bears responsibility for that, patient satisfaction or understanding of their condition, and opinions about the referring dentist's overall competence were given secondary position. In many cases, hypothetical additional material was imagined that would account for the clinical situation without having to take into consideration any other factors such as iatrogenics, patient satisfaction, or responsibility. Respondents stayed as close to their interpretation of the clinical situation as possible.

To quote an exemplary case where the patient seemed to be aware of the complications of placing veneers on periodontally compromised teeth and asked the consulting dentist what he or she thought that meant about Dr. X generally: "I don't really want to answer that question. I can give you

my opinion about what I see. I'm an endodontist so I am not in the best position to comment on the situation. I am not a general dentist. I do not know what conversation occurred between you and Dr. X before you agreed to have this work done. So I cannot tell you about Dr. X and I can only tell you what I see at this point in time. I think you need some endodontic work."

There were 14 cases and five patient perceptions of them. Because these were selected randomly, the study presented 70 combinations of the following factors: objective clinical condition (from "nice work" to cosmetic work on periodontally involved teeth); patient awareness (from fully informed referrals to

Dentists respond to the interpretation of presenting situations, not the situations themselves.

The major theme to emerge from the reflections of subjects playing the role of consulting dentist in this exercise was the effort to narrow one's responsibility to objective commentary on isolated clinical examples.

undisclosed instruments in the sinus); and patient satisfaction (from aggressive defense of the treating dentist to requests for guidance on legal action). Respondents focused for the most part on the clinical situation, with guarded responses about awareness and almost universally ignoring issues of patient satisfaction. Prominence of the clinical situation naturally led to focus on informing the treating dentist. The prominence of that path was already described in Study #2. In the majority of cases, the interaction with the treating dentist was limited to noting the consulting dentist's finding. There was no case of follow-up to determine whether the patient had been properly treated, and each incident was generally treated in isolation without identifying a pattern of treatment quality on the part of Dr. X. The overwhelming majority of responses to cases of possible gross or continuous faulty treatment were to let the treating dentist know of a difference of observation regarding the presenting condition and nothing more. As reported in Study #2, most cases ended in overlooking the

matter or in having notified the treating dentist.

Six specific themes emerged regarding the interpretation of ambiguous cases by practitioners.

1. Alerting the treating dentist is

sufficient: When an action was taken by the consulting dentist it was most often first and entirely a matter of altering the treating dentist to the presence of a condition that might be considered below the standard of care.

"I am not giving an opinion about your judgment, I am only reporting what I have found."

"Report objective findings, and it's back in his ball court."

"I practice above the standard of care, and I expect everyone else to as well."

"There is a confusion in these cases. It seems that Dr. X has had some things go wrong, but the major issue is his inability to explain these to the patients."

"What can I say? I wasn't there. I'm sure he's trying to do the best he can."

"Okay, I might say that the patient should get a second opinion. But where do I get an outside opinion?"

"One does not judge a colleague's work. Describe or inform, and leave it up to them."

"I would just advise Dr. X as a friend."

"It would be unprofessional to draw conclusions about the quality of work based only on the outcome or to take a patient's word for it that they had been treated rudely."

"Just document everything; that usually will take care of it."

"I think he is aware now that I have mentioned the open margin. I trust him."

"No follow-up needed with Dr. X. The marketplace will sort [this out] through the natural selection process."

"If Dr. X does not want to talk about the case, I would typically let it go at that."

"I've talked to this guy three times and he is arrogant as well as doing crappy work. He should be run out of town." [Dr. X was not reported; the matter was simply dropped after making that comment.]

"He is my chief referral source. This is a small town. Whatever you ask me, I'm going to say, 'He is a benefit to the profession.'"

"If I alert him that the patient is considering litigation, isn't that sufficient?"

2. Patients are informed tenuously:

Patients are often informed of the existence of a compromising condition, although that information may be ambiguous, and consulting dentists resist responding to patients other than regarding the technical nature of their clinical condition.

"Your case involves occlusal abnormalities but may even entail myofunctional dynamics."

"Now I'm just going to retreat this [poorly done endo] and not say anything to the patient. If she asks me whether that is because Dr. X did not do it right, I'll just make up something about new circumstances requiring special additional care."

“I would tell the patient there must be some miscommunication.”

[Poorly done root canal by Dr. X.]
“I would not tell the patient anything about this until I had talked with Dr. X to find out what he wanted me to say.”

“I would probably suggest to the patient that the outcome might have been a bit different.”

“There may have been a mishap with some of your previous treatment. I am sure this can all be taken care of.”

[Patient: what is an “open margin?”] “Sometimes multi-surface restorations are not ideal because of problems with the matrix or something that the patient does. You can speak to Dr. X about that.”

“Let’s keep our attention on this particular tooth.”

“So I wouldn’t actually say anything to the patient about the endo file. It might not have been the fault of Dr. X, but if it was, that would be his responsibility to inform the patient.”

[High crown] “Sometimes things just happen and maybe that was a difficult tooth.”

“I would just state the facts about what the X-rays say on 3, 4, and 5 and that there appears to be an instrument where it shouldn’t be. I do not want to alarm the patient.”

“I will treat that part of the case that has been referred to me. All the rest is the responsibility of the treating dentist.

“If I feel I’m not connecting with the patient I tell them to get a second opinion.”

“If the patient wants to know about the perforation I would say that sometimes these things happen and we don’t know where they come from. Dr. X is confident that I can fix this for you, however.”

3. Reframing the situation as convenient hypotheticals: Consulting dentists reframed the presenting case as either so underdefined as to excuse involvement or by imagining additional facts that excuse the need to become involved.

“I do not want to be responsible for making a poor personal judgment. I’d rather not have anything to do with it.”

“But I would not say anything to anybody because I do not know under what conditions the restorations were done.”

“It’s a gray zone. Most of us live in gray zones. We develop and perfect a tunnel vision. We focus on the job at hand. If there’s a mistake, we mentally wipe it out and do another one.”

“If I have a good relationship with Dr. X, everything should work out just fine.”

“Somebody else needs to be involved here...third opinion.”

