

Dental Ethics Primer

2017 Edition

1/3/18

Bruce Peltier PhD, MBA
Larry Jenson DDS, MA

Dr. Peltier is Professor of Psychology and Ethics at the Dugoni School of Dentistry, University of the Pacific in San Francisco, where he has taught for 25 years.

Dr. Jenson served as Clinical Professor of Dentistry and Lecturer at the University of California, San Francisco for 23 years and practiced in Nevada and California for 30 years. His Master's degree is in Philosophy.

The authors of this text are dental educators and ethicists, not attorneys. Please do not construe the contents of this document to be legal advice.

Note: This version is a working draft and will be adjusted and edited in the future. Please do not forward or publish it without permission. Use bpeltier@pacific.edu to contact the authors.

DENTAL ETHICS PRIMER

Bruce Peltier PhD, MBA

Larry Jenson DDS, MA

This text is written for dental students and residents. While other readers may find it useful, its purpose is to provide a brief and clear introduction to the ethics of the profession of dentistry. A more complete introduction follows the ToC below.

TABLE OF CONTENTS

Introduction

Chapter 1: Foundations and Theory

1.1 The Nature of Dental Practice

1.2 Ethics, Law, and Risk Management

1.3 Professionalism and the Nature of Professions

Professionalism Checklist

1.4 Standard of Care and Scope of Practice

1.5 Ethical Sensitivity

1.6 Ethical Decision-Making: Essential Theories and Methods

○ The Publicity Test

○ The Driving Home Test

○ Decision Method #1: Principlism: The Principle-Based Method

The Principles

○ Decision Method #2: Utilitarian/Consequentialist

○ Decision Method #3: Values-Maximizing Method

Ozar's Hierarchy

○ Decision Method #4: The Four Quadrant Approach

An Illustration of how to use the methods

1.7 Ethics in Dental School

1.8 Building Moral Capacity

References

Chapter 2: Your Profession and its Formal Codes

2.1 Organized Dentistry

2.2 Codes of Ethics

2.3 Peer Review

References

Chapter 3: Commerce and Care

3.1: Incompatibilities and Tension (Theory)

Commerce and Care chart

Competition and cooperation

3.2: Making a Living in Dentistry

- Dentist owned and operated solo or group practice
- Dentist owned solo or group practice that hires a Dental Service Organization (DSO)
- Corporate DSO owned group practice
- Knox-Keene insurer/provider group practices
- Government agency group practice.

3.3: Specific Ethical Traps and Pitfalls in Business

3.4: Working with Third-Party Payers (“Insurance”)

Common legal and ethical traps in working with “insurance”

Conclusions

Reference

Chapter 4: Informed Consent

4.1 The Basic Concept: The Patient's Right to Choose

- The Autonomy-Paternalism Spectrum
- General Components of the Informed Consent discussion

4.2 What to Do and How to Do It (Informed Consent)

Specific components of the discussion

4.3 Who Can Consent for What?

Adults Who Cannot Consent for their Own Treatment

Summary

References

Chapter 5: Intraprofessional Relationships (other practitioners)

Cooperation and Self-Regulation

- Sharing patients
- Error
- The work of other dentists
- Gross or continual faulty treatment
- Impaired colleagues

References

Chapter 6 : Confidentiality and Mandatory Reporting

6.1: The Nature and Importance of Confidentiality

6.2: Managing Confidential Information

Record-keeping and record management

6.3: Exceptions and Mandatory Reports

- Categories of abuse
- Child abuse
- Elder abuse
- Domestic violence and abuse
- Developmentally disabled adults

6.4: Other responsibilities related to confidentiality

- Dangerous or suicidal patients
- Criminal patients
- Patients with infectious diseases
- Adolescent patients

Summary

References

Additional Resources

Chapter 7: Challenges in the Doctor-Patient Relationship

7.1: Doctor Values and Patient Values

7.2: Dual Relationships

7.3: Unacceptable Patient Behavior

7.4: Ending the Doctor-Patient Relationship

7.5: Harassment and Hostile Environment

7.6: Gifts

- Why do patients give gifts?
- Potential problems
- How to decide?
- How to respond?

Summary

References

Future Chapters and Sections:

Case Book for Discussions

Section X . Other Important Ethical Challenges

Advertising and Social Media in Dentistry

CAMBRA, Restoration, and OHI

Access to Care and the Underserved

Referring: Relationships Between Specialists and General Dentists

The Dental Team: Relationships with Assistants and Hygienists

Language, patients, and maledicta

Common ethical situations faced by dentists, hygienists, assistants, and dental students.

Glossary of Important Terms

FAQs

Recommended Readings

DENTAL ETHICS PRIMER

12/27/17

Bruce Peltier PhD, MBA
Larry Jenson DDS, MA

Introduction

Key Concepts

- ✓ Ethics is the study of right versus wrong, good or bad, and better-worse.
- ✓ Every clinical situation has ethical components.
- ✓ This text assumes you are interested in doing the right thing.
- ✓ Essential ethical skills can be taught, learned, and improved.
- ✓ No one is perfect; everyone makes clinical and ethical errors.
- ✓ There are practical (as well as emotional) benefits of doing the right thing.

Ethics is the study of right and wrong, good and bad (in the moral sense), and better or worse solutions to human problems and decisions. This introductory handbook is intended as a guide for the dentist in the process of recognizing and making daily decisions about clinical ethical behavior. It addresses these two critical questions: **How do you decide what's right and wrong,** and **how do you get yourself to actually do the right thing?**

Ethics is the study of right and wrong.

1. How do you notice ethical issues?
2. How do you decide what's right?
3. How do you get yourself to do the right thing?

Ethics also concerns itself with

questions of more better and less bad. Sometimes ethics involves a choice between two positive things or between two less desirable actions. This text uses the terms

“good” and “bad” in a moral sense rather than in a practical or preferential one. For example, a decision to take back roads instead of the freeway is a typically a practical one and the choice of raspberry ice cream over strawberry is a question of preference or taste. One could make a good decision or bad one, but these are not moral or ethical questions.

While dental education necessarily tends to focus on technical clinical tasks, ethics adds a crucial dimension. *No dental decision or clinical action is strictly technical.* The question of whether a clinical action is correct *always involves ethics.* The distinction between these two types of problems (clinical-technical and ethical) will become clear as we go along; in fact part of the study of dental ethics is making this distinction more clear. For now, consider that an ethical issue is a problem that involves questions of right and wrong and is not easily solved by a technical clinical action (such as the use of a different material). Clinical decisions are *informed* by technical considerations, but as we will see, not fully determined by them.

There is no such thing as a strictly clinical decision.

We are ethical beings, that is, most humans are by nature concerned with the effect that our behavior has on other people. This text assumes that you are deeply interested in doing the right thing in your practice. If you are uninterested in doing the right thing you will no doubt find this text worthless, and perhaps you ought to find a different occupation. But a concern for others often results in ethical questioning, and it is not always clear what we should do. Even when we are clear, we may find that others disagree, or that our preferred solution is inconvenient or embarrassing.

This text assumes that you are interested in doing the right thing.

Ethics can be taught and learned. Claims are sometimes naively made that ethics cannot be taught, or that students come to dental school more or less fully formed as ethical beings. Some believe that a person's moral attitude is set at an early

age and does not change appreciably over the years, or that some people are just good by nature while others are not. We often hear that if a certain level of moral behavior is not attained by a young age then there is little that can be done. We believe otherwise, and empirical research and teaching experience support our belief. The study of dental ethics can have a direct influence in the moral and professional development of the dentist. Studies have shown that moral development does indeed occur and is an ongoing process throughout one's life. Plus, when you become a dentist, you will be confronted with unique ethical problems that do not generally occur in normal day to day interactions outside of dental practice. **Being an ethical dental professional is a complex skill that can be successfully taught and learned.** Dental practice involves a specific set of complicated moral questions and problems that anyone who has not attended dental school would be hard pressed to understand. Most dental students arrive in school with moral values and views that were formed by families, communities, and religious environments, but they have little exposure to the challenges they will face in the clinic. As a result, they do not immediately think much about what counts as right and wrong clinical behavior. They rely on general rules and principles that are so internalized they rarely give them a thought; they act spontaneously or rely on decisions made by clinic faculty. Many dental students are shocked when they first face complicated issues on the clinic floor, and they find themselves at a loss to know what to do. This is to be expected.

Dental students can learn specific components of clinical ethical decision-making so that they can be prepared to deal with the complex and challenging ethical problems they will face in clinic and later on in their career. Such learning will greatly enhance their practice, the treatments they provide, their careers, and how they feel about their work.

This text does not intend to teach you what you should think about your clinical practice. A recent magazine essay captures this point well:

“There’s a saying common in education circles: Don’t teach students what to think; teach them how to think. The idea goes back at least as far as Socrates.”

- Lukianoff & Haidt, 2015

Conversely, this text is not aimed at turning dental students into philosophers. It is written to provide tools for moral decision-making in day-to-day clinical practice.

The study of dental ethics serves to supplement the general rules and principles that students bring to the profession and asks such questions as:

- What are the ethical issues facing me in this case? What issues lay just below the surface?
- How do I decide between one action and another? How do I get to the right answer?
- How do I make myself do the right thing, especially when it is difficult?
- Once I settle on the right thing to do and convince myself to do it, how do I proceed and what do I say?

The role of health care provider involves a multitude of important responsibilities. Dentists perform tasks that make a big difference in people’s lives, for better or for worse. They can help and they can hurt. It is essential to take these responsibilities seriously, even though the right path is not always obvious or even easy to find. Most dental students are eager to do the right thing and wary about making mistakes. This text is written to provide a map for good, solid, ethical decision-making in real life dental practice.

Here are some fundamental issues for anyone interested in dental ethics:

Who determines what counts as right or wrong behavior in the practice of dentistry? This primer asserts that what counts as right or wrong behavior is determined by all of the people who hold an interest (“stakeholders”) in healthcare;


providers, patients, and society. Professional codes of ethics such as those developed by the ADA, ACD and other professional societies are good places to start, and we will refer to their collective wisdom during our discussion of specific issues. However, current codes of ethics developed by professional organizations lack any significant input from patients and society at large and are therefore not definitive.

Another basic premise of this handbook is that **ethical questions do, indeed, have answers.** Too often we hear that ethics is a mere matter of personal opinion, that ethical questions have no “correct” answers, and that no one can say for certain what a dentist ought to do in a given clinical situation. We reject this thesis. Though ethical questions frequently require careful and nuanced consideration — and reasonable people often disagree — it is our position that reasonable people who have all the available relevant facts of a situation can and do come to conclusions about behavior that is supported by a consensus. In the end, reasonable people can at least agree to narrow down the correct answers to a very small number, and to reject other ones. In these pages, we hope to make clear what principles, rules, and actions have been generally accepted by years of scholarly thought, discussion, and clinical practice.

No text on ethics would be complete without at least a quick review of two basic frameworks for moral reasoning, development, and decision-making.

Moral Judgment: Six Stages of Moral Reasoning

The best known description of the stages of moral reasoning is that of Lawrence Kohlberg, who created a six-stage system that describes progressive “levels” of moral development. He observed that people grow from one stage to the next as they age. He asserted that the stages follow one another and cannot be skipped. Not everyone makes it to the “highest” level of moral development.



Stage One: Obedience and punishment. You are motivated and guided by a desire to stay out of “trouble.” An action is wrong because it is likely to get you punished.

Stage Two: Pragmatic individual interest. You are guided to do things based on what you can get out of them. (“What’s in it for me?”).

Stage Three: Social approval. You do things so that others will approve of you and like you. You strive to fit in.

Stage Four: Obey. You follow the rules and conform to the prevailing social norms. (“Law and order,” respect the law and maintain order.).

Stage Five: Social contract. You are motivated to uphold your end of the social bargain. If we all cooperate and behave well, we can count on each other, and we all benefit. You do your part, and rely on others to do the same.

Stage Six: Internal moral values and conscience. You do the right thing simply because you believe it is the right thing to do. You believe in “universal principles,” and your actions may not always be popular or convenient.

Background information and readings can be found at [summary of the stages](#) and [Lawrence Kohlberg](#), and [here](#). References are [below](#).

Moral Reasoning and Action: Rest’s Four Components Model

The terms *moral* and *ethical* are sometimes used interchangeably. This text uses the term “moral” to refer to the totality of one's moral existence and not just the morality that applies to one's profession. We use the term “ethical” to refer to the unique (and more narrow) moral demands and behavior of a profession like dentistry.

James Rest (Rest & Narvaez, 1994) noted that there is more to morality than just *judgment*, and he devised a system of the determinants of moral behavior that includes four parts. It is called “The Four Components Model.” These are the general components of moral behavior.

Moral reasoning and action:

- Moral Sensitivity
- Moral Judgment
- Moral Motivation
- Moral Character

Moral Sensitivity:

In order to take moral action one must first spot moral issues when they present themselves. You cannot solve an ethical issue if you don't notice it or view it as an "issue." Moral sensitivity includes an awareness that our actions will impact others. First year dental students cannot be expected to spot ethical issues in the clinic because they do not have enough clinical experience to be able to anticipate things that might happen in the future. In an ethical sense, they just don't know what they are looking at or what is liable to happen next. That said, simply getting more experience will not necessarily result in ethical competence, but the formal study of ethics increases one's ability to identify issues. Dental ethics classes are designed to accelerate your ability to spot issues in the clinic.

Moral Judgment:

Once you have recognized an ethical problem, you are confronted with a decision about what to do. As mentioned, we often act spontaneously based upon the internalized rules and principles we learned while growing up, or by our perception of social norms. Beginners (appropriately) make decisions that imitate the behavior of their teachers. These approaches lack an important ingredient: that of reflection and reasoning. A course or handbook in dental ethics offers guidance on effective reflection and reasoning about ethical problems. A dentist ought to be able to give good reasons for his or her ethical behavior just as a dentist ought to be able to justify any diagnosis or treatment decision. This handbook will offer a variety of reasoning methods to clarify and improve your ethical choices.

Moral Motivation:

If one has recognized an ethical issue and reasoned well to a good decision (the right thing to do), two questions still remain: *Why do the right thing?* and *How do you get yourself to do it?* Make no mistake: Ethical action can be difficult, and sometimes

embarrassing or costly. Good ethics can seem to get in the way of good money, for example.