“My advice, speaking as a caring, professional colleague, is that ‘you had better do the right thing and it’s important to do it well.’”

“I would not want to comment without knowing everything about the case.”

“I’d just try to find out what the evidence is, and all the evidence that I possibly could. And then just document what I saw in my record without...” [thought stopped at that point].

“If I’m ever in doubt I would definitely contact the dental society. I would definitely contact my dental malpractice insurance advisor, just get some advice about what I need to do. Fortunately, I have never been in that kind of situation.”

“Just because a person isn’t competent in one aspect of dentistry doesn’t mean that he is “incompetent.”

“I begin with the assumption that there is nothing any dentist can ever do that would warrant being reported for investigation.”

“The important thing is to resolve these matters ethically, and to do the right thing. These things need to be handled right and resolved peacefully, I mean without entanglements. I’m not sure specifically what I would do.”

[On consulting a colleague, the consulting dentist is read 4.C from the ADA code.] “I would have hoped for something more from my colleague other than reading from the ADA code. That doesn’t help solve particular cases.”

“If I start to see a pattern I would do something.”

“I just looked at the tooth. The tooth looks okay to me.”

“Well, now, it’s one thing if the patient is 85 and another if she’s a lot younger...” [That was the end of the consideration, it was never decided what the patient’s age was, so the matter was left hanging.]

“Look, there are two problems here. The patient needs an endo and the patient is upset with the previously treating dentist. I would certainly do the endo, but I do not want to get involved with the other business.”

“This is gross negligence. But, obviously there are other issues going on that I am not aware of. Perhaps he needs to take some CE courses or something. Not even my responsibility to make suggestions.”

[What would be an example of a situation of gross treatment?—asked of a 36-year veteran]: “I don’t know. It has never happened. Well certainly, a case like the endo file in the sinus [that was just passed over by the subject] might be a case, but probably not. One never knows.”

“The case never actually says that Dr. X did this work. The patient might have just walked in off the street. Let’s just assume that this is a newly presenting case.”

“If there is an infection or if there is some other thing you would do one thing, otherwise maybe not.”

4. Patterns and general conclusions are avoided: Individual cases tend to be considered separately; the dominant context is the current clinical situation and elements of comprehensive care and generalizations about the treating dentist are suppressed.

“I would show the patient visually what needs to be done. No value judgments. This is what I think needs to be done.”

“This whole situation is kind of wiggly and squirmy.”

[Experimenter: You have seen six cases of faulty treatment. Is that enough to establish a pattern of “continuous” faulty work?]

“Maybe, but maybe not. I would like to see at least two more.”

[The next two cases are pretty bad.]

“That’s just two cases. Two cases don’t make a trend.”

“One can’t put a probability on an opinion about whether Dr. X is competent. I’m prepared to say that he’s not totally incompetent.”

“I think I see where this is going. At some point I am going to have to make a decision about Dr. X.”

[There was no such decision and the experiment was stopped after all 14 cases had been considered.]

“I would approach him one last time as say ‘Hey, look, I seen a lot of stuff...’” [Two more unfortunate cases were reviewed.] “I guess I would need to see some more bad examples before I do anything, maybe eight or ten in all.” [After twelve bad examples, the consulting dentist was still unsure.]

“General things are not something I like to talk about.”

“I can only comment on the problems I am seeing. The bad one that happen to show up might be just part of his practice. He might generally do very fine work.”

“There’s no line that separates competent from incompetent.”

“I would certainly deal with the tooth in question. I’m not sure about the rest of what’s going on here.”

“I would only report this if there were a pattern of bad outcomes and if Dr. X seemed to be ignoring me.” [Both conditions were clearly met, but no action was taken.]

5. Responsibility for corrective action rests with the patient: The consulting dentist is responsible for addressing the referral (if indicated), the treating dentist is responsible for restoring the patient to prior clinical standard, and the patient is responsible for everything else, including action against the treating dentist for general incompetence.

“It’s really for the patient to return to him [Dr. X] to clarify what’s going on in his mouth.”

“I wouldn’t respond to the patient’s concerns about Dr. X generally. I don’t think that’s relevant. So I would just ignore that kind of a comment.”

“I think we finally have a pattern here. So I would recommend that the patient go to peer review, if the dentist is a member of the ADA.”

“I would tell the patient that for a full account of their oral health they should go back to Dr. X.”

In many cases, hypothetical additional material was imagined that would account for the clinical situation without having to take into consideration any other factors such as iatrogenic, patient satisfaction, or responsibility.

“There is an issue of cost here [for retreatment] of course. But the patient will have to work that out with Dr. X.”

“I would not report this matter myself. I would refer the patient with the complaint to PR.”

“It all depends on the reputation of the patient.”

“Okay, I see it, a high crown. The patient has a problem.”

“If the patient has selected Dr. X and agreed to the treatment proposed, then it is in the patient’s hands.”

[To patient who asks what can be done, having lost confidence in Dr. X]: “I wouldn’t know what to do in your situation. I don’t know anything to tell you.”

“It is obvious that X is incompetent and disrespectful of patients. Perhaps this is something that one of his patients will take up.”

“The market will fix this. Sooner or later patients will stop going to Dr. X or he’ll only get the crummy ones.”

“Quality work is a dying thing. Most of success in dentistry is communication. If this guy can fool the patients, without really hurting them of course, he’ll do fine.”

6. There is no sense of general professional responsivity: There is no “we” in these cases; treating dentist, consulting dentist, and patient have separate interests that are confined to individual treatment and they do not work together for a general resolution of difficulties or a general elevation of the profession.

“Everything described here could happen to anybody. It is not really anything to be concerned about.”

“Refer the patient back. But stay away from any discussion of who pays for retreatment.”

“Well, I would suggest that you go back to Dr. X and report that I could not find a problem and that you may not need a root canal.”

“If the guy doesn’t respond [to my feedback], I’d just let it lie. Pretty soon something really bad will happen and then maybe somebody will do something.”

[Matter of friend in community asking for advice on treatment of his wife]: “Tell him dentistry should not be discussed outside the dental office. The patient is acting unprofessionally.”

“This is about me and Dr. X. He’s bad for my practice. I’m just going to stop dealing with him. Others can do what they want.”

“I call ‘em like I see ‘em. If he doesn’t value my opinion, there are other endodontists in town.”

“I am only qualified to comment on the matter that was referred to me. I suggest you pay for a second opinion. Perhaps the dental society could give you some names.”

[Following reading a card where a colleague says that dentistry is a profession where dentists follow their own standards and the ADA discourages comment on other’s work]: bemused smile, shaking head, just picked another case.

“This is a free country.”

Interpretation of Radiographs

The correlation between imagined image of the case and action was $r = 0.512$, a moderate value that is statistically significant at .001. The subjective stimulus tended to match or “justify” the chosen action.

Study #4

Components of Justifiable Criticism

Purpose

The goal of the fourth study was to make first approximations regarding what factors dentists consider most important when deciding whether an incident of ambiguous quality warrants referral for review and possible disciplinary action. The number of factors is unlimited in fact, but basic groups can be isolated. In this study, type of incident, treating dentist, and consulting dentist were considered as major sources of explanation for variation in the target outcome of probability of referral.

The technique used is known as variance analysis. This procedure allows for assigning the totality of all variance (difference in outcome) to the measured sources (incident, treating dentist, and consulting dentist in this case), to the interactions among these sources, and to unidentified random error. One hundred percent of the variation will be apportioned to various considerations. The results are expressed as proportions of variance. The most important sources of variance should be considered first when planning improvements, as they have the largest impact.

The three sources of variance were operationally defined as follows:

1. *Type of incident:* Twelve of the cases used Study #2, representing the range of situations that might be considered as triggering report for possible disciplinary action. The two incidents where the work was described as being appropriate or unremarkable were excluded.
2. *Characteristics of the treating dentists:* Described as (a) a long-term acquaintance and veteran practitioner in the community, (b) a new dentist in the community, or (c) a candidate on a one-shot initial licensure examination.
3. *Characteristics of the consulting dentist:* A new sample of 62 dentists completed a survey were all experienced clinicians, each bringing his or her personal standards to the situation.

Materials and Methods

Sixty-two clinical faculty members at the University of Pacific Arthur A. Dugoni School of Dentistry participated in this study. Thirteen percent of respondents identified themselves as specialists; 85% said they were ADA members.

The following instructions were given and reinforced verbally.

- Assume you are a specialist who sees the work of many dentists in your area and have served as a state board examiner. For each of the following, rate the probability the

candidate or dentist whose work you observe SHOULD be disciplined (fail the board or referred to component society) based on the condition described. You actually see or have direct knowledge that it certainly happened. 0 means you would certainly say nothing; 50 means it is a toss-up whether you would say something; 100 means you would certainly say something.

- In every case, assume that the candidate did the work as part of the board or that the patient gives credible detail that the practitioner had done the work but had not been informed of any mishaps.
- For each condition, consider three individuals associated with the work: (a) a candidate on the licensure examination, (b) a new dentist in your community, (c) a veteran dentist. Rate all three in each case.

Results

The surveys were analyzed, with the following preliminary findings.

Table 4:1. shows variation across treatment situations (cases) in the work of colleagues in terms of presenting a concern to practitioners. Starting a complex case that appears to be proceeding appropriately was judged worthy of being sent to peer

Table 4:1. Results of a survey on likelihood of reporting a colleague for possible disciplinary action relative to an incident of ambiguous quality.

	<i>Probability of disciplinary referral: average (standard deviation)</i>			
	Total	Board Candidate	New Dentist	Veteran Dentist
1. Complex work started, not conventional but it looks like it might work	19.34 (29.25)	25.74 (34.23)	17.28 (27.31)	15.00 (24.68)
2. Two Class II amalgam restorations have smoothed off damage on both adjacent teeth	25.61 (34.43)	36.69 (41.09)	19.78 (28.89)	20.37 (29.70)
3. Patient says RCT in #3 diagnosed, but you find no endo involvement	30.81 (36.73)	38.82 (40.51)	25.59 (33.01)	28.01 (35.44)
4. Patient complains about recently placed crown causing facial pain, bite is high	31.54 (37.65)	40.59 (41.57)	26.76 (34.70)	27.26 (35.20)
5. RCT begun, but access is much too large and undermines structural integrity	34.09 (36.79)	41.47 (39.61)	29.78 (34.29)	31.03 (35.68)
6. Huge overhang on #2	39.00 (41.03)	55.25 (45.38)	29.56 (35.20)	32.13 (37.45)
7. Patient reports that recently placed crown has fallen off three times, dentist blames patient	44.41 (38.22)	53.46 (40.40)	39.85 (36.22)	39.93 (36.85)
8. Recently placed restoration has large open margin and patient is sensitive to cold	46.76 (41.07)	56.62 (41.21)	42.57 (40.14)	41.10 (40.64)
9. Veneers started, perio involvement, patient says no mention was made of perio	51.07 (39.19)	63.79 (39.33)	44.71 (37.18)	44.71 (38.44)
10. Recent RCT causing pain, x-ray shows poor obturation and poor fill, missed canal	53.55 (40.06)	62.06 (40.97)	47.94 (38.37)	50.66 (39.97)
11. X-ray shows perforation in work done two years previous, but patient was not informed	53.63 (40.03)	61.25 (39.98)	49.63 (39.80)	50.00 (39.82)
12. Broken endo file in sinus	65.60 (41.96)	73.04 (39.12)	61.47 (43.22)	62.28 (43.02)
Total	41.28 (40.25)	50.74 (42.22)	36.24 (37.98)	36.87 (38.77)

Eleven of the respondents (16%) either entered “0” for every case for every operator or wrote on the form that the task was “unrealistic” or “inappropriate” to report faulty work under any circumstances.

review by 20% of the respondents. (This is almost certainly a “generalization” on the part of respondents. Because there is nothing in the prompt that hints at faulty treatment, respondents are very likely responding to their general impression of “big cases,” which in some cases are really overtreatment. The most serious concern was the endo file in the sinus about which the patient had not been informed. In and of itself, this was deemed sufficient cause for action by two-thirds of the respondents. Figure 4.1 also shows that a different standard is applied to candidates for initial licensure. Generally, a problem would be about 15% more likely to cause a failure to earn a license among candidates than the same behavior would be to prompt a disciplinary inquiry if attributed to a licensed practitioner.