One essential motivation is a personal commitment to becoming a *professional*. This text will examine the crucial question: *What does it mean to be a professional, and why should you care?*

Moral Character and Action:

Lastly, one might aspire to be a professional, become good at recognizing ethical problems, and learn to reason well about these problems, yet still fail to behave in an ethical manner. You must implement your decision and put it into action. Knowing the right thing is not the same as effectively doing the right thing. Why is this so? It is often difficult, awkward, and uncomfortable to implement the right decision, and there are practical ways to accomplish effective ethical action. Such solutions typically involve sophisticated communication. This skill, while not always easy, can be learned with thought, rehearsal, practice, and then reflection.

Some additional thoughts

Professional ethical decisions often (but not always) involve personal sacrifice. There are actually several good, practical reasons to do the right thing. When you do the right thing:

- It tends to be good for other people.
- People like you better.
- It is a great practice builder.
- It tends to keep you out of “trouble.”
- You feel better at the end of the day.

There are smart, practical reasons to do the right thing.

The downsides of good ethical action and practice are few, and they tend to be temporary. Sometimes ethical action costs you money, as you might refund a fee or redo a treatment for no additional charge. Sometimes it can be embarrassing to admit a mistake in practice or judgment. But these negatives aren't long-lasting, while your reputation is. The overall impact of a good decision tends to be positive over the long haul.

Ultimately, development of the moral skills and resolve needed to act ethically is up to each individual dentist. We hope to encourage commitment and aspiration. We believe that reflection on professionalism and the benefits of high ethical behavior will lead to a deep sense of personal satisfaction in the admirable profession you have decided to join. Wouldn't you rather feel good about yourself and your work?

This text is written to provide basic background instruction for dental students, and it is written for anyone desiring a fundamental understanding of the discipline of applied clinical dental ethics. You will not find it to be highly philosophical, although the basics of moral philosophy are included as necessary. We hope that you will find it readable, instructive, and useful as you begin your journey as a doctor and professional in the healing arts.

References

- Kohlberg, L. (1981) *Essays on Moral Development: Vol. 1, The Philosophy of Moral Development*. San Francisco: Harper and Row.
- Kohlberg, L. (1984) *Essays on Moral Development: Vol. 2, The Psychology of Moral Development*. San Francisco: Harper and Row.
- Lukianoff, G. & Haidt, J. (2015). The coddling of the American mind. *The Atlantic*, September. (<http://www.theatlantic.com/magazine/archive/2015/09/the-coddling-of-the-american-mind/399356/>).
- Rest, J. & Narva'ez, D. (1994). *Moral Development in the Professions: Psychology and Applied Ethics*. Hillsdale, NJ: Lawrence Erlbaum.

Chapter 1: Foundations and Theory

Peltier & Jenson

(12/26/17)

1.1 The Nature of Dental Practice

1.2 Ethics, Law, and Risk Management

1.3 Professionalism and the Nature of Professions

Professionalism Checklist

1.4 Standard of Care and Scope of Practice

1.5 Ethical Sensitivity

1.6 Ethical Decision-Making: Essential Theories and Methods

The Publicity Test

The Driving Home Test

Decision Method #1: Principlism: The Principle-Based Method

The Principles

Decision Method #2: Utilitarian/Consequentialist

Decision Method #3: Values-Maximizing Method

Ozar's Hierarchy

Decision Method #4: The Four Quadrant Approach

An Illustration of how to use the methods

1.7 Ethics in Dental School

1.8 Building Moral Capacity

References

Key Concepts

- ✓ Several aspects of clinical dental practice make good ethics difficult.
- ✓ It's important to understand the difference between Law, Risk Management, and Ethics.
- ✓ "Professionalism" is an important, yet complex and poorly understood concept.
- ✓ Professionals take excellent care of people who do not understand (and cannot evaluate) what they do.
- ✓ You must practice within the Standard of Care and your Scope of Practice.
- ✓ Standard of Care and Scope of Practice are complicated, poorly understood concepts.
- ✓ It is typically impossible to know, for certain, the standard of care in individual clinical cases.
- ✓ There are two elements of Scope of Practice: the scope of dentistry in general and your personal scope of competence.
- ✓ Four formal methods for ethical decision-making and two informal ones are described in detail in this chapter.
- ✓ Dental students face ethical quandaries every day.

Section 1.1: The Nature of Dental Practice

Good, ethical practice is challenged by numerous realities of modern dental practice.

What follows are some important components of dental practice that can influence your ethical decision-making. Dental school is difficult enough, but the actual practice of dentistry is challenging in ways that directly and indirectly influence moral behavior.

- Dentistry is generally hard and stressful.
- Dentistry is practiced in a competitive market arena.
- Dentistry is a people business.
- Dentistry is service-oriented.
- There are always three treatment options.
- Third-party payers (“insurance” plans) influence decision-making.
- You are always looking at other dentists’ work.
- You can always get sued.

Dental practice is hard, and it is stressful.

The practice of dentistry is difficult in several ways. On a very basic level it is physically hard. The hours can be long, and the work can be damaging to one’s body. The ranks of dentistry are riddled with those whose necks, backs, elbows, and ears have been ruined by the grind.

The work is interpersonally stressful. Patients fear the dental appointment. Many have had traumatizing experiences in the past, some due to the behavior of other dentists, some due to their own personal negligence, and some due to the nature of dentition and the life process. Many patients perceive (falsely, of course) that you, their dentist, should assume all the responsibility for their oral health. Some patients, in response to powerful feelings of anxiety or loss of control, behave poorly or strangely in

the operatory. Some act irresponsibly and miss appointments or show up late. Others complain about the high cost. Many feel compelled to tell you how much they dislike dentistry.

The management and leadership of a dental office is typically complex and challenging. Team members don't always behave perfectly, and staff turnover is common. Sometimes they don't get along with each other. Some patients try to pit or triangulate office staff against the dentist to get their way. Occasionally team members triangulate patients against the doctor.

The work is hard from a business perspective. It is not always easy to make ends meet, to bring in more money than you pay out, and to make a worthwhile amount of profit. When you don't have enough patients you don't bring in enough revenue; when you have more patients the work-load is higher and harder. In other words, dentists can feel stressed when patients do show up and when they don't. Dental practices are very costly to run, and only the dentist can truly appreciate that particular stress. All of this is made more challenging because dentistry is expensive relative to average American incomes and to the cost of things that people routinely purchase. As an example, a root-canal and crown can cost \$3,000, an amount that's roughly equivalent to a school teacher's after-tax income for an entire month.

Dentists traditionally value perfection. It is a standard taught in dental school and advocated later, yet impossible to attain. Reconciling one's actual practice against a standard of perfection is stressful for many.

Dentistry is practiced in the context of a competitive, commercial, free-market economic environment.

Dentistry in the United States is practiced mostly in the marketplace, meaning that practitioners are compensated for their work in the context of a buyer-seller exchange. Buyers and sellers compete, each striving to make their best "deal." The

arrangement works well in the everyday interactions found in stores, but creates profound ethical challenges in the healthcare arena, mostly because patients cannot effectively compete with doctors. Caveat emptor, or “buyer beware” is a defining characteristic of the commercial marketplace, but it has no place in the doctor-patient relationship. Instead, patients must trust doctors to look after *their* interests as well as the doctor’s own interests. This important matter is examined in depth later in this text.

Dentistry is a people business.

Dental education tends to focus on the technical aspects of care, the preps, the margins, the occlusion, the anatomy, and the materials and procedures. Virtually all dentists eventually become competent or expert in these aspects. But, interpersonal interactions with patients and team members tend to be endlessly challenging. As Sartre noted in his 1943 play *Huis Clos (No Exit)*, “Hell is other people.”

Unlike physicians, dentists spend significant time with their patients. While an M.D. might spend 12-15 minutes in a consultation, dentists sometimes spend anywhere from thirty minutes to three hours with the same patient. Dentists also put their hands and instruments to work on patients for long periods while patients are in a conscious, aware, uncomfortable state; in most cases dentists do not have the luxury of putting patients to “sleep” for long surgical procedures.

Dentistry is a service-oriented enterprise in healthcare.

The whole point of being a doctor is to provide service to others who need it, cannot take care of it for themselves, and may not even comprehend it. This requires a somewhat selfless point of view as well as occasional self-sacrifice. One need not *always* put patient needs ahead of one’s own, as this would eventually lead to burnout or compassion fatigue; however, it is the defining feature of a professional to effectively serve others.

There are always at least three treatment options.

While many patients expect their dentist to simply make a proper diagnosis and then execute the proper treatment, it turns out that there are typically several adequate options in every clinical situation, such as:

1. The optimal treatment (often the most expensive).
2. Alternative treatments (including extractions) that are acceptable and usually less expensive.
3. Doing nothing (patients always have this choice). The choice to do nothing is rarely life-threatening in dentistry.

Three treatment options:

- Optimal tx
- Alternatives
- Do nothing

These options open the door to numerous complicated opportunities for ethical challenges when negotiating a treatment plan, especially when money is tight for the patient or when dental (insurance) plans are involved in treatment decisions. Decisions are often complicated by the fact that patients and dentists do not always share the same values when it comes to dentition. It can be heartbreaking to extract a tooth when better, more complex and costly options exist, but many patients simply do not value their teeth as the dentist does.

Third-party payers (“insurance”) play an important role, for better or worse.

Dental “insurance” is a wonderful and troublesome thing, both at the same time. It is wonderful because it allows for the cost of dental care to be spread over large numbers of people and long periods of time, subsidized by employers, so that care becomes affordable when a patient needs it. However, it is unfortunate when insurance rules and cost-cutting measures interfere with good treatment decisions. Dentists are regularly confronted with quandaries related to dental plan coverage of treatments. Some patients have become “spoiled” by their medical plans, such that they do not feel that they should have to pay anything out of pocket for their care. Dental insurance, unlike medical insurance, rarely covers all needed treatment. Some

patients will consent only to treatments that their plan will cover, while others fully expect their dentist to routinely waive co-payments, which is illegal. Occasionally a plan will only pay for a treatment that seems inferior.

You are constantly looking at another dentist's work.

This might not sound like a very big deal, but it can be difficult to know what to do when you see treatments (or lack of treatment) that seem bad or dangerous. Often patients do not even know that anything is wrong, and they really must be informed. As you will learn later in this text, you have a duty to inform patients about the “current status of their oral health.” You must tell them what you see. But, you really don't know how it happened, how they ended up with something inadequate or even dangerous in their mouth. So, you must restrain yourself and avoid criticizing other practitioners or even speculating much about the situation. This is not always an easy discussion, and patient reactions vary significantly. Sometimes they are glad that you told them, sometimes they get annoyed or angry or even suspicious. They are often confused. Sometimes they might try to recruit you in a blame game that might result in litigation.

You can always get sued.

The following question inevitably comes up in discussions of cases involving dental ethics: “*Could I get sued...?*” The answer in every case is: Yes. Health care providers can always be sued. This does not mean that you will lose that lawsuit, but it will no doubt cause you some distress. Fear of lawsuits is a sad component of the American healthcare scene. The upside of suits is that patients have some recourse when doctors have done them wrong, made an error, or mistreated them. Lawsuits do have a way of keeping providers “honest,” but this aspect of the doctor-patient relationship comes with significant negative side-effects.

You can
always get
sued.

Sometimes dentists are victims of specious legal actions. The most pervasive side-effect however, is that risk management sometimes takes center stage in patient care. Discussions of ethics aimed at determining right action get washed away by the specter of a lawsuit. This can cause people to take actions that are aimed at self-protection rather than the best interests of the patient. This is certainly an ethical problem.

“One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions.”

- Arnold Lazarus, 1994

Ethical practice takes courage, and the most conservative, risk-averse action is not always the right way to practice. Dental practice involves risk. In the end, there is no certain way around that. The best defense is to practice competently and conscientiously at all times, take good care of patients, have prudent practice management policies, have a thorough understanding of the law and associated rules of conduct, keep diligent records, always strive for clear informed consent, and maintain viable malpractice insurance. Sometimes the best defense is to simply say no and decline to treat a patient. Even then, there are no guarantees that a suit will never be brought against you.

Sometimes dentists (and healthcare providers in general) respond to this reality by becoming overly defensive, by viewing patients as threats, and by withdrawing from all conceivable risks. This can surely result in unethical behavior and poor care and, as we will see later in this text, it does not tend to keep patient needs in the forefront of one’s practice. Thus, the role of being a “doctor” requires courage.

Section 1.2: Ethics, Law, and Risk Management

Ethics, law, and risk management have differing purposes and goals. Each is important. It is useful to understand the relationship between them.

Basic definitions are a good place to begin a study of professional ethics. When dentists and students discuss cases and the matter of ethics comes up, the discussion often goes into the weeds because discussants do not have a clear framework to organize their ideas and assertions. This chapter is written to define, organize, and clarify the difference between law, ethics, and risk management in dental practice.

This text focuses on right and wrong behavior in your role as a dentist.

Discerning right from wrong may seem simple at first. However, "right" and "wrong" are terms that mean different things in different contexts. Consider, for instance, your choice of material to be used for a restorative procedure. Choosing the wrong material in clinical situation might be said to be "wrong" in a *technical* sense: you should have known that it would not work well given the clinical circumstances. However, it may not be "wrong" under the law, and it may not be "wrong" in the ethical sense either. An action could also be technically correct, but ethically wrong (e.g., putting a perfect crown on a tooth that did not need a crown). This section will help make these distinctions clear.

Laws are written by legislators, to create formal rules to constrain the behavior of practitioners, mostly with a goal of patient safety. As a practitioner you obviously have a responsibility to know the law and to practice within it. These laws form the *lowest* standard of behavior expected of dentists, hygienists, assistants, and other providers. If you think about it, they are mostly written for practitioners who need clear, strict guidance so that they do not do things that will hurt or cheat patients. They are written for the least ethical members of the profession, and many dentists hardly need to pay much attention to laws because their professional

Laws
represent the
lowest level
of expected
behavior.

standards are generally much higher than laws dictate. The state is most interested in protecting the public from people who are not qualified to practice dentistry, who are dishonest, incompetent, or impaired. Everyone needs to be aware of the law, but it is unwise to focus your practice on just meeting legal standards and staying out of trouble. It is an unsatisfying and often unprofitable way to practice.

Dental law is promulgated in a document called “The Dental Practice Act.” Each state has its own Act that is written by experts and government administrators and published by the state dental board. Dental law varies somewhat from state to state. Dental Practice Acts are typically full of bureaucratic language that non-lawyers and regular people cannot readily understand. They contain pages and pages of administrative details, but in the end, the law asserts this: You must practice within the *Standard of Care* and within your *Scope of Practice*. Those two concepts are complex and important, and they are discussed in detail in the pages ahead. Dental Practice Acts do relatively little to define clinical standards. Dental law rarely gives specific direction on how to practice dentistry day-to-day. Legislatures and courts give the profession wide latitude in deciding for itself how dentistry is to be taught and practiced. You will not find clinical standards or the ethics of the profession in the Dental Practice Act, nor will you find the standard of care that determines what constitutes dental malpractice. This is good news for dentistry, as it allows the profession to determine these things for itself for the most part.

You must practice within the **Standard of Care** and your **Scope of Practice**.

Dental malpractice is closely related to law. While both are part of the legal landscape, dental law is concerned with crimes, penalties, and sanctions imposed by the state, while dental malpractice is concerned with civil actions (lawsuits brought by patients). You can commit malpractice without losing your license, and you can commit

a crime under the dental practice act without being sued for malpractice. Sometimes both happen at the same time.

Risk management is an important concept that focuses on the well-being and security of one's dental practice and license. Doctors manage risk so that they (themselves) are safe. It has little to do with patient well-being, except as it impacts one's practice. Risk management is about staying out of trouble, avoiding lawsuits, and maintaining one's license to continue to practice. This is extremely important, and worth attending to. That said, risk management is not the same as ethics, and sometimes dentists, when faced with an ethical quandary, focus first on self-protection. Such a focus can start an ethics discussion off on a wrong track, where patient well-being takes a back seat. For example, when a student asks how to handle a complicated clinical-ethical situation, many faculty members answer with the old saw: "*Document, document, document.*" While good documentation is extremely important, it is usually not the answer to a question of ethics. This bit of faculty advice — while worthy on its face — is prescribed to protect practitioners from patients and lawyers, and not necessarily to help the patient. If the discussion stops there, ethics never even gets consideration.

Risk Management focuses on protecting the dentist from harm.

Taken to an extreme, the surest method to minimize risk would be to decline to treat patients at all (except in a medical emergency). That makes no sense.

Ethics is about right and wrong; good and bad; and better or worse. It is about the task of discerning the best, right action and then taking it. Laws and ethics inform each other and are generally aligned. Laws, at their best, are a codified version of what the community perceives to be fair and safe, and one's ethics typically represent a higher standard than what law

Ethics is about **right and wrong.**

prescribes. Ethics tend to be aspirational, representing a view of how one would like to be when they are at their best.

Practicing within the law and avoiding malpractice suits does not make one an ethical dentist. This concept is one of the most difficult to understand. Many dentists believe that if they practice within the law and do not damage a patient through negligence, they have met their professional obligations. Nothing could be farther from the truth. Dentistry is a profession (a term to be defined and discussed later), and those who become part of the profession agree to abide by its obligations. There are significant obligations owed by professions in addition to those stipulated by law. Abiding by the law that governs the practice of dentistry is the absolute minimum behavioral requirement for dentists. It is possible to do something that is perfectly legal, but ethically questionable.

Consider this example: you can get your patient to follow your treatment recommendation by deceiving or coercing them.

This action is not specifically illegal according to the dental practice act and unless your care is negligent and the outcome a bad one, it is not grounds for malpractice. Nonetheless, lying to patients or shading the truth for such a reason is typically considered to be unethical. Along the same lines, it is often possible to convince patients to consent to treatments that, while perfectly legal, are treatments that are not best for them.

Unlike the situation in dental law, there are usually no sanctions against you for practicing unethically. That's mostly true, but if you belong to a professional organization such as the American Dental Society, you could lose your membership due to unethical behavior. As mentioned earlier, legislatures, courts, and society allow the dental profession to be self-regulating; they expect that as a professional you will not

only practice ethically yourself, but you will take action when other dental professionals are acting poorly.

This entire text is intended to help you understand exactly what your ethical obligations are and what is expected of you as a professional.

Section 1.3: **Professionalism and the Nature of Professions**

Professionalism and the term “professional” are of extreme importance to dentistry, yet the concepts are poorly defined and often misused. Clear thinking about these abstractions is essential to your development and identity.

Every student of the healing arts hears the term “*Professional*” frequently throughout their schooling. The sheer number of times you hear it begins to wear on you soon after matriculation, and problems with the term are magnified by the way that different authority figures use the word. It’s difficult to know what your professors and mentors actually mean when they urge you to be professional. In fact, it’s entirely possible that they don’t really know what they mean when they say it. Often the term is used to nudge you to “straighten up,” to work harder, to prepare better, to be on time, to look neater or more formal, to wear your name badge, and to improve your manners. These are all good things, but it’s confusing to use the term “professional” to communicate them. And it cheapens a very important concept.

The term “professional” and the idea of a profession have a long and interesting history. Dentistry was not always a profession, and its roots were in the trades. Historically, craftspeople such as carpenters, electricians, and printers were considered “tradesmen.” Trades people formed unions and guilds which tended to look (only) after the interest of their members, in a structured way.

Doctors, lawyers, psychologists, and accountants are considered professionals and are members of a profession. While some of the distinctions are a bit arbitrary and

even self-serving, there is a way to view professions that is of great value. What follows is a definition and description of the concept of “professional” that should be useful in your career.

First, clear your mind of all the things you’ve been told about being professional, especially those things related to manners and dress. This definition has little to do with whether you wear a tie or appropriate blouse.

The key idea is this: *As a professional, people (patients) who are in a vulnerable position can count on you to serve them well.* Your patients do not understand their dental situation in any deep way, and must rely on you to take care of them. In fact, **they must trust you to tell them what they need to know, and to do an excellent job.**

Patients must *trust* professionals to take good care of them.

When that job is done, they have no effective way to evaluate what you did, so they must assume you did the right thing. This differences in the power and informational dynamics of the relationship are what makes it unique and makes professional behavior so important.

There are five components of this definition.

Component one. Professionals possess an important and exclusive expertise. This expertise is relatively rare and hard to come by. Dental school is difficult, long, and expensive, and few people possess a DDS or DMD. By the time you have a few years of practice experience under your belt you will possess a high level of competence and you will use special instruments and equipment that are not available to the public. Your skills are of extreme importance to the community, and patients become acutely aware of your importance when they have a toothache. They are not aware of the range of devastating things that can happen to their oral cavity and the potential dangers involved in your treatments (including possible death). Professionals refrain from taking advantage of their status and do not

Important and exclusive expertise.

hustle the public or make claims that cannot be substantiated. This would be relatively easy to do, but tends to diminish public trust and jeopardize public health.

Your special expertise and status constitute a monopoly for all intents and purposes. Only dentists (or other licensed care-givers) can provide dental care. Unlicensed dentistry is against the law. Patients cannot restore their own teeth. They occasionally extract a tooth using pliers in the garage, but that's obviously a terrible idea. Patients need you, with your special skills and instruments.

Autonomous
practice.

Component two. You practice autonomously. No one outside of dentistry tells dentists how to practice. There are, of course, laws written by legislators that constrain dentistry, but those laws essentially require that you practice within the standard of care and within your scope of practice. Those two essential concepts are described later, and they are defined by dentists, not legislators or bureaucrats.

Professional autonomy is attractive, and you may, in fact, have picked a career in dentistry because of the autonomy that dentists enjoy in practice. There are hundreds of examples of your professional autonomy. You can choose what treatments to provide, you can decide whether you will perform root canals or orthodontics, and you can add treatments (such as implants) to your repertoire by enhancing your skill set. Once you have learned how to perform a new treatment, you get to decide when you are ready to perform it on a real patient in actual practice. You don't have to check with anybody, and the public must trust your judgment. You can decide whether to practice on weekends, you can decide who you want to treat, and you decide what you will charge for your services.

Component three. In exchange for your autonomy you have an obligation to be competent and trustworthy. A professional has mastered his or her skills, and they continue to sharpen and develop

Competent
(excellent) and
trustworthy.

those skills and judgment throughout their career. This is something of a “social contract.” If the public is going to trust you, you must be trustworthy. It’s a kind of an exchange, although most people don’t think of it very often. Doctors are granted autonomy as long as they perform an important social good on behalf of patients and the public. This social good probably includes some responsibility for the dental care of all the public, and that challenge will be explored in a subsequent chapter. If dentists were to lose the trust of the public, legislators and lawyers might create restrictive laws and rules. OSHA regulations are an example. Dentists usually do not like these constraints.

Component four. Professions create structure for themselves

in the form of professional organizations such as the American Dental Association. Dentists formally organize themselves to ensure that members are trustworthy. Professionals manage the behavior of other practitioners on behalf of the public. When they become aware of poor or dangerous behavior of a colleague they find a way to remedy the situation. They self-regulate on behalf of the public interest, partly because the public cannot do this effectively (they can’t understand what you do). This self-regulation serves to protect your professional autonomy, reducing the essential role of government in regulation of the activities of the profession, and allows members to take charge of the evolution of the field. Professional organizations serve to manage the behavior of members, and to enhance the expertise of practitioners. Professionals are in a far better position to make rules for each other, as they understand things from the perspective of an insider, and they have the interests of practitioners as well as patients in mind. They have a more nuanced view of the situation than legislators typically possess. In addition to providing structure and education, professional organizations also create and reinforce norms for the profession. Professional organizations publish written codes to express those norms for all to see, and members strive to adhere to the codes.

Professionals
organize to
self-manage.

Component five: Doctors sacrifice for the patient's best interest.

While it is not necessary to put your patient's interests *ahead* of your own *at all times*, a professional dentist must occasionally be willing to make sacrifices of their personal interests in order to serve their patients properly.

Professionals
prioritize
patient needs.

For example, dentists must accept:

- **Greater than normal health risks:** Patient care frequently requires one to treat patients with infectious diseases. Denying a patient care due the patient's infectious status would be unprofessional in all but rare cases.
- **Greater than normal legal risks:** every patient encounter could potentially become a malpractice suit. Denying a patient care or altering a treatment plan to avoid legal risk is generally unprofessional behavior.
- **Greater than normal financial risks:** the business of dentistry is not the same as commercial businesses. Denying a patient appropriate care based on the patient's financial situation can be unprofessional. You have duties to your patient's health that are somewhat independent of their payments. The health and well-being of the patient are central; money is important, but secondary. This concept is discussed in more detail later in this text.
- **Greater than normal inconvenience and personal discomfort:** Patient needs do not always occur during business hours and often require unanticipated extra time to resolve. Dentistry is physically, emotionally, and mentally challenging work. Achieving excellence in treatment often takes a toll on a dentist's body.
- **Some level of uncooperative patient behavior:** denying a patient care solely due the patient's uncooperative behavior would be unprofessional in some

Professionals
endure risks
and discomfort.

cases. Many patients are lovely people who manifest their fear of dentistry by behaving poorly.

There are other qualities that contribute to the concept of professionalism. A true professional can be counted on in several related dimensions.

- Professionals have mastered their skills, and continue to sharpen and develop those skills throughout their career.
- Professionals possess a service orientation. They focus primarily on the service they can provide the public, and they tend to make a good living by doing this. The health and well-being of the patient are central; money is important, but secondary to service. (This does not necessarily mean that professionals must put patient needs ahead of their own at all times, but some self-sacrifice is required from time to time).
- Professionals manage the behavior of fellow practitioners on behalf of the public. When they become aware of poor or dangerous behavior of a colleague they find a way to remedy the situation.
- Professionals refrain from taking advantage of their status and do not hustle the public or make claims that cannot be substantiated. This would be relatively easy to do, but tends to diminish public trust and jeopardize public health.

Manners and Attire. The way you dress and the way that you treat others is obviously salient in any discussion of professionalism. Most important is the way that you treat patients and behave around them. Because patients are the *point* of the entire professional enterprise, they are to be treated with the utmost respect. This is true even when they do not behave ideally, when they are “difficult” or challenging to you, and especially when they do not understand your care, methods, or treatments.

Your appearance and behavior should engender trust and respect.

True professionalism requires that health care practitioners be fully present when interacting with patients, and not allow themselves to be distracted by the infinite number of other things there are to think about. Professionalism includes a respect for your patients' time and attention, and you shouldn't keep them waiting unnecessarily. Your language must be understandable and respectful, and your attire should communicate conscientious attention to detail and meticulous cleanliness. The particular clothing or haircut fashion you choose is your business, but it certainly ought not offend or put your patients off. The way that you look and behave influences the way that patients decide to trust you—or not. When they trust you, they can feel safe and can relax and participate effectively in treatment.

Be fully present

Identity. It is ideal when dental students and young dentists adopt the *identity* of a professional. This means that you invest in your career in ways that are personal, and that you come to view your profession as an essential, cherished part of who you are. You don't just "do" dentistry; *you are a dentist*, and you feel a deep sense of pride and joy about that. A high level of "professional" behavior becomes normal and natural for you. Your "work" becomes less onerous and more joyful, and care of patients is viewed as a duty that you feel privileged to discharge. Eventually, it becomes difficult to even think of yourself detached from your sense of being a doctor. It's part of who you are.

Adopt the identity of a professional.

Review: Quick Summary Checklist on Professionalism

A professional:

- ✓ **Provides a service that is difficult to learn**, involving a skill-set that requires extensive formal education and training. Few people possess the necessary skills and knowledge.
- ✓ **Has mastered the skills**. Has a deep understanding of the area of expertise, and can be counted on to deliver services at a consistently high level, even when conditions vary from standard situations.
- ✓ **Performs activities that are important** (they may involve life-threatening or life-saving situations, or situations that are irreversible and non-trivial).
- ✓ **Performs services for people who are in a vulnerable position**. Dentistry involves a fiduciary relationship wherein a person must trust a professional. The patient cannot adequately evaluate the situation or the actions of the professional. The person receiving the services is not able to direct the provider. As a result, the provider must be trustworthy.
- ✓ **Has a monopoly**. People outside of the profession are not permitted to perform these services or activities.
- ✓ **Makes sacrifices for the benefit of patients**. Service to others is central to the identity of the person and the group (the “profession”). Health and well-being of the client or patient are central; money is important, but secondary. (This does not necessarily mean that professionals must put

patient needs ahead of their own at all times, but such self-sacrifice is required from time to time).