Net-net, 41% of the incidents were deemed to warrant reporting for investigation. Individual propensity of respondents assuming the role of consulting dentists make a report across all treating dentists and types of incident ranged from 0% to 92%. Some respondents were the “reporting type” and some would not do so under any circumstances. Merely performing complex reconstructions were suspect in 19% of the cases (presumably because the consulting dentist was making additional assumptions). At the other end of the continuum, a broken endo file in the sinus about which the patient had no knowledge was likely to be overlooked in one-third of the cases (again, presumably based on information the respondents assumed to be the case). Averaging across respondent and across type of incident, half of the ambiguous cases were marked for reporting are performed by candidates on state boards. There was no difference in likelihood of reporting for new dentists and veterans, both being a reportable concern in 36% of the cases.

The standard deviations in these results are very large. That reflects the fact that some respondents professed a view that these cases “should” cause disciplinary action while others were loath to favor that option. Eleven of the respondents (16%) either entered “0” for every case for every operator or wrote on the form that the task was “unrealistic” or “inappropriate” to report faulty work under any circumstances.

The reported probability of disciplinary action is considerably higher might have been expected. It is certainly greater than what is reported in Study #2. The difference is most likely attributable to the difference between “somebody should do

something about this” (Study #4) and “I should do something about this” (Study #2).

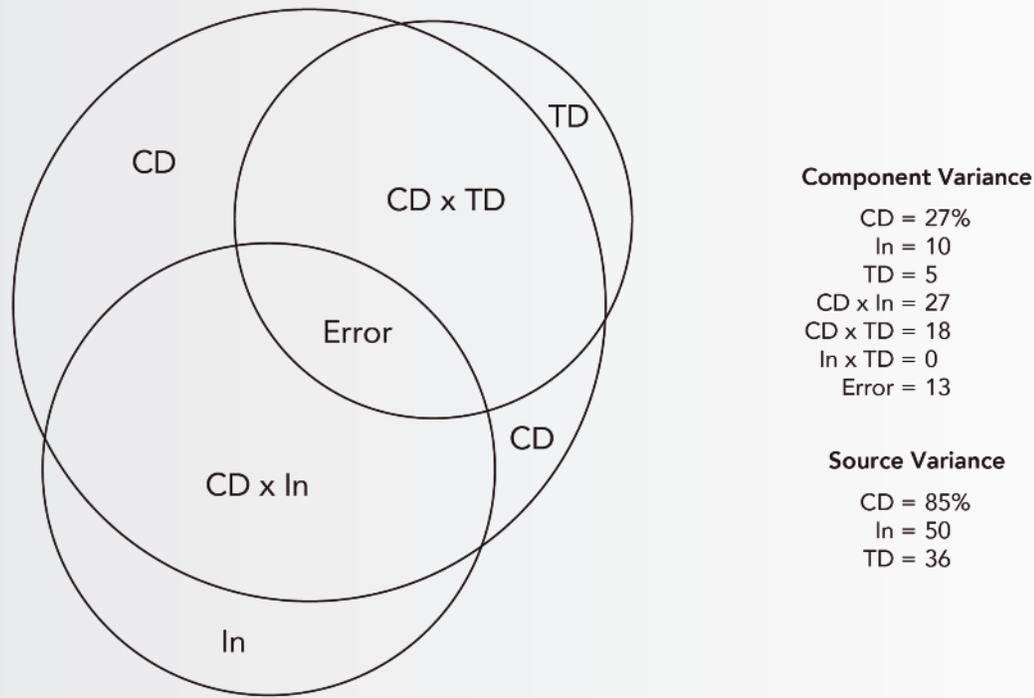
Two-factorial analysis of variance (ANOVA) was performed on these results. A very large and statistically significant ($p < .001$) effect was found for operator ($F = 126.708$, $df = 2$) meaning that a single instance of faulty treatment was judged much more harshly in candidates for initial licensure than when attributable to licensed practitioners. A large and statically significant ($p < .001$) effect was also found across the twelve cases (types of “faulty” treatment) ($F = 86.640$, $df = 11$). There was no interaction effect. There were no faults that were especially grievous among candidates but not among practitioners who had passed the board exam.

The final part of this preliminary analysis was a generalizability test to isolate the predominant sources of variance that contribute to favoring disciplinary action. The study design permits exploration of three sources and their interactions: (a) consulting dentist (who judges the work), (b) treating dentist (whose work is being judged), and (c) case (nature of the fault). Figure 4:2 shows the generalizability analysis. The relative weight of each contributing factor is proportional to the area in the diagram.

It is clear from the variance diagram that the major source of variation in whether an incident will be reported for possible disciplinary action is the consulting dentist, the practitioner who observes the incident. Most of the variation in outcomes (27%) comes from the personal standards of the consulting dentist, with an additional 27% from the combination of the consulting

FIGURE 4:2. Schematic representation of the sources of variation in likelihood of reporting a colleague for possible disciplinary action relative to an incident of ambiguous quality.

CD: Consulting Dentist; TD: Treating Dentist; In: Incident



dentist and the type of incident. The later effect (what is known technically as an interaction) means that some consulting dentists thought one type of ambiguous situation was reportable, but other consulting dentists were more concerned with other types of incidents. The type of incident itself, in some objective sense, was a minor determinant of likelihood of being reported (10%). There is little evidence for the generalization that consulting dentists consider the nature of the treating dentist when deciding whether to report an incident.

These findings raise some questions about one-shot initial licensure examinations. Single examples of nicked adjacent teeth, open margins, high crowns, or

overhangs would normally be considered grounds for failing candidates on boards. They are generally overlooked among established colleagues, however. This discrepancy calls into question the “objective” nature of one-shot licensure examinations. In practice, professionals realize that competence is a reflection of a pattern of performance. But the one-shot nature of the current testing system (as opposed to the portfolio alternative that has been considered) does not permit the establishment of a pattern. This means that greater variability in determining competence on boards

exams; that is tantamount to saying that the one-shot system is invalid and that some candidates are passed who should not be. The latter is obvious from the fact that licenses are regularly disciplined by state boards.