- ✓ Belongs to a group of people who **formally organize themselves** to maintain high standards, self-regulate on behalf of the public interest, and maintain a service orientation. This serves to protect professional autonomy, reducing the essential role of government in regulation of the activities of the profession and allows members to take charge of the evolution of the field.

Section 1.4: Standard of Care and Scope of Practice

Two foundational concepts – standard of care and scope of practice – describe and limit the clinical treatments and activities of dentistry. They are very important, yet somewhat difficult to define.

While these concepts are essentially legal in nature, they are so fundamental that students must understand them in order to practice ethically.

In every patient encounter, you are confronted by a variety of questions about what to do. There are technical questions about the right tests and radiographs to order, the right way to examine the patient, the right way to arrive at a diagnosis, the right way to select therapy that will help the patient, and also questions about what you are legally allowed to do. These questions are best answered by reference to empirical research and accepted practices and the law. But there are also non-technical questions that will determine how you treat patients correctly. These questions involve ethics, psychology, and communication, and are not easily answered by referring to the dental research literature, accepted practice, and the law.

Dental Practice Acts and Codes of Ethics are essential guides to clinical practice, but they are not always very helpful, as they tend to be vague and offer only guidelines. They almost never answer the following clinical questions: *“What should I do now?”* or *“What is the correct treatment in this case?”* or even *“What material should I use?”* This problem highlights the importance of ethical decision skills. When laws and codes are vague or insufficient, ethical tools can fill the gaps.

The Dental Practice Act is not very helpful.

Most of the answers to these questions are based on patient characteristics and technical options, and there are always options. Nonetheless, anything you do for a patient *must* align with the standard of care and *must* be within your scope of practice

and competence. This chapter will define both of those concepts and briefly describe some complications. A more detailed discussion can be found in the essay, “Standard of Care” by Curley & Peltier (2013).

Standard of Care

Healthcare rules and dental law require that you practice “within the standard of care.” In order to meet legal standards of negligence and malpractice attorneys must show that the behavior of the clinician was not within the standard of care. Practicing below the standard of care is considered negligence because it puts patients at risk for harm and will play an important role in deciding whether or not malpractice has occurred. This obviously means that you must know what the standard of care is at all times. If you don’t know the standard of care, you must figure it out before you execute a treatment.

Standard of Care is an essential but difficult concept to understand.

It is hard to imagine a concept in health care more important than standard of care. Virtually every clinical decision must conform to that standard. It seems strange, then, that there is so much confusion and misconception about the concept. This confusion is rarely articulated.

- Curley & Peltier, 2013, p. 53

Standards of care delineate the dental procedures and techniques that are least likely to harm patients and most likely to help them. These standards are in most cases rather well established, and should be known by any well-educated and up-to date practitioner. In some specific cases the standard of care is not clear and can only be determined by evidence and testimony by experts in the field, usually in a court of law. In still other cases, there may be no standard of care because there is not enough evidence to establish one. Nonetheless, the burden is on the dentist to determine what the standard of care is and whether or not he or she is practicing within that standard.

The dentist cannot simply look to legal statutes to determine the standard of care because legislatures, in general, do not determine the nature of clinical care; they leave this up to the profession. It is important to note that the standard of care is not written down in any one single place. You cannot find a website that defines it. Furthermore, the standard of care is dynamic. It's changing all the time. As new materials, techniques, and equipment evolve, so do the standards. It's a moving target and practitioners have to keep up.

The Standard of Care evolves over time.

Dental students are confronted with the following koan:

1. You must always practice within the standard of care.
2. (Therefore) you must know the standard of care.
3. There is no single place where you can go to look up the standard of care.
4. It is typically not possible to know, for certain, the standard of care in the case facing you in your operatory.

We can extend the confusion by adding that various experts and veterans do not always agree on the standard of care in many clinical situations. To make things worse, egos get involved, and clinicians sometimes cling to their own preferences as if they were dogma.

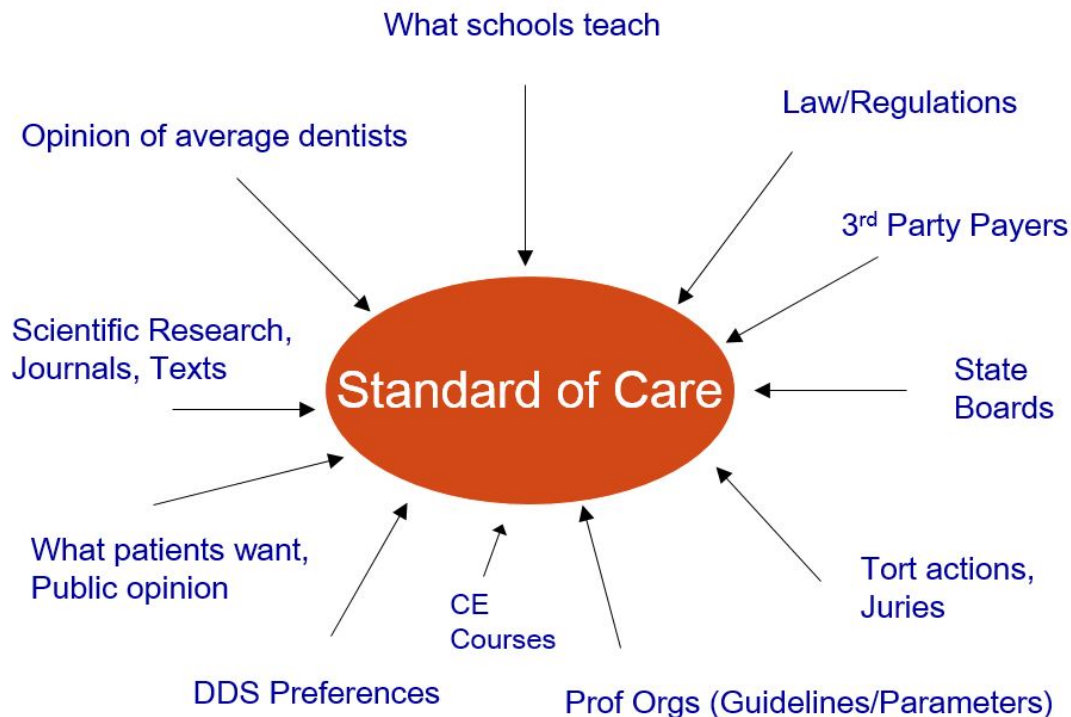
The simple answer. If you call an attorney (who specializes in healthcare) he or she will tell you that the standard of care is:

“The level of care that a reasonably prudent dentist would exercise under the same or similar circumstances, time, and location.” (Curley & Peltier, 2013).

This definition is brief, legal, and actually pretty vague, but it is used all the time. You will be held to this standard if you end up in court. This definition implies that you could get a pretty good idea about the standard of care if you asked several competent, well-informed, reasonably prudent colleagues.

The Standard of Care is essentially a group opinion.

The more complete picture. While there is no perfect single place where you can find the answer to the question, “*What should I do?*” there are obviously many sources to turn to. The chart below shows you most of them.



These are sources that contribute to the standard of care. Some of them (such as professional organizations) often think that they define the standard, but they do not. They contribute in important ways. In actual fact, unless a similar case or situation has been litigated or regulated, the opinion of professional organizations is just that – an opinion (Curley & Peltier, 2013, p. 56).

Happily, it is not up to lawyers or legislators to determine the standard of care for dentistry. Because of the professional autonomy that dentists enjoy, dentists generally determine the standard of care in dentistry. While there are a few clear exceptions (HIPAA and some government regulations) the standard gets articulated (only) when adjudicated in court. In legal cases (when a patient sues a dentist) each side recruits the best expert they can afford (usually a dentist or a scientist or both), and the experts opine about their

view of the clinical or technical standard of care that should have

Two situations where you know the SOC for certain:

1. When law defines it explicitly (rare).
2. When a court renders a decision on a specific case (also rare).

been rendered in the case at hand. Then a judge or jury deliberates and decides which expert was most compelling. That opinion becomes the standard of care for situations exactly like the one in court, and everyone else watches from the sidelines to figure out what that legal opinion might mean if they ended up in court in a similar case. This then informs us of what the standard of care is *likely* to be in our own clinical situations.

Best Practices. “Best practices” delineate the dental procedures and techniques that experts feel are most likely to be effective in helping patients; these are also determined by research and experience, and are often published in professional journals. As with standards of care, there are many procedures and techniques that have been well established as best practices, and other situations that have not yet been determined to have a best practice. Often best practices are evolving and in transition. It is up to the dentist to be up to date on best practices for any procedure he or she performs. In the absence of evidence for a best practice, a dentist may choose a procedure or technique that is within the standard of care and has produced good results in her or his clinical experience.

In specific clinical cases one may not know the standard of care, so doctors must practice based upon their best educated guess of what that might be. This guess is

called “clinical judgment.” The clinical judgment of a beginner is obviously not as well-developed as that of a veteran, so beginners must regularly seek consultation.

There are many different ways to practice dentistry that are within the standard of care. For example, the selection of impression materials and techniques includes dozens of formulations and technologies. There is wide latitude within the profession on what procedures and techniques a dentist may use to achieve an outcome and every dentist has the right to personal preferences when there is no clear consensus on which procedure or techniques is most effective. The law and the dental profession could not possibly stipulate every critical technical decision a dentist must make in their treatment of patients, so a dentist has a general, broad authority to determine how best to manage any procedure she or he might attempt.

The bottom line. Except when clear regulations exist, there is no way to know the standard of care for certain ahead of time. Your best bet is:

1. Check to see if a government regulation exists that might cover your clinical situation. This is usually not the case.
2. Ask smart colleagues or experts what they would do. Find out what they think the best treatment or decision would be. Stay connected to your colleagues.
3. Read available practice guidelines found in your professional journals. Stay current.
4. Take continuing education seriously. You must take a certain amount of CE courses each licensing cycle. Use those courses to maintain and upgrade your skills and judgment.
5. Practice as you were taught in dental school.

6. Do what is in the best interest of your patient. Keep this in mind at all times.

Some important things to keep in mind about the standard of care:

- Standards do not really vary from community to community (even though many people think that they do, and actual practices may vary). Today, with easy access to the same information, all dentists who practice within the United States can be expected to be held to the same standard of care. Rural dentists can access the latest innovations and practices using the internet. They can even get online case consultations from experts at dental schools and universities.
- Standards do not vary from generalist to specialists. If you are a practicing general dentist and are performing a specialty procedure, you will be held to the same standard that a specialist would. If you don't think that you can do a root canal to the standard that endodontists feel is acceptable, refer to someone who can.
- Standards are not simply determined by what everyone else is doing. If many dentists are practicing below the standard of care, this does not imply a low standard. While there is some safety in running with the herd, don't pick the wrong herd, and be sure to think for yourself. You, alone, are responsible for the treatments you attempt and provide. (Remember: best interest of the patient).
- Standards are not determined by the newest technologies. Dentists are allowed to use traditional methods that produce good results in their hands regardless of what the majority of dentists do. Older technologies often prove to be equal to or better than the newer ones.

Ongoing engagement with professional colleagues is a powerful and important way to stay current with the standard of care. This implies that it is a good idea to maintain membership in various professional organizations, to attend meetings, and to take continuing education courses very seriously.

Conclusion. Here is another serviceable definition for the ethical standard of care in dentistry: *the conscientious application of up-to date knowledge, competent skill, and reasoned judgment in the best interest of the patient, honoring the autonomy of the patient.*

To be within the ethical standard of care, the practitioner need only ask, “Am I up to date in my knowledge of the procedure, sufficiently experienced in the procedure, and making the best interest of the patient central while respecting the patient’s autonomy, then acting accordingly?” This is what we mean by being conscientious.

Was what I did good for the patient?

Acting below the ethical standard of care implies that one never considered these questions at all or is acting contrary to one’s honest answers to them. Regardless of outcome, the question is always: *Did I act conscientiously? Was what I did good for the patient?*

Scope of Practice

Scope of practice, while just as important as standard of care, is less difficult to define but still subjective. It defines what a practitioner can and cannot do, based upon their license, training, competence, and experience. Scope of practice dictates and limits what techniques you can use, what pathologies you can treat, and what procedures you are allowed to perform. As a simple example of this concept, a dental license authorizes you to restore teeth but not perform knee surgery. Unlike the standard of care, many

Scope of Practice determines what one can and cannot do with a DDS license.

regulations define the exact nature of the scope of practice, and dentists must practice within that scope.

The actual scope of practice of dentistry is defined by each state's Dental Practice Act. The American Dental Association encourages states to use the following definition:

Legal definitions of Scope of Practice.

Dentistry is the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law.

California's Dental Practice Act defines the practice of dentistry as:

...the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents and physical evaluation.

- Section 1625 of the California Business and Professions Code

Definitions like this are intentionally broad because the state stipulates particular procedures only in limited circumstances. For example, in California, a dentist may not provide general anesthesia for treatment without special training and licensure. In general, state legislatures prefer to leave the fine-grained determination of dental care up to the profession. The definition of dental practice, as stated above, does make it clear that a dentist cannot provide care that is not directly related to the oral cavity and associated structures. For example, breast exams are not allowed, nor is the diagnosis and treatment of diabetes or hypertension, but acupuncture and hypnosis are allowed as long as the goal of treatment is related to oral health. Each state has its own laws

relating to dental practice and may define dentistry differently. It is your responsibility to know the local law in the state where you practice.

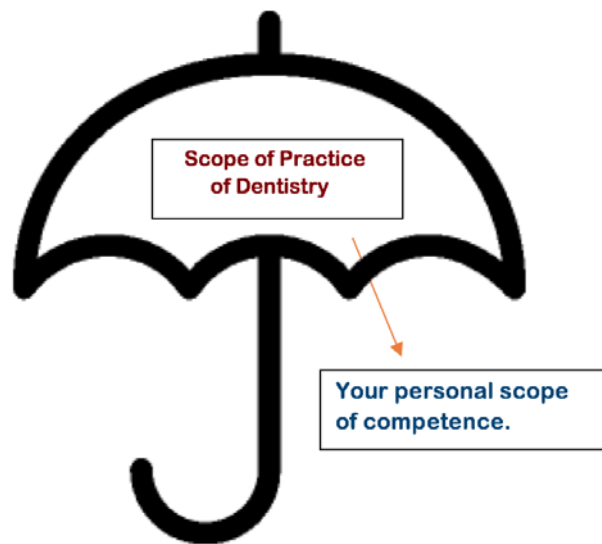
Dental practice laws also stipulate what people under your supervision may and may not do based on their training and experience. These stipulated procedures are much more detailed than they are for the dentist, and as an employer you are legally responsible for the actions of your employees or anyone else you directly supervise. For example, your dental assistant may take radiographs only if he or she has had the proper training and certification to do so.

There are two components of scope of practice.

1. There is a scope of practice that is **defined by your license as a dentist** (or hygienist or registered dental assistant). This scope is quite broad, and it allows licensed dentists to perform a very wide range of activities related to the oral cavity (and sometimes outside of that space). It permits the use of hypnosis and acupuncture, for example.
2. There is also a more limited version of the scope of practice **based upon each practitioner's personal and professional training, experience, and competence**. Just because a treatment or procedure is within the scope of dentistry, it is not automatically within your scope of practice. One must be personally competent to perform that procedure in order for it to be within his or her scope of practice. This version is often referred to as "**Scope of Competence**." Obviously, one's scope of competence is virtually always more narrow than the larger generic scope of practice of dentistry.

Two kinds of Scope:

- what your license allows.
- what you are personally competent to practice.



So, while implants or surgical extractions are within the scope of practice of dentistry, they are not within your personal scope unless you are fully trained and competent in those procedures.

Another example of the importance of professional autonomy of dentists is this: **dentists determine whether they (themselves) are competent to perform procedures.** Though the law may allow a dentist to perform a variety of procedures, the *dentist* must decide if he or she has the competency to do so. The public trusts you to carefully decide whether you are ready to take on a new procedure in your practice, as well as when you should stop performing procedures that you may no longer be competent to perform. While this trust results in a great benefit for dentists, it incurs a great responsibility. Patients must rely on your integrity, especially when financial incentives nudge you to push the envelope. There are typically no tests or certificates or board exams required when one acquires a new skill set or sophisticated new piece of equipment.

Once you have obtained a license to practice general dentistry, you are legally permitted to practice all procedures within dentistry with few exceptions. You are allowed to practice oral surgery, orthodontics, endodontics, implantology and everything that is within the definition of dentistry. However, it is very unlikely that you will have the training and experience in each of these areas that would allow you to practice them within the standard of care upon graduation. As mentioned earlier, you will be held to the same standard in any specialty work you perform. You must judge for yourself whether or not you have the training and experience and skill to perform the intended procedure. If you would like to expand your personal scope of competency, it is your responsibility to obtain sufficient training and experience before performing the new procedure. For example, it would be unrealistic to expect that a weekend course in orthodontics would allow you to competently practice orthodontics within the standard of care of a specialist who has two to three years of focused, advanced residency training.

Another factor in determining your personal scope of competency is less about past training and experience and more about your current physical and mental condition. If you are overly tired, physically ill, depressed, distracted, visually or chemically impaired, or have any other condition that limits your ability (and therefore your competency) you should reconsider moving ahead with a procedure.

You can (and certainly should) grow your skills to expand your personal scope of competence over time.

It is a good thing for dentists to continue to enlarge their personal scope of competence and therefore, their scope of practice, but it is challenging to determine when you are “ready” to perform a new procedure for the first time in practice, especially when there is money to be made by doing so. These decisions pose ethical questions, to be sure. It is often prudent to recruit an informal supervisor or colleague to help you decide when you are “ready.”

Board Certification. Many dental specialists pursue further training and examination that qualifies them to be "board certified" in their specialty. This certification process is important for the advancement of the specialty, but it is not a legal distinction, and is not required. It does not bestow upon a dentist any additional legal rights. Board certification is voluntary, and boards are independent from government. One may practice a dental specialty without board certification. Patients rarely understand the implications of board certification. Each healthcare profession has a different take on the importance and role of board certification. For example, in Psychology, board certification is of little or no practical significance; in Medicine, certification is a prerequisite for privileges at most hospitals and for credentialing by most insurers.

Some questions to ponder before you treat:

1. What is the standard of care?
2. Are there best practices established and published for the intended procedure?
3. What are my personal preferences for a successful outcome? Are my standards higher or lower than the standard of care?
4. What does the law allow me to do?
5. What does my training and experience allow me to do?
6. Am I physically and mentally capable of performing this procedure?
7. Am I the best person to treat this patient?
8. Are there financial forces (money to be made) that could influence my decision to treat or refer?
9. What is in the best interest of the patient?

The bottom line.

- You must practice within the Scope of Practice of Dentistry as defined by law.
- You must also practice within your own personal scope of competence, as determined by you (with some help from others).

Conclusion

The standard of care is not always clear and unanimously understood, and scope of practice includes much gray area and judgment. **This means that — in the end — ethical considerations are an essential component of each clinical decision.** They often carry the day and help finalize the important decisions. Remember that the public trusts you to make these decisions with their safety and interests in mind.

Section 1.5: Ethical Sensitivity

As mentioned in the introduction, the first step toward enhancing your ability to resolve ethical issues is to be aware of them and notice them when they present themselves. This is called “ethical sensitivity” and it is not easy for beginners. You can’t address ethical problems that you don’t notice. Consider the following clinical scenario:

You can’t address ethical problems that you don’t notice.

Dr. Lu is a recent graduate of a good dental school in San Francisco. On her first day of work as a new associate, she sees Mr. Payne. Mr. Payne is in excruciating pain; he has not slept for two nights, his jaw is swollen and he pleads with Dr. Lu to "extract the damn tooth." After taking a radiograph and examining the area, Dr. Lu concludes that tooth #19 is abscessed and is the most likely cause of his pain. She tells Mr. Payne her diagnosis and informs him of the cost of the extraction. He readily agrees and she performs the procedure. Mr. Payne is relieved and is completely satisfied with the treatment. Dr. Jones, the senior dentist in the associateship commends her for a job well done.

Ask yourself if there are any ethical issues here and, if so, what they are.

It may seem at first that this is a simple situation: one that happens frequently in dental practice, and it appears that Dr. Lu has acted in a competent and professional manner. One might be tempted to say that there are really no ethical issues here at all. On closer inspection and with more experience you should, however, notice several ethical problems.

From a technical point of view, Dr. Lu has done a good technical job of thoroughly examining the patient, taking appropriate radiographs, making a good clinical diagnosis, and successfully extracting the tooth. From an ethical point of view; however, several important errors have been made.

Error #1: The patient is in extreme pain and hardly in the best frame of mind to make an important, irreversible decision. The dentist has an ethical responsibility to determine whether or not their patient has the capacity to make good decisions.

Error #2: There are alternatives to the treatment suggested and performed. The dentist has an ethical responsibility to present all viable treatment options: patients cannot give informed consent without knowing their options along with the risks, costs, and benefits of each. (The authors have much more to say on informed consent in Chapter 3.)

Error #3: Given Dr. Lu's training it is unlikely that she thinks that extraction of a salvageable tooth is the best treatment. All dentists are committed to oral health and the long-term viability of teeth. Dentists have an obligation to do what is in the best interest of the patient; simply agreeing to patient demands at all times is not ethical behavior, and patient requests do not always represent what's best for them. This is a complicated matter, to be sure.

Error #4: Though it may not be as apparent from the brief description of the scenario, there may be a financial incentive for Dr. Lu to acting quickly and to move on

to the next patient. Time is critical to the business side of dental practice, but a doctor's financial interests do not trump a patient's long-term oral health. That said, treatments aimed at saving that tooth might be expensive, but should have been discussed.

As you can see, there are many things going on in this case that involve ethical considerations. If you recognized all these issues, you have a high degree of ethical sensitivity. Hopefully, this text and your ethics course will help you with "issue spotting." As we have said, each clinical encounter will have ethical components, so keep this in mind as you go through your clinical training. In each case, see if you can spot potential ethical problems as you learn about the patient, their needs, and any treatments you might offer.

Start by asking yourself these questions:

1. Is the patient capable of making good decisions?
2. Have I presented all viable solutions to their problems?
3. Have I done a good job of communicating the risks, costs, and benefits of each solution?
4. Have I really listened to the patient's point of view and taken their concerns seriously? Do I understand the situation and what matters to the patient?
5. What am I willing to do for this patient and what am I not willing to do and why?
6. What outside influences (legal, economic, institutional, familial, self-interest) will impact what is best for this patient?

Section 1.6: Ethical Decision-Making: Essential Theories and Methods

Good ethical decisions require more than intuition or a “gut feeling,” and many clinical decisions in dentistry are not easy or obvious. Formal, rational decision methods are available to help with ethical issues. Each of the methods offered here has a different theoretical basis though they often produce the same moral conclusions. Each method has strengths and weaknesses. None works perfectly all the time.

Everyone makes moral decisions every day, even when they are not aware that they are doing so. In fact, most of the time we are not aware that we are exercising some form of moral behavior as we make our way through each moment of each day. Anytime your decisions affect other people directly, you are in the domain of morality. Because your decisions about what to do as a health care professional usually impact others (primarily patients, but also team members and family members) you will find yourself constantly in the moral domain. Most of us don't usually slow down to deliberately consider the moral implications of our decisions, and yet, as you learn to be a good dentist you will first need to learn to pause and think through decisions involving patients, colleagues, and the community.

While we usually don't put much conscious thought into ethical decisions, we do have some basis for making them. They are rarely random or simply intuitive. Here are some examples of the methods or ways that people typically deal with day-to-day moral decisions:

1. We use intuition or we “go with a gut feeling.”
2. We check to see how it's always been done (tradition).
3. We check to see how others are doing the same thing.
4. We think about practical outcomes (what will yield the most good or the most bad for us or others).
5. We ask a mentor or trusted friend for advice.

6. We check with an authority figure (an expert or teacher).
7. We read an authoritative book or journal, or we look on the internet to see if there's anything helpful there.
8. We think about how religion would guide us.
9. We follow such moral maxims as "The Golden Rule."
10. We anxiously procrastinate until the decision is made for us by default.

These are all normal, standard ways that people deal with situations with a moral component. Some work quite well in many circumstances, while some are less effective. Most of us tend to favor our intuition or "gut." However, your intuition cannot always be trusted in your new role as a dentist, and often what you think is a dependable gut feeling is actually the product of an irrational set of processes that include prejudices, stereotypes, and skewed cognitive patterns that you have developed over the years. Sometimes our "gut" favors decisions that result in higher revenues. We all use such irrational thinking...with fair regularity. That said (and much of this text is based upon this assumption), decisions that are thoughtfully considered have a better chance of ultimately being good ones.

Clinicians should be prepared to explain the rationale for their decisions.

Getting Started

When you are confronted with an ethical problem, begin by reflecting on what you would *prefer* to do in that situation. Begin with your intuition about what seems right to you, and then consider the following two quick tests of the soundness of that choice.

Decision Models for Dentists:

- Publicity Test
- Driving Home Test
- Principle-Based Method
- Consequentialist/Utilitarian
- Value-Maximizing (Ozar's Hierarchy)
- Four Quadrant Approach

The Publicity Test: This is essentially a social test. Imagine if your decision were made public. Ask yourself what other people would think of your decision. If everyone

knew about your action, would you still do it? If your mother or father or partner knew, what would they think? How about your instructors and classmates or your dean? How would you feel if your decision were posted on Facebook or printed in a newspaper? If your response to this reflection is one of embarrassment or anxiety you may be on the wrong track.

The Driving Home Test: This test uses your “conscience,” and it assumes that you have one (some people don’t). In dental school and your career thereafter, you are likely to find yourself reflecting on your clinical decisions at the end of the day, after the dust settles. You will find yourself wondering — while driving home or lying in bed at night trying to get to sleep — whether you did the right thing or the best thing. You may wake up in the morning with a patient or case on your mind. You may not be able to get completely comfortable with decisions you have made. Perhaps you sense some regret or remorse. Perhaps you feel that something is incomplete about your exchange with a patient. These are all indicators that further thought and analysis might be needed. Ask yourself what it would take for you to become comfortable with your decisions.

That said, the fact that you are comfortable with your decision and would gladly have it publicized is no guarantee that you have made the "right" decision. There are four more available decision methods.

Formal Decision Methods for Clinical Dental Practice

What follows are several rational methods you can use when confronted with a challenging clinical situation. As you are relatively new to dentistry you may not appreciate how frequently such challenging ethical situations occur and how difficult and even gut-wrenching they can be.

These methods are derived from a variety of normative (prescriptive) theories developed over the history of philosophy. People have mused about ethical decision-making for many centuries. The philosophical derivation of these methods is beyond

the scope of this text, but we hope that your curiosity about ethics will increase and lead you to some of the [references](#) listed at the end of this chapter. The models are presented here in a very basic, stripped-down form designed to be immediately useful.

Decision Method #1: **Principlism, the Principle-Based Method**

This approach to ethical decisions is based on the notion that cases can be decided by reference to a general principle or to rules that are derived from those principles. For example, if you were to borrow some money from someone and promise to pay them back, then you ought to pay them back according to the general ethical principle: We should keep our promises. Though this example seems simple enough; consider one that you might encounter as a dentist.

In this method, an ethically correct decision is one that does not violate any of the principles.

A patient of yours has asked you to keep the results of your examination from her spouse or parent. What general principle can we look to to make our decision? It happens to be that in this case, we could look to the ethical principle of respect for autonomy (see below) that says, in part: always respect the patient's right to privacy. Applying this principle would lead us to the conclusion to respect the patient's request and not divulge any information to her family. This method requires that you check to see if your action would violate or honor certain immutable principles, obligations or rules. If you were to violate a principle, obligation or rule, your action would be considered wrong.

So, what are the principles, obligations and rules that are relevant to dentistry? Here is a list of general ethical principles that garner a great deal of agreement among bio-ethicists and dentists. In fact, these principles form the basis of the American Dental Association Code of Ethics that we will address later in this text. The descriptions here are brief, and they are more thoroughly explained in Beauchamp and Childress's *Principles of Bioethics* (1994). They are often called “Normative” Principles because they are prescriptive; they instruct you about norms and standards, and what you should do.