This argument is muted, however, by the fact that virtually no cases of disciplined licenses exist because of technical matters, minor (such as overhangs) or major (such as endo files in the sinus).

Study #5

How Patients View Justifiable Criticism

Purpose

The dental profession has asked the public to trust them regarding self-policing of the quality of work performed by practitioners. It is appropriate to inquire whether patients feel this trust is well placed, including what they believe dentists actually do with respect to justifiable criticism and what they hope dentists would do. In particular, it is worth inquiring about the extent to which patients want to be informed about unplanned outcomes and how much they wish to be involved in correcting problems caused by dentists.

Materials and Methods

A separate sample of patients was surveyed regarding the 14 incidents used in this research. Each of the incidents was described, as much as possible in lay terms, and subjects were asked two questions:

1. What do you expect the consulting dentist will tell you or do for you?
 - (a) Nothing in particular, this is not remarkable
 - (b) Notify me that some less-than-ideal condition exists and fix it if possible
 - (c) Notify me that some less-than-ideal condition exists and refer me back to the treating dentist

2. Do you expect that the consulting dentist will contact the treating dentist regarding my situation?

Forty-eight “patients” completed this survey. They were selected as volunteers from two book clubs and from patients and parents or others accompanying patients at a dental school.

Results

Table 5:1 summarizes data from three studies. The responses of 23 dentists who participated in the vignette study are shown, as well as the likelihood of reporting each type of incident from the survey of 92 dentists. The table should also be consulted for a summary of the results of the survey of 48 patients regarding their preferences for the way the consulting dentist should handle each incident.

The first six columns are from the 23 subjects in vignette study. The “dentist survey” column is from the 74 of the 92 dentists in the study who indicated the probability that an incident should be reported. The last four columns are from the 48 lay individuals who reported their preferences as patients. “Pass” means that the incident is passed without comment; “Dentist” means that the consulting dentist at some time consulted the treating dentist with regard to that incident. “Patient” means that the consulting dentists contacted the treating dentist. “Peer” means the consulting dentist spoke with a professional colleague.

Percentages combining these classes may exceed 1.0 where multiple actions are taken in response to an incident. For patients, “pass” meant no comment expected, “inform” meant that the consulting dentist was expected to alert the patient to a condition needing attention and perhaps provide that care, “back” mean that the patient expected the consulting dentist to inform the patient he or she should return to the treating dentist. “Tell” indicated an expectation that the Consulting dentist would inform the treating dentist about the case. “Report” indicates that the incident was involved with a report for possible disciplinary action. This does not indicate the likelihood that the particular incident triggered the report, only that at some time the consulting dentist saw that incident among the patients referred by Dr. X.

Table 5:2 is based on the same set of data from dentists in the vignette study and patients in the separate survey. It shows correlations rather than averages. The tables give a complementary picture of the relationship between dentist and patient perceptions of the same 14 incidents. The correlations show similarities or differences in ordering of the 14 incidents; the tables with average percentages shows similarities or differences in average weights for various choices.

Table 5:1. Responses to ambiguous incidents [partial repetition of Table 2:1].

Incident	N	Study #2 (N = 23)					Study #3 (N = 62)	Study #5 (N = 48)			
		Pass %	Dentist %	Patient %	Peer %	Report %		Pass %	Inform %	Back %	Tell %
Good composite	10	90	10	10	0	0	–	71	14	14	0
Case in progress	11	64	36	16	46	18	–	100	0	0	11
Big reconstruction	11	73	27	9	18	18	19	63	13	25	11
Nicked near tooth	6	83	17	0	0	0	26	17	50	33	11
Missed vital tooth	10	50	40	40	0	0	31	0	0	100	89
High crown	14	29	57	43	7	0	32	0	13	75	88
Excessive access	8	38	63	38	0	0	34	0	71	29	67
Overhang	15	33	60	20	20	13	39	11	0	89	44
Complaining friend	10	30	50	30	0	10	44	17	17	67	44
Open margin	10	10	90	20	0	0	47	0	14	86	78
Veneers on perio	13	31	85	46	15	8	51	0	0	100	78
Faulty endo care	8	25	38	38	0	0	54	0	86	14	77
Perforation	10	30	50	30	0	0	54	0	71	29	44
Endo file in sinus	6	0	100	67	17	17	66	0	63	38	67
Averages	9.92	41.8	51.9	30.5	8.8	6.0	41.4	19.9	29.4	52.0	50.5

Table 5:1 shows great consistency in expectations for contacting the treating dentist when the consulting dentists recognizes an ambiguous incident. Together, 50.5% of patients expected this, and 51.9% of dentists working through the vignettes did so. The high correlation coefficient of $r = 0.709$ shows that across the 14 incidents, there was a consistent ordering of those cases thought to most warrant involving the treating dentist.

The *first* response of dentists in the vignette exercise was most typically to ignore the situation: 40.3% of the time. This is different from the *total* responses shown in Table 5:1. The next most common first move was to contact the treating dentists (not the patient) in 35.3% of the cases. Following consultation with the treating dentist, the consulting dentist conferred with the patients

Table 5:2. Correlation matrix for preferred response to an incident by a dentist participating in the vignette study and by patients expressing their expectations for what a consulting dentist should do.

	Dentist			Patient			
	Dentist	Patient	Peer	Pass	Inform	Return	Alert
Dentist							
Pass	-0.882	-0.706	0.093	0.696	-0.255	-0.355	-0.763
Dentist		0.673	-0.085	-0.570	0.056	0.427	0.709
Patient			0.203	-0.377	0.165	0.127	0.626
Peer				-0.609	-0.415	-0.229	-0.327
Patient							
Pass					-0.390	-0.592	-0.817
Inform						-0.498	0.128
Return to treater							0.594

21.1% of the time and let the matter drop 55.3% of the time. Sometimes (24.4%) the consulting dentist began with the patient. When starting from the patient's perspective the consulting dentist passed on to the treating dentist in 57.0% of the cases and stopped gathering information in 42.8% of the incidents. In 20.9% of cases, the consulting dentist involved both the patient and the treating dentist; in 40.3% of cases, neither was consulted. But it was about 30% more

likely to end information seeking with only dentist input than with only patient input.

Dentists and patients also tended to agree on which incidents could be passed without comment, $r = 0.696$. But they strongly disagreed on where to draw the line for comment. More than four in ten vignettes were thought not to be deserving of comment by dentists, compared with two in ten among patients. This is statistically significant and shows a gap between how much patients feel consulting and treating dentists should coordinate care provided compared with dentists' willingness to accept desperate standards. This finding should be taken in combination with the figure reported in the preceding paragraph. Dentists felt the need to involve the treating dentist in the same

proportion of incidents as did patients, but they were half as likely to include the patient in these same incidents.

Finally, both dentists and patients favor informing patients in about 30% of incidents. Patients expect to be informed of their situation, either with the consulting dentists managing the problem or having the matter referred back to the original treating dentist, in about 80% of the situations. This is a large and statically significant effect ($\chi^2 = 26.956$, $df = 2$, $p < .001$). Further, although there was a very modest association between dentist intention of involving patients and patients expectations about being informed ($r = 0.143$), there was insignificant agreement over which incidents warranted patient involvement.

Ethical Challenges in Forensic Dentistry and the Need for Enhanced Education

American Society for Dental Ethics

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Abstract

Forensic dentistry provides an important method for the identification of human remains and all dentists have a professional obligation to be knowledgeable and able to participate in the process, both in antemortem record keeping and postmortem examination of remains. Ethical challenges arise when dentists do not complete accurate and thorough records for their patients, when dentists are asked to release confidential records to third parties, when mass casualties demand efficient management, and when dentists are called upon to provide legal testimony. The nature of these ethical challenges mandate a reconsideration of training for dentists to ensure an adequate level of knowledge and skills in forensic dentistry in order to meet professional obligations.

Death is rarely on the mind of most practicing dentists due to the general focus of dentistry on improving quality of life in an outpatient setting. However, there is one arena in which dentistry is forcibly intertwined with death: forensic odontology, a discipline of dentistry that utilizes dental and orofacial structures as evidence for human identification within the legal system (Krishan, 2015). Human identification is necessary and useful when catastrophic events such as tsunamis, earthquakes, landslides, bombings, terrorist attacks, or transportation accidents occur, leading to deceased bodies with

limited recoverable remains (Saxena, 2010). For example, the terrorist attacks on September 11th, 2001 resulted in almost 3,000 deaths. As of 2010, only 1,626 victims had been positively identified, 500 of which were identified through dental record comparisons (Senn & Weems, 2013). Dentists are occasionally called on to assist military and legal authorities in identifying unknown individuals in both criminal and postmortem investigations, as well as to recognize malpractice, negligence, fraud, and abuse (Senn & Weems, 2013; Verma, 2014). In answering this call, the ethical principles of confidentiality, beneficence, and veracity, in addition to several others, are likely to arise.

Forensic Methodology

According to the 2013 Manual of Forensic Odontology, “a dental identification is the most common biometric method for identifying burned, decomposed, skeletonized, and fragmented remains” (Senn & Weems, 2013). Hard tissues such as teeth are considered to be the most durable parts in the human body; thus, they tend to be preserved after death even when exposed to relatively hostile environments. Every individual has a unique set of dental characteristics, defined by features such as tooth morphology, pathology, tooth size, dental restorations, missing teeth, wear patterns, and tooth

positioning. These dental features serve as a reliable means for identification through the comparison of antemortem and postmortem records (Saxena, 2010). In situations where an antemortem dental record is unavailable, dental profiling is conducted, whereby a postmortem dental profile is created to narrow the search for alternative antemortem materials (Gupta, 2014). Radiographs are an especially useful component of the dental record and produce a high degree of reliability. Other techniques used in forensic odontology include, but are not limited to: anthropology, rugoscopy (palatal grooves), cheiloscropy (lip prints), bite mark analysis and dental DNA analysis. Cheiloscropy, bite mark analysis and dental DNA analysis are frequently used in criminal investigations to link a suspect to a crime scene. Sex crimes, physical altercations, child abuse, and theft are common scenarios where such evidence may be useful (Gupta, 2014).

The Need for Efficient Identification & Forensic Education

A report published in 2007 by the U.S. Department of Justice indicated that roughly 13,500 unidentified human decedents existed on record at 2,000 medical examiner and coroner offices that perform death investigations in the United States. It was also estimated that 4,400 unidentified decedents are reported annually, with 23% percent remaining unidentified after one year, and only 49% of medical examiner offices had policies for retaining records after a year's time (Hickman, et al, 2007). Policies were highly

variable in those offices that actually had them.

The failure to identify a cadaver is significant for numerous reasons. On a psychological level, the concept of closure has been demonstrated to be essential to the grieving process (Senn & Weems, 2013). The social networks of the 1000 deceased people that remain unidentified after a year endure an emotional limbo, either holding out hope that their loved one is still alive, or left to speculate on the circumstances of death. Similarly, only 600 of those 1000 unidentified decedents undergo final deposition, which, for the religiously minded, may carry profound consequence (Hickman et al, 2007).

From a medicolegal perspective the ramifications are many, as a positive postmortem identification is required for issuance of a death certificate. Without a death certificate, estates cannot be closed, transfers of child custody can be delayed, wills cannot be executed, life insurance policies cannot be paid out, and pensions cannot be disbursed. Essentially, all fiscal and personal matters pertaining to the event of death are stalled. In many cases, both legally and religiously, spouses are unable to remarry unless the death of their previous spouse is confirmed (Senn & Weems, 2013; Gosavi & Gosavi, 2012). Additionally, criminal investigations and prosecutions cannot proceed without a positive identification, and it is worth noting that roughly 27% of unidentified persons in the Federal Bureau of Investigation's National Crime Information Center are believed to be homicide victims (Hickman et al, 2007). There exists a cost-benefit judgment between the value of alleviating personal and legal inconvenience, and the costs of forensic processing.