The Principles:

- Non-maleficence
- Beneficence
- Autonomy
- Justice
- Fidelity
- Veracity
- Reparations
- Mercy

The Normative Principles

Non-Maleficence: Do not harm or hurt people; prevent harm whenever you are able.

Patients should not end up worse because of their interaction with a dentist. We shouldn't make things worse for patients, by intention or indifference or incompetence.

Several rules for dentists can be derived from this more general principle:

Non-maleficence:

Do no harm; don't make things worse.

1. Do not take advantage of patients by deception or coercion; patients are in a very vulnerable position and rely on their health care providers to always act in their best interests.
2. Do not be careless or unprepared in your treatment. Be conscientious and careful, even meticulous in the preparation and execution of care.
3. Do not recommend treatment, exams, or tests that have no therapeutic benefit to the patient. Do not suggest treatments that may do more harm than good.
4. Do not treat beyond your scope of competence. Seek consultation and refer appropriately when the patient's needs exceed your ability; be up to date on all diagnosis and treatment protocols.
5. Do not do anything that increases the risk of harm to a patient relative to the expected benefit to the patient.
6. Decline to treat a patient who exhibits behavior that will impede a good outcome.

7. Decline to treat anyone if your physical or psychological state prevents you from performing in an optimal matter.
8. Prevent harm to patients who are in your practice by reporting colleagues who are impaired or otherwise practicing negligently.

This principle does not mean that dentists are expected to be perfect; sometimes, despite their best intentions, dentists do harm patients, as errors are an inevitable part of life, even professional life. However, the ethical dentist makes every effort to prevent error, and then deals with it appropriately when it happens.

Beneficence: We should strive always to **do some positive good** for patients. This, of course, is what the doctor-patient relationship is all about. Patients should benefit from their contact with us; they should be better off after we have intervened.

Beneficence:
Do something good; make things better.

Some rules derived from this general principle:

1. Work to contribute to the overall health and well-being of the patient.
2. Take actions to remove patients from the risk of further harm.
3. Promote prevention practices that will enhance health.
4. Determine the risks, costs, benefits, and alternatives for any procedure and make treatment decisions that support the best interests of the patient.
5. Promote and enhance a patient's understanding of their health status and possible ways in which to improve it.
6. Collaborate with colleagues and specialists in a manner that enhances the care of the patient.
7. Share the results of one's research with all members of the profession.
8. Report instances of abuse to the proper authorities.
9. Support public health initiatives and public policies that enhance oral health.
10. Support dental education and dental research.

Respect for Autonomy: Self-rule, self-governance. This principle is sometimes referred to as “respect for persons,” and it means that we honor the right of each patient to make their own decisions. Patients have the right to make choices for themselves based on their own values and beliefs.

Autonomy:
Self-governance.

We begin with the premise that all persons have autonomy; it comes with being human. We do not *give* autonomy to patients. They have it, and we can choose to honor it or violate it. In healthcare we strive to “honor” patient autonomy. We inform patients properly and include them in the treatment planning process. This means that we must get patient permission before we touch them or do anything to them. Autonomy is one of the most important, yet complicated principles.

Beauchamp & Childress (p. 121) define personal autonomy this way:

“...personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding.”

This means that we must honor independence, and we must refrain from manipulation, as well. It also implies that we must provide adequate information so that patients can exercise real autonomous choice.

We use the legal mechanism of informed consent to ensure that patient autonomy is properly accommodated. That process is described later in this text.

There are two categories of patients whose autonomy is limited or non-existent. These are people thought to be incapable of adequately understanding things, such that they cannot make proper decisions about their own care. The two categories include minors and people with limited cognitive or decision-making capacity. People in these two categories generally cannot give consent, although the matter is quite complex in actual practice. For example, can a mature seventeen-year-old elect to have braces

removed if parents disagree? Can a person with schizophrenia give consent during a period when their thinking is quite lucid?

Respect for autonomy is also complicated by culture. Western (northern European/American) culture tends to prioritize individual autonomy over family determination and harmonious interdependence. In other cultures, this is not always the case. For example, in some cultures the decision to have one's remaining teeth extracted can be a decision that is to be made by the entire family or by key family decision-makers, not simply by the patient alone.

Some rules that can be derived from the general principle of autonomy:

1. Make a strong effort to understand, appreciate and incorporate the cultural and world-view of the patient when making treatment decisions. Respect their views.
2. Be as certain as you can be about the capacity of the patient to make an informed choice; if you have doubts, get expert advice.
3. Give complete and honest information to the patient.
4. Encourage full participation by the patient in treatment decisions.
5. Inform the patient of all risks, costs, benefits and alternatives to any treatment decision.
6. Keep patient information confidential.
7. Develop and employ good communications skills. Listen as well as talk.

Justice: Treat people equally. This is the **fairness** principle. **Everyone gets their fair share.** People get what they are entitled

to and what they deserve, and they do not get treated differently based on irrelevant factors (such as race, gender, or personal appearance). Most people agree with this notion, at least in theory, but the waters get muddy very quickly in dental practice. There are many ways that some patients get treated better than others. Because dentistry is practiced in a free-market economy, fee-for-service context, you don't get dental care unless you can pay for it, and dentistry is expensive. Dentists deserve to be

Justice:
Treat people equally.

paid for their services, and dentistry is not a hobby. It is hard work, and practice overhead is high. This means that people lacking a good dental plan and/or the means to pay for dental care are less likely to receive high quality care—or any care at all. The ADA’s code of ethics (p. 8) even states that “dentists...may exercise reasonable discretion in selecting patients for their practices....” Because of justice, they are cautioned not to discriminate based upon factors of race, creed, color, sex, or national origin, but discriminating based upon a patient’s ability to pay is certainly not just, even though it happens all the time, for reasons that are completely understandable.

Rules that can be derived from this principle:

1. Treat all patients equally.
2. Support public policies that enhance the health of all people.
3. Support the most effective and appropriate use of society’s dental care resources.
4. Make a reasonable effort to open your practice to all people.

Fidelity: Keep your promises and commitments. This refers to the quality of being faithful, faithful to your word and faithful to others with whom you have a relationship. It means that you honor your agreements. In dental practice it means that you finish treatments that you start. It would be a violation of fidelity to stop treatment because a patient runs out of money or because their dental plan has been terminated. You cannot leave a patient in temporary crowns after it is clinically safe to do so. Fidelity is especially important in the doctor-patient relationship because trust is so essential. Patients are in a position where they must trust their doctor because they do not deeply understand pathology, diagnosis, and treatments. In fact, the therapeutic relationship—that which promotes healing—is directly connected to trust and rapport.

Fidelity:
Keep your promises
and agreements.

The obligation of confidentiality can also be understood as a function of fidelity. You owe patients discretion, partly because of healthcare’s implicit, general promise to

keep patient information private. Most patients expect confidentiality. The doctor-patient relationship is special, perhaps sacred in some sense.

Veracity: Tell the truth. All our professional interactions are to be truthful. Think of it this way: What would you do (as a patient) if you thought that your doctor was being dishonest with you? The answer is obvious. The relationship collapses, and the care becomes worthless or worse. The doctor-patient relationship is fundamentally built on trust, and that trust is based on honesty and transparency. This standard seems simple and perhaps a no-brainer, but it too gets complicated sometimes.

Veracity:
Tell the truth.

Complex pragmatic challenges arise from the following question: What if lying or shading the truth might produce some greater good or avoid serious harm? What if you could help a patient by lying? You will certainly be asked by patients to lie or shade the truth on insurance forms in the future – so that they can receive much-needed care. That problem will be addressed elsewhere in this text. On the other hand, what if lying indemnifies you from embarrassment?

Reparation: Fix what you broke. Dentistry has a long tradition and culture that honors this principle. It seems woven into the DNA of the profession. If you perform a procedure or treatment, and it fails or turns out to be inadequate in some way, most dentists feel compelled to make things right. The differences between “bad outcomes” and “bad work” will be examined later in this text. Obviously, you are not responsible for all treatment failures, but dentists are generally quite willing to stand behind their work. It’s an important component of the professional identity of dentists.

Reparation:
Fix what you broke.

Mercy: Treat people with kindness. This one simply means that we **treat people with kindness and compassion**. When faced with difficult situations or conflict, we favor a humane approach.

Mercy:
Treat people
with kindness.

Using the Principle-Base Approach

Application of the principle-based or deontological method is simple (in theory). When faced with a difficult decision that has ethical components (which is true for all clinical decisions), one simply follows these steps:

1. Determine which principles are relevant to the situation.
2. Determine which of the available options honors or violates a principle.
3. Reject any action that violates a principle.
4. Choose the action that honors a principle or principles.
5. Should principles conflict with each other, make your decision using a different method (the principle-based method is not helpful when this happens).

As an example, if one of the “solutions” to a clinical problem requires lying to a patient, it is rejected (as unethical) because it violates veracity. This seems pretty simple, and on the face of it, it is. But, in real life things are rarely so simple. Often an attractive option honors one principle but violates another, and the only reasonable option that would honor the other principle violates the first one. Any available option would violate at least one of the principles. You are faced with something called a “moral dilemma.”

In fact, there are three categories of moral problems within the principle-based decision method:

1. **Moral Weakness;** when you are choosing between an option that forwards an *interest* of yours (such as money) but violates a principle.

Categories of Moral Problems:

- Moral Weakness
- Moral Dilemma
- Moral Uncertainty

2. **Moral Dilemma;** as in the example above, where any action you choose will violate a principle. Principles themselves seem in conflict with each other.
3. **Moral Uncertainty;** when you must make a moral choice, but are missing essential information...and you must make the decision without the needed information.

An example of “moral weakness” is when you choose to falsify an insurance document, or shade the truth to a patient (a violation of veracity) in order to make more money (enhancing your “interest”).

An example of “moral dilemma” is when a friend asks you how you like their new haircut (it’s awful). If you tell the truth you honor veracity but violate non-maleficence (at the same time) by hurting their feelings. If you lie and say that the haircut looks great you honor non-maleficence (by protecting their feelings), but you violate veracity. This is a no-win situation, and when faced with a moral dilemma the principle-based method does not help much. We need to use one of the other methods instead.

An example of “moral uncertainty” is when a patient claims that a treatment (which has failed) was done recently, but records are lost or incomplete, so you do not know the truth about when it was done. You must decide whether to redo at no cost or find some other solution, but you must do so with incomplete information.

More Methods

Most bio-ethicists observe that a strictly principles-based approach has serious limitations. First, there is no certain way to determine which of the principles is better or best. Are some of the principles more important or powerful than others? Do some take priority? If so, when? Second, two principles often clash in a given situation and there is no obvious or easy way to decide which principle should prevail over the other. In other words, following one principle may lead to the exact opposite conclusion that following another principle would produce. For example, if a patient of yours would like

to have cosmetic veneers placed on teeth that are not periodontally healthy, you would have a conflict between the principle of autonomy (doing as the patient requests) and the principle of beneficence (improving the oral health of the patient) and perhaps nonmaleficence (doing harm). There is no easy way to solve this problem using principles. In fact, it may be best to view the normative principles as “prima facie,” a first impression that might be accepted on its face, pending further investigation. In the case of moral dilemma — when principles clash — a different method is probably required.

One possible way around this problem is to use a different decision method, one that uses a “utilitarian” perspective and recommends actions that produce the most good while avoiding the most bad.

Decision Method #2: Utilitarian/Consequentialist

This method is highly practical and commonly used to make difficult decisions. “Utilitarian” means that the best moral action is the one that maximizes utility (what is more useful or valuable). Utilitarians are consequentialists, and they believe that the moral worth of an action is determined solely by the consequences it produces, regardless of any other moral principles. This method is sometimes referred to as “the greatest good for the greatest number.” One should act to maximize the greatest good for the greatest number of people. The consequences or outcome of an action determines whether it was right or wrong. Are things better or worse as a result, and for whom? That’s the big question. This method can be very useful in clinical dental practice.

First, you must understand the concept of “*interest*.” In ethics this term usually means: “stake in the outcome.” It does not mean that you are interested in something like your favorite sports

Utilitarian-Consequentialist Method:

- Weigh everyone’s interests.
- Choose a path that maximizes the most important ones.

“Interest”

A stake in the outcome. You are better or worse depending on how things work out.

team or your hobby. Having an “interest” means that you stand to be better or worse off, depending on how things work out. If you own stock in a company you might be completely uninterested in that company’s product or service, but you certainly have an *interest*, a stake in the outcome, given that you gain or lose money depending on how the company performs.

You start the utilitarian process by determining which **parties** have interests in the case or situation. In dental practice this typically includes:

- patients
- dentists
- practice team members (assistants, hygienists, administrators)
- third-party payers, dental plans
- family members of the patient

In dental school this typically includes:

- patients
- students
- the clinic, the school
- faculty members
- third-party payers, dental plans
- family members of the patient

Next, you determine the **interest profiles** of each involved party. Some examples of interests include:

- money
- time
- esthetics
- functional outcome
- self-esteem
- pain
- reputation
- graduation

Parties who have interests (in dental school):

- ✓ patients
- ✓ students
- ✓ the clinic, the school
- ✓ faculty members
- ✓ third-party payers, dental plans
- ✓ family members of the patient

Typical **interests** that they have:

- ✓ money
- ✓ time
- ✓ esthetics
- ✓ functional outcome
- ✓ self-esteem
- ✓ pain / comfort

Typically, patients have money, functional outcome, comfort, and time as primary interests at stake. Students have graduation, self-esteem, reputation, money, and time as interests. The clinic has money, reputation, and its survival as an organization at stake.

Once you have a clear picture of the parties and their interests you determine how each possible action might enhance everyone's interests. Think of it in this way: if course of action "A" enhances more interests (or more important ones) than action "B," you should choose to do action "A."

Here are the steps involved in weighing the consequences of each possible course of action:

1. Make a list of all the people and institutions that have an interest in the outcome of the situation.
2. Make a list of all viable options.
3. For each option, consider its impact (positive and negative) on those who have interests and what impact each option has on the interests involved.
4. Weigh the positive and negative outcomes to determine a best choice of options based upon whatever maximizes various interests.