Virtually all cultures hold dearly a set of customs for the passing of a community member, and forensic processes must be respectful and facilitative of those procedures.

However, from a moral perspective, concern for human dignity may trump those costs. Virtually all cultures hold dearly a set of customs for the passing of a community member, and forensic processes must be respectful and facilitative of those procedures. It seems a matter of justice that an individual who must be identified by forensic methods be afforded the same rights and rites in death as an individual who is not. Ethical frameworks often endeavor to protect vulnerable populations, and bereaved families and victims of crime certainly fit that profile. In some sense, the deceased themselves are vulnerable in that they have suffered a complete loss of agency. As previously mentioned, a positive identification is required for the execution of a will—the posthumous manifestation of legal autonomy. Overall, the management of death should reflect reverence for life. Thus, overall, postmortem identification is of immense practical and moral importance.

Unfortunately, however, our current system of medical examiners and forensic laboratories appears unable to handle the volume of cases with which it is inundated. The most

recent survey data indicate that roughly one-fifth of human deaths are investigated by forensic scientists, which constitutes only half of the cases referred to them by authorities (Hickman et al., 2007). Similarly, 4.1 million requests were issued to publicly-funded forensic crime labs in 2009, of which 1.2 million were considered backlogged at yearend (Peterson & Hickman, 2005). These figures demonstrate a shortage in a healthcare resource, which consequently requires rationing, and thus has the potential to engender concerns regarding distributive justice. In order to meet the forensic need, obligations fall to all those involved in the process to ensure efficiency and productivity – which includes dentists. But evidence suggests that the U.S. dental education system is inadequate in preparing dentists to perform their role.

In 1978, Herschaft and Rasmussen were the first to document the variability of formal dental forensics education in the U.S., noting that 42% of schools offered no formal forensic odontology training, with the remaining schools offering solely didactic coursework. As of 2002, it would appear little had changed as only 38% of dentists responded to an American Dental Association survey indicating they had received any training in dental forensics (Lund, 2002). Stoeckel, Merkley, and McGivney (2007) further noted a possible insufficiency of dental forensics education, as well as Hermes and Johnson in 2011. Part of the reason that this potential deficiency is so concerning for the dental profession and the population at large is that forensic odontology bears significant ethical and legal responsibilities due to its medicolegal functions. This essay asserts that all dentists carry some responsibility in this arena.

Potential Ethical Shortcomings Due to Insufficient Knowledge

The utility of dental records in forensics is entirely dependent on their accuracy and completeness, and the responsibility for that accuracy and completeness falls entirely on the dentist. To ensure that responsibility is upheld, it is important that dentists are educated on the potential applications of their records in the context of dental forensics. This is a domain in which every dentist holds some degree of ethical obligation. Devadiga reported in 2014 on a worldwide insufficiency of dental record keeping. One study revealed that while 85% of Minnesota dentists believed their record keeping was adequate, data required by the American Dental Association guidelines for record keeping was missing 9% to 87% of the time (Osborn, et al, 1999). In another study, only 56% of dentists felt their records would be extremely useful in dental identifications (Stimson & Delattre, 1999). These statistics are telling and are of consequence considering the aforementioned ramifications of a failed identification.

Practitioners must understand the status of the dental record as a medicolegal document, and realize that a single incorrectly documented dental restoration can nullify an identification. An additional factor limiting the usefulness of dental records in forensic investigation is their very existence. Currently, the length of time a dental practice is legally required to maintain records following the last patient visit varies between states, but the Health Insurance Portability & Accountability Act (HIPAA) mandates that records be retained for six years following the last

patient visit, and two years following patient death (ADA, 2007). However, legality and morality are not always congruent. It is difficult to place a universal, stringent minimum on the duration a dentist is ethically obligated to retain records. The adoption of electronic documentation, while introducing a host of confidentiality concerns, has made patient information less burdensome to store. Should the technology advance accordingly, it seems plausible that dentists could retain patient records in perpetuity, with little cost or inconvenience.

Presently, however, it would be prudent for practitioners to at least be knowledgeable enough on the subject of forensic dentistry to act judiciously with regard to their records. For example, after a certain amount of time a dentist could perhaps decide to retain only the information that might be of forensic use. Also, a dentist may wish to retain their records longer than required if they live in an area with a high volume of forensic activity, such as New York City or Cleveland (Hickman et al., 2007). Overall, education is a critical component of ensuring that dental practitioners maintain records to standards and durations conducive to forensic utility.

One of the most important aspects of the dental record is its status as Protected Health Information, meaning its contents must be kept confidential (ADA, 2007). The ethical principle of confidentiality is an integral part of dentistry and facilitates a trust between provider and patient that is necessary for proper care (Graham, 2006). If a dentist discloses

private information about the patient to a third party without patient consent or court order, it is considered a breach of confidentiality, and a violation of ethics and professionalism will almost always jeopardize the relationship between doctor and patient (Devadiga, 2014; Garbin, 2008).

Implicit in the responsibility of managing confidential patient records, is the obligation to be informed when sharing records with a third party. There are times when patient information may need to be shared, such as collaboration with other medical professionals to formulate treatment plans, or communicating with insurance companies. In the case of forensic dentistry, dental records must be released to third parties in order for the identification process to take place at all (Charangowda, 2010). This is a situation that any dentist may encounter. When these situations arise, the provider should know who will have access to the information, and exactly what the information will be used for. However, if a dentist has not received proper education in forensic odontology, he or she would likely be unprepared to fulfill this obligation when called upon to release antemortem records. For example, there are currently national forensic databases of dental records, an initiative that could be considered biobanking, a highly contentious ethical matter (Senn & Weems, 2013).