It should be obvious that while describing this process is simple, the actual decision process can become complicated, even messy. One challenge is to determine the relative “weights” of each party’s interests. How do you compare a student’s interest in graduating on time against a patient’s interest in saving several hundred dollars on a less-expensive treatment? Another problem is that decision-makers often must act as if the interest of a stranger is as important as their own interests. Critics note that you might be tempted to put your thumb on the scale when the stakes are high. Can you consistently make your patient’s interests equal to your need to graduate from dental school on schedule, with high grades? Does the well-being of a stranger count as much as that of your family or kids? There are many other philosophical challenges to utilitarianism that are beyond the scope of this text. Consequentialism is often characterized as “*the ends justify the means*,” implying that one could justify bad behavior because it produced a “good” outcome. Notice that such an assertion would not be justified by a principle-based approach.

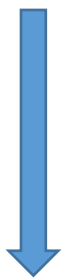
Decision Method #3: Value-Maximizing Method

One of the most practical utilitarian methods is David Ozar's (Ozar & Sokol, 2002) values-maximizing approach, and it is designed specifically for dentistry. In every ethical situation, if we ask ourselves what action would produce the most good and avoid the

most bad, we can produce a clearer picture of what we should do. However, we must ask ourselves what exactly it is that defines "good" and "bad." This is not as easy or obvious as it may seem. Ozar observes that every profession has certain values that are essential to proper practice. In dentistry he refers to these as "The Central Values of Dental Practice." The values of the dental profession are the things that every dental professional aspires to achieve. For example, the dental profession holds oral health as a high value; this is why you do dentistry in the first place; to enhance the oral health of our patients. This makes the values of the dental profession different from, say, the legal profession, which has its own set of values and priorities. Thus, with a values-maximizing approach to dental ethical issues, one should always act in such a way that maximizes the values of the profession. Ozar has identified six central values of the dental profession, listed in order of importance:

Ozar's hierarchy of values:

1. The overall health of the patient
2. The oral health of the patient
3. The patient's autonomy
4. The dentist's preferred method of practice
5. Esthetics
6. Judicious use of dental resources



1. The overall health of the patient
2. The oral health of the patient
3. The patient's autonomy
4. The dentist's preferred method of practicing
5. Esthetics
6. Judicious use of dental resources

In any given patient interaction, members of the dental profession should aspire to produce as many of these values as possible when acting. But all professional values are not created equally and Ozar's theory ranks these values in a **hierarchy**. Higher ranking values always trump lower ones on the list. For example, the overall health (life or death) of the patient is more important than the oral health (teeth and gums) of the patient and so on down the list. You can read more about his reasons for ranking these values in the book *Dental Ethics at Chairside* (Ozar & Sokol, 2002). A third edition will be released in 2018.

Here is how the hierarchy and theory work: Take the example above where a patient desires cosmetic dentistry on periodontally unhealthy teeth. If you were to decline the patient's request, you could justify this by saying that while patient autonomy is a high value in the profession, the patient's oral health is a higher value and therefore more important in deciding what to do. You have maximized value by acting consistent with the ranking of the profession's values. Think of it this way: the higher the value is in the ranking, the more good is produced by achieving it.

For any given ethical situation:

1. List the choices available in the situation (not just the ones you might favor).
2. List the relevant professional values (of the six) that come into play.
3. Determine the potential good and bad outcomes of each action on your list.
4. Rank your list of choices by appealing to the values involved and their relative position in the hierarchy.
5. Justify your rankings by reference to the possible outcomes or consequences (good and bad) for each action and reconciling these with the values of the profession. Ask yourself: does the number one action on your list best maximize the professional values involved?

Decision Method #4: Four Quadrant Approach

A case-based approach to ethical decision-making takes the position that every case is so unique that applying generic principles or weighing interests using a formula will not suffice in many specific cases. A case-based method, sometimes referred to as “casuistry” advocates a thorough understanding of the specifics of the case and then a reasoned application of good judgment in deciding which specifics ought to determine a course of action. This approach, developed by Al Jonsen (Jonson, Seigler, & Winslade, 2010), is helpful in that it gets to the specifics of a case rapidly and predictably. Though the “reasoned application of good judgment” may seem vague, judgment, wisdom and experience play a strong role in all the methods presented here so far. There is no algorithm that will automatically decide what to do in every case. Law schools and business schools often use versions of casuistry in teaching.

The Four Quadrants:

Dental Indications	Patient Preferences
Quality of Life	Contextual Features

Quadrant #1: Dental Indications

What can be done for the patient? List the technical facts of the case: What is the diagnosis? What are the possible treatment options? What are the potential benefits, risks, and costs of each treatment options? What are the goals of each treatment option? What is the prognosis for each treatment option?

Quadrant #2: Patient Preferences

Is the patient capable of making an informed choice? What are the patient’s expressed preferences for treatment? What does the patient value? What is important to the patient? Are there unexpressed preferences?

Quadrant #3: Quality of life

How will each treatment option impact the quality of the patient's life? Will there be compromises to adequate oral functioning? Will there be compromises to other life functions? How much pain or other suffering will the patient need to endure for the treatment to be successful? For how long?

Quadrant #4: Contextual Features

What other specifics of the case must be considered? List the contextual features of the case; these include family preferences, legal constraints, institutional constraints, limited resources, and cultural differences.

Once these questions have been adequately answered, you must weigh the relative importance of each consideration to arrive at an acceptable decision. One important way to do this is to look for "paradigm cases," cases that are similar to the one that confronts you and whose resolution has been generally affirmed and accepted. Then, compare your case to the paradigm case to determine if there is enough similarity to decide what to do. If there is, you can have some confidence in your decision. If the specifics of your case are so unique that no other case seems to apply, you must then use your best judgment and justify your decision. As we have said, this type of judging requires sensitivity, experience, and wisdom. Consultation with others who have more experience is essential in these situations.

Application of the decision methods: A brief illustration

Here is a brief, non-dental example that demonstrates how different decision methods might result in different decisions about right and wrong action. Consider the following scenario:

Your aging mother has become chronically anxious and sometimes agitated. She lives with you and your family. One evening you slip some marijuana into her tea without her permission or knowledge. It clearly makes things better. She calms down and gets a good night's sleep. Everyone feels better, including her.

The driving-home test is not of much use. As you reflect on your decision you do not achieve any additional clarity. You can imagine yourself choosing either path (marijuana or no marijuana), and wouldn't have strong feelings either way. You might feel vaguely guilty if you surreptitiously gave her the drug, but don't really see any potential for harm, so it doesn't bother you.

If you apply the publicity test: When you think about going "public" with your action, you have serious second thoughts. While your mother was not generally a "fan" of marijuana, she did not have strong negative feelings about it. You'd never actually discussed the issues with her. What would your father say or have said? What would your other siblings and family members think? Some would clearly disagree and think that you have taken advantage of your aging, unsuspecting mother. As you reflect on things, it occurs to you that your plan might be "wrong," given that you never intended to offer her a choice. Why not? You cringe at the thought of posting this episode on social media (a publicity test).

From a principle-based point of view: not telling your mother violates the principle of autonomy (nobody got informed Mom or got consent) and probably veracity (as it seems deceptive and therefore dishonest). On the other hand, the "medication" seems to have made her feel and sleep better, so the principle of beneficence and perhaps mercy have clearly been honored. You are faced with a moral dilemma (two principles are in conflict). This conflict might have been resolved by getting Mom's permission first, but you are pretty sure she would not consent. It is possible that you favor this action because of your interest in this action: your mother

became less difficult for you to deal with ... a clear benefit to you. This looks like a case of moral weakness.

From a utilitarian point of view: When you weigh things out it appears that more good than harm was done. Your mother has an interest in feeling calm and getting sleep. Your family has an interest in a serene evening and some peace. No obvious harm was done, although you could make the case that your relationship with Mom could be damaged, especially if she found out. There is also the possibility that she might feel violated or betrayed, as well.

From a case-based, Four Quadrant point of view: This is not a medical case as a physician is not involved. However, questions about medical indications in the first quadrant have not been adequately answered and for that reason alone we should be suspicious of this decision. Similarly, questions of patient preference in the second quadrant have not been considered at all. There are clear examples (paradigm cases) through the years wherein physicians have been less than truthful with patients to achieve a benefit for them. One would have to examine this case more closely to see if this case should be treated the same way. It is highly unlikely that any formal medical case (involving professionals) would have come to the same decision given the circumstances provided.

Section 1.7: **Ethics in Dental School**

Attention to ethics cannot wait until graduation.

Ethics education is not only focused on future practice. In dental school you find yourself in a pressure-packed ethics lab every single day. Dental school provides an opportunity for you to practice and develop your ethical skills and habits now.

Here are some areas of dental education that are ripe for examination and attention:

Common ethical challenges in dental school.

Competition and Cooperation. Pre-med and pre-dental students are necessarily competitive. They must compete to secure a spot in a dental school. Once in school there is further competition for specialty programs and even for grades. Competition is a good thing when it motivates a person to work harder, work more, and focus more sharply. That said, healthcare professions such as dentistry are necessarily *cooperative* endeavors. Competition can get in the way of excellent treatment. Dentists must cooperate with patients, and with colleagues, as well. You cooperate with patients because they are not able to compete with you; you cooperate with other dentists to share knowledge and provide optimal care for patients.

Many students enter dental school ready, willing, and able to compete with their classmates. They have been doing this all their life; it's normal. However, since competition is not such a good thing in dental *practice*, dental school is the time to make a transition to a cooperative stance. Dental students need to learn to look after each other, to support each other's work and success, and to share knowledge and skills. This may not come naturally, but it is essential. Hopefully, your dental school experience reinforces cooperation. Cooperation can be challenging in a competitive school culture.

Working for Grades vs. Learning to Serve. Along the same lines, it is very easy to get caught up in the stress and day-to-day whirlwind of dental school requirements and grades. Sometimes students lose sight of the real goal: to become an excellent doctor. Keep your eye on the prize and don't let the immediate task of grade-seeking get in the way of learning how to be really good at taking care of patients.

Patients are Ends Rather Than Means. The eighteenth-century philosopher, Immanuel Kant proposed a second categorical imperative (an unconditional requirement), that

One must act to treat every person as an end and never as a means only.

We do not “use” people as a means to get something we want. This imperative is exquisitely applicable to senior dental students (two hundred years after Kant) who struggle to fulfill all their graduation requirements on time. Patients are sometimes valued because they need a treatment that a student must somehow perform or test-case to graduate. Certain patients in the dental school clinic are sought-after because they can further a student’s progress toward graduation. Students even talk about their patients as if they were procedures rather than people. *“I’ll trade you my three-unit bridge if you will give me your multi-rooted endo case.”* This is obviously odious when you stop and think about it. But the problem isn’t that such a trade is possible. It could be a “win-win-win” if done properly, with good communication, openness, and respect for patients’ autonomy. But making such “trades” under the table, without patient or faculty involvement and understanding is ethically questionable at best.

In the “real world”— after dental school — similar temptations arise when money takes the place of “requirements.” The temptation to recommend a treatment or manipulate patients for profit never truly goes away.

Attendance. Most, if not all dental schools have mandatory lectures, where students are required to attend. Most dental students are used to undergrad systems where they can pick and choose lectures to attend and others to skip. Some students skip most or all the lectures in some of their college classes. They find other ways to learn and pass exams to get an “A” grade. Some students get little from formal lectures, and have come to view them as a waste of time. This becomes an issue in dental training when faculty members insist that students must be present to adequately learn

essential material. The classic example is when a faculty member worries that a student might miss the lecture when appropriate drug dosages for children are discussed. Students feel imposed-upon and resent being treated like a child without autonomy. Teachers observe that students are not in the best position to know which lectures they can miss and which they must attend. Students feel that some lectures are a waste of their valuable time. The worst ethical scenarios are when a) attendance is low (in violation of the rules) but never discussed; and b) students sign-in for absent classmates.

Cheating and Whistle-Blowing. There are an astonishing number of ways that dental students might cheat in school, and dental students tend to be bright and clever. Some of the potential cheating is significant enough to take one's breath away, while many opportunities are "smaller," more pedestrian, and more easily overlooked. In theory, no one agrees with cheating. But, in a high stress, high-stakes environment most people's impulse control gets tested from time to time. Occasionally dental students convince themselves that they face an overwhelming situation, and cheating seems somehow viable, or a necessary last-resort for survival. A cooperative culture is less likely to produce such a situation, but temptations will always exist. They always have and always will. It's part of the human condition.

That said, it is essential for dental schools to have sensible systems in place to discourage cheating, make it harder to do, and to respond when cheating occurs. Ongoing, open discussions are healthy; denial, whispering, and innuendo are not.

Administrators and faculty members are not as skilled at discerning cheating as students can be. Often students know much more about these things than faculty. This means that students must be involved in creating a culture and system that limits cheating and deals with it effectively when it occurs.

Dental students are extremely reluctant to come forward and report the cheating behavior of classmates, but this must be done from time to time. The "narc" viewpoint,

one that conflates whistleblowers with tattlers or snitches, rats, stoolies, or informers, is counterproductive. It makes cultural self-correction impossible. Somebody must step up and take a stand. Membership in a profession requires that members monitor and manage each other's behavior. This task cannot be left to dental boards alone, and patients rarely discern when they have been cheated. Remember, professionals monitor each other.

All of this is in service of the fact that patients must be able to trust their doctors. Without trust, the doctor-patient relationship crumbles. Dental students must learn to be trustworthy in dental school if they are to practice with integrity in the future. It makes no sense to hope that students could graduate from a cheating culture one day in June and then flip a switch to suddenly practice dentistry with great honesty and integrity, especially when clinical practice gets hard.

Student Autonomy in Treatment Decisions. Obviously, students are not qualified to determine treatments for patients. That's what clinical faculty are for. They have the required training, experience, and judgment. Plus, they have a license. But if you have spent any time in a dental school clinic you notice that it isn't very hard for students to take charge of that process. Students learn to anticipate faculty responses. They know which teacher is likely to choose one treatment over another. So, they effectively choose their patient's treatments by choosing this faculty member or that one, based upon how each teacher will respond to the clinical situation. This autonomy is not absolute, of course, as all clinic faculty are assumed to be making decisions that are within the standard of care. But students have plenty of leeway, and patients who come to dental schools must be able to trust them. Keep this in mind when you are shopping your patient around for the "best" faculty member. Whose interests are being served? Are you selecting a faculty member because they are likely to recommend a treatment that you need to graduate, or because you have a well-formed opinion that such a treatment is best for your patient, and you know your patient better than a part-

time teacher? Are you shopping because you perceive that one faculty member is an “easier” grader? Are you shopping to avoid performing a treatment that intimidates you? These are important questions, and students are left to provide answers themselves. Learning to act in the best interests of your patient and learning to occasionally sacrifice your interests towards that goal is part of becoming a professional, and it must begin now.

Section 1.8: **Building Moral Capacity**

There is more to being a good, ethical dentist than having a highly developed ethical sensitivity and the practiced ability to apply reasoning methods to ethical problems. An ethical dentist also develops his or her ethical character along the way. Character is a collection of personality traits expressed consistently through behavior. These traits (sometimes called virtues) can best be described as a person’s tendency to act in a certain, often positive, way. Honesty is such a trait, for example, and having that trait means that one is more likely than not to act honestly in any given situation. Other familiar positive traits include being trustworthy, loyal, calm, and reliable. Character traits can be negative, as well. Virtues are, by definition, positive.

There are some traits that become increasingly essential when one becomes a health-care professional. These are traits such as compassion, attentiveness, kindness, caring, conscientiousness, discerning, self-awareness, cultural sensitivity, responsiveness, sympathy, and empathy. It would be hard to consider a dentist to be fully ethical if any of these traits are absent or severely underdeveloped.

Though it is often difficult to assess our own character, friends, family and patients can give us helpful feedback on how we are perceived by others. If we are good professionals we should seek out feedback and be open to it if we are to grow and keep our commitment to being the best dentists we can be.

Usually it is easier to see a lack of character in others. We recommend that as you examine cases and observe other students and instructors, ask yourself the following question:

Are practitioners being kind, compassionate, responsive, conscientious, caring, sympathetic and empathetic? Or are they being dismissive, ignorant, careless, deceptive, insensitive, detached and arrogant? How can you evolve your own capacity in these areas?

References

- American Dental Association (2012). **ADA Principles of Ethics and Code of Professional Conduct**.
(http://www.ada.org/~media/ADA/About%20the%20ADA/Files/code_of_ethics_2012.ashx).
- Beauchamp, T. & Childress, J. (1994). **Principles of Biomedical Ethics**. (4th Ed.). NY: Oxford University Press.
- Curley, A. & Peltier, B. (2013). Standard of care; The legal view. Issues in Dental Ethics, **Journal of the American College of Dentists**, Vol 80 (3), 53-58.
- Jenson, L. (2014). Six common misconceptions about the standard of care in dentistry. [Journal of the American College of Dentists](#), Vol 81(1):59-63.
- Jonsen, A., Seigler, M. & Winslade, W. (2010). **Clinical Ethics; A Practical Approach to Ethical Decisions in Clinical Medicine**. NY: McGraw-Hill.
- Lazarus, A.A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. **Ethics & Behavior**, 4 (3), 255-261.
- Niederman, R., Richards, D., & Brands, W. (2012). The changing standard of care. **Journal of the American Dental Association**, 143, 434-437.
- Ozar, D. & Sokol, D. (2002). **Dental Ethics at Chairside: Professional Principles and Practical Applications**. (2nd Ed). Washington, DC: Georgetown University Press.

Chapter 2: Your Profession and its Formal Codes

Peltier & Jenson

(12/26/17)

2.1 Organized Dentistry

2.2 Codes of Ethics

2.3 Peer Review

References

Key Concepts

- ✓ Dentists organize themselves to manage their profession and look after the interests of patients and themselves.
- ✓ Taken together these various organizations (e.g., ADA, CDA, SFDS and many others) are referred to as “Organized Dentistry.”
- ✓ While a license to practice is mandatory, membership in Organized Dentistry is voluntary.
- ✓ State dental boards do not look after the interests of dentists. Their mission is to protect patients and the public.
- ✓ Most, if not all professional organizations (and dental schools) have a published ethics code to guide members.
- ✓ Most professional organizations offer Peer Review services to members (along with other valuable services).

Section 2.1: Organized Dentistry

Professions organize themselves to maintain high standards and the trust of the public.

Our description of “professionalism” (in Chapter 1) emphasized the concept that being a professional means that dentists are allowed to practice

- Professionals take good care of people who must trust them.
- Dentists practice with substantial autonomy.
- Autonomy is granted by the public.
- Professions organize themselves to ensure that they remain trustworthy and maintain autonomy.

with a great deal of autonomy, a good thing for dentists. This autonomy, granted by society, obligates members of the profession to be trustworthy and competent, partly because the public cannot monitor you, because they do not understand what you do, and also because there is often much at stake. Since patients don’t really understand your work, you must – as an individual and as a group – monitor yourselves and the behavior of your colleagues. If you can’t or don’t, the public may perceive you as untrustworthy or even dangerous. They may decide that it is not safe to visit you, or they might feel that dentists are taking advantage of patients by charging too much or doing unnecessary work. This would obviously be a bad situation, and patients might reach out to legislators or attorneys for help in overseeing the profession. If this notion is too abstract to imagine, just think of OSHA and HIPAA. Most dentists are not eager for more outside supervision of their day-to-day work.

If the public loses faith in you it will create more regulations.

One way that professionals accomplish this monitoring and maintenance of standards is by organizing themselves into “professional organizations.” Each profession has one, and some have several. Medicine has the AMA; psychology has the APA; dentistry has the American Dental Association, and many more. Each dental specialty area has its own organization. Endodontists have the American Association of

Endodontists (AAE), orthodontists have the AAO, and dental educators (your teachers) have the American Dental Education Association (ADEA). Many of these national organizations have state branches (such as the CDA) and dental associations have local branches such as the San Francisco Dental Society (SFDS). There is an international dental society, called the Fédération Dentaire Internationale. There is also the National Dental Association which began in 1900 (when African-American dentists were denied membership in existing organizations) and has as its mission, “to promote oral health equity among people of color.”

Virtually all of these organizations sponsor a journal or newsletter to publish research and to further relevant interests.

Taken together, these organizations are referred to as “*organized dentistry*.”

Taken together these organizations are referred to as “Organized Dentistry.”

While you are not forced to join any specific organization, being a professional implies that you should participate in some sort of organization that supports the values of the profession and insists on high technical and ethical standards.

Self-monitoring is not the only thing that professional organizations do, however, and a brief discussion of the differences between professional organizations and other similar groups is called for. Dentistry has historical roots in the salon of the barber-surgeon, that person in each community who was most likely to provide oral care from about 1500 until 1900 CE. Such practitioners did not always view themselves as “professionals” in the ways that dentist do now, and it is important to distinguish a professional organization from a guild, a trade union, a craft union, and a fraternity. The main difference – at least in theory – is that professions are not exclusively self-interested as those other organizations have tended to be. For example, the ADA code asserts that

...dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in the community...

and

*The American Dental Association calls upon dentists to follow high ethical standards which have the **benefit of the patient** as their primary goal.*

The CDA code says that

Service to the public is the primary obligation of the dentist as a professional person. The privilege of being a dentist comes with a responsibility to society and to fellow members of the profession to conduct one's professional activities in a highly ethical manner. While serving the public, a dentist has the obligation to act in a manner that maintains or elevates the esteem of the profession.

Service to the public is the primary obligation of the dentist.

That said, it does appear that the main professional organizations in dentistry substantially serve the interests of members, and the ADA and CDA are widely respected as powerful supporters of the interests of dentists. Here's a recent quote from the *Wall Street Journal*. Note that it refers to the ADA as a "trade":

The American Dental Association is one of the most influential trade lobbies in the country.

*WSJ Capital Journal
August 24, 2012*

This matter is somewhat controversial, as some dentists feel that the ADA is "too commercial" while others figure that the ADA's primary purpose is to ensure the financial viability of members' private practices. Many professions, such as medicine, nursing, and psychology have made the fiduciary role a pillar of their codes (fiduciary, meaning that one person must trust another to take care of their interests, because they cannot do it for themselves).

Fiduciary: When a person takes care of someone who must trust them. A person who has the power and obligation to act in the best interest of another.

These organizations have much to offer you, and you have much to offer them. They represent a way for you to stay connected with your profession, with colleagues, and with the norms, standards, and culture. The ADA and CDA provide a wide range of services including liability insurance, free consultations, support, and advocacy for issues such as fluoridation, while lobbying for dentists' interests in state and national governance. As an example, the CDA offers a substance abuse diversion program for members who struggle with addiction.

Organized dentistry is unique in the professions in that it requires you to join three groups at once. If you decide to be a member, you must join the ADA, your state organization such as the CDA, and your local component chapter such as the Alameda County Dental Society. You cannot choose to join only one or two of these. Dentistry is also unique in that it has a very high rate of membership, higher than other professions. Typically, 60-70% of dentists are members, while only 20 – 30% of physicians are members of the AMA and about 40 - 45% of psychologists are members of the APA. Membership is not cheap, especially when you are starting out, but most organizations have a discounted dues structure for new members early in their career.

Dentistry has a high rate of membership relative to other professions.

Section 2.2: Codes of Ethics

Professionalism is an agreement among members of a professional group about how they expect other members of the group to behave.

*David Chambers
CDA Journal, 2014*

Most professional organizations have a code of ethics that is written by and for members to set out aspirations and expected behavior. Codified prescriptions of desired behavior have been around forever if you include the Ten Commandments, the Five Precepts of Buddhism, the Persian Furūsiyya, the Hindu Kshatriya, medieval warrior codes,

and even the Code d'Honneur of the French Foreign Legion. Dental schools all have a code of ethics, as well, and the Dugoni Dental School also has a formal “Patient Relations Philosophy Statement” that describes how we aspire to treat patients.

Codes typically are a mix of abstractions, such as *“obligations arising from the implied contract between the dental profession and society”* and concrete rules, such as *“It is unethical for a dentist to increase a fee to a patient solely because the patient is covered under a dental benefits plan.”*

The ADA code’s official title is American Dental Association Principles of Ethics and Code of Professional Conduct, and it consists of three sections. Many of the abstract ideas are listed in the first section of the ADA document titled, “Principles of Ethics.” That section is organized around five of the Normative Principles described in Chapter One of this text. The second section is called “the Code of Professional Conduct,” and it includes fairly specific rules about behavior expected of member dentists. The third section is titled “Advisory Opinions,” and it is interspersed throughout the document. These opinions serve to flesh out the meaning of the “Code” sections and provide clarity.

Purposes of Codes

An ethics code typically serves the following purposes:

1. **Present shared aspirations.** The document expresses the group’s view of the behavior expected of all members of the profession, and the goals of the profession in general. It is an assertion of who you think you are, what you stand for, and who you strive to be.
2. **Provide a starting point for discussion and reflection.** It can be very useful in creating dialogue and thoughtful efforts to enhance the profession.
3. **Provide a vehicle for education.** Codes are written to be instructive and are used to indoctrinate new members, such as dental students.

4. **Provide a basis for sanction.** A code can be used to decide if a member deserves some sort of punishment or restriction because his or her behavior is out of line with professional values.

The question of sanctions opens the door to a larger discussion of where ethics and law interact in day-to-day practice. The chart below should be helpful.

	Ethics	Law
Concerns:	Right-wrong, aspirations, reputations	Baseline minimal expectations, protect the public
Admin by:	ADA,CDA, SFDS Organized Dentistry	State Board (DBC) Dept of Consumer Affairs
Written down:	Ethics Codes	Dental Practice Act (Codes, Regulations)
Vehicle:	Peer Review and Ethics Committees	Board Staff and Attorney General
Leverage:	Membership, bad publicity	License revocation (suspension)

Once again, you can see that law and ethics, while similar and complimentary, exist in slightly different realms. They have differing concerns, and they are tended to by different agencies. This is important to understand for at least two reasons.

First, the state dental board is not “your board” (as a dentist or student). The mission of the Dental Board of California is clear:

*“The Dental Board of California's mission is to protect and promote the health and safety of **consumers** of the State of California.”*

The mission of the Dental Board is to look after the interests of patients, not dentists.

DBC Website
http://www.dbc.ca.gov/about_us/mission_vision.shtml

The dental board in California is part of the Department of Consumer Affairs and patients (“consumers”) are their actual clients, not you. It is the board’s responsibility to protect dental patients and keep them safe from you, the dentist. It is not their job to advocate for you or protect your interests. They aim to be polite and civil and fair to you, but they do not look out for you. The reason they administer “boards” (that you must pass in order to practice) is to protect the public from you.

So, who takes care of you and your interests? That’s where your professional organizations fit in. If anyone is going to look after your interests (aside from yourself) it will be them or your liability/malpractice insurance company, which is likely to be of great help to you if you are in a fix, because they lose money if you make a mess or get in “trouble.” They have a financial interest in keeping you out of trouble, and will offer important assistance if you reach out to them. Do not be shy about calling them for advice before problems unfold. They have an 800 number for just that purpose.

Who looks after the interest of dentists?

- Organized dentistry
- Your malpractice (liability) insurance company.

The second important thing in the chart has to do with sanctions. Since your professional organization did not issue your license, the ADA or CDA do not have jurisdiction over it.

The state dental board has authority over your license; organized dentistry does not.

Only the board has authority to discipline your license. If you violate conditions of the Code of Ethics, the only real power those organizations have is to urge you to get in line or to dismiss you from the organization and publicize that action. They could, of course, write a letter to your state board, and the board is likely to take such a letter very seriously.

As we mentioned at the beginning of this section, you have much to offer your professional organizations, and it is wise to join and remain an active member. Soon after joining you are likely to

A license is mandatory. Membership in organized dentistry is voluntary.

be asked to contribute, and one of the many ways you can contribute is to participate in ongoing updates and revisions of your codes of ethics.

Ethics Codes in Dental School

Dental schools have a code of ethics as well, and a mechanism for enforcement, usually called the “ethics committee.” Sanctions in school can be more consequential than those found in the profession once you graduate. For example, most, if not all dental schools are willing (if reluctant) to dismiss a student found guilty of serious cheating, especially when it involves the doctoring of school records or a conspiracy (a coordinated group effort to cheat). Schools must provide “due process,” (a fair