Dentists should know the law, standard of care, and potential uses of databases before releasing records. As another example, cadaveric remains do not qualify for human research subject protections under the guidelines of the National Institute

of Health under Exemption 4.¹ The dentist should be aware that the released records could potentially be used for research, which could perhaps be considered an infringement on patient autonomy. While some may argue that confidentiality and autonomy do not concern the deceased, it is not hard to imagine that in life, many people care about matters that could be altered by forensic information after their death—such as reputation. It is also important to note that forensic information also has implications for the living. Some information surrounding a forensic case may be troubling to those who knew the victim, and may be unwanted knowledge. For example, children of the deceased may find the more specific details of the rape or torture that was endured by their parent emotionally traumatizing. It is because of these implications that a dentist is ethically obligated to be informed when releasing patient records for forensic use.

In many cases regarding release of records to third parties, informed consent is obtained from the patient. While obtaining consent for forensic use has implications outside the scope of this discussion—including adding an additional encumbrance into an overworked system—of relevant concern is the word “informed.” When obtaining informed consent, the provider has a duty to convey all relevant information to the patient in a cogent and comprehensible manner prior to treatment. However, one cannot inform what one does not know. It is literally impossible for a dentist to obtain informed consent for forensic use from a patient or proxy if the dentist has no information. Educating dentists on forensic methodologies could mitigate some of these concerns surrounding confidentiality,

as the dentists could perhaps perform the identifications themselves.

Particularly pertinent to the issue of consent and confidentiality in forensic dentistry is the common practice of marking dental prosthetics with the owner’s information. These markings are of immense forensic utility when the appliance is recovered as a component of human remains. The American Dental Association first officially recommended this practice in 1982,² and as of 2011, regulations for the process existed in 24 states (Mohan, 2012). In many states prosthetic marking is legally required, though in some states a patient may decline if they sign a release. One possible objection to this practice is a concern for patient privacy. For example, a patient may be afraid of inadvertently revealing their edentulism. Regardless of which state a dentist practices in, and the restrictions under which they operate, it would be ideal for dentists to be educated on the forensic value of prosthetic labeling so that they are able to convey its importance to patients. This is especially true in situations when the patient is considering opting out. Overall, privacy is an essential consideration in forensic odontology. In many situations, medical confidentiality endeavors to deidentify information, while dental forensics quite literally seeks to identify. This profound entanglement further demonstrates the necessity of adequate forensics education.

Ethical Responsibilities

As previously mentioned, the more forensic functions a practicing dentist can perform, the less information will need to be released. While it is difficult to defend universal partici-

Particularly pertinent to the issue of consent and confidentiality in forensic dentistry is the common practice of marking dental prosthetics with the owner's information.

pation in forensic identifications in typical circumstances, dentists themselves do remain a potential untapped resource for disaster scenarios. If they do not possess a modicum of basic exposure to the methods of forensic odontology, their extensive knowledge of oral structures cannot be used in situations such as mass casualties. Many healthcare professionals are bound by a duty to act when called upon in emergency situations. That is to say, many can be held accountable for failing to provide professional service, in that they have failed to uphold their obligation to beneficence. While a duty to act rarely applies to dentists, one circumstance in which it would be plausibly appropriate would be mass casualty incidents, such as acts of terrorism or natural disasters. The duty to act is most commonly applied to first responders, and while a legal duty to act may not exist when the responder is not on active duty, there has been discussion in recent years about a moral duty to act, as well as the public's perception of that moral duty (Wolfberg, 2013). As previously mentioned, forensic odontology played a major role in identifying the victims of the September 11th terrorist attacks, a process that still remains unfinished. In situations such as these,

informed dentists with a moral or legal duty to act would be of immense value, especially considering most forensic work is performed for relatively little compensation or even pro bono. However, no moral imperative effectively exists so long as a significant portion of dentists remain unfamiliar with dental forensic methods. DiMaggio, Markenson, Loo, and Redlener (2005) found that the willingness of first responders to respond to terrorist incidents was greatly increased by both having received relevant previous training and by the recency of that training. Presumably then, the provision of forensic education could greatly increase a dentist's willingness to act when a community is in dire need.

In addition to affecting the ability of dental practitioners to contribute in times of crisis, a deficiency in working knowledge of forensic odontology limits the ability of dentists to uphold their ethical and professional standards in the court of law. When dentists are sworn in as witnesses, they take an oath to speak the truth—a continuation of their ethical obligation to the professional principle of veracity. There are varying degrees of uncertainty inherent in forensic methodologies. For example, accuracy of a bite mark analysis is limited by shrinkage over time, motion of the imprinted object and completeness of the mark (Pramod, 2016). Furthermore, rugae patterns can be altered by denture wear, and due to genetic determination are more accurately associated with populations rather than individuals, thereby limiting the value of rugoscopy (Kapali, et al, 1997; Thomas & Kotze, 1983). These uncertainties greatly affect the confidence with which a dentist can provide testimony. If a dentist

is unaware of these uncertainties, he or she may inadvertently overstate the value of the evidence they are presenting, while still believing themselves to be truthful. There is a strong moral onus on the dentist to know their limitations and the limitations of their methods, in order to not only achieve accuracy (veracity), but also to avoid the maleficence of a wrongful conviction or incorrect identification. This is especially true in a legal system that requires proof beyond a reasonable doubt. The ability to parse through the shortcomings and biases of forensic evaluation is only enabled by proper training, and thus education is required for dentists to perform professionally when providing legal testimony.

Conclusion

Dental forensics remains an integral tool in identifying deceased individuals—a process of profound moral consequence, imbued with a concern for human dignity. There is evidence of a potential deficiency in forensic training at U.S. dental schools, which could engender ethical failures on the part of practicing dentists when managing patient records in circumstances such as mass casualties and during court proceedings. Irresponsible distribution of health information for forensic use poses risks to patient confidentiality. A lack of preparedness and duty to respond in times of disaster could result in an inadequate or incompetent response by the profession. Uncertainties in forensic methodologies potentially cloud the degree of veracity attainable when providing expert testimony. These concerns can be readily ameliorated through proper education,

and so, for these reasons, the profession should reevaluate the training of dentists in forensic odontology, to ensure professional obligations are met. It will be important to determine the exact nature, approach, and breadth of that training. There may be a need for content standardization to further optimize communication, and to ensure competency and validity of technique. Without such education the profession cannot discharge its ethical responsibility to the dead as well as the living. ■

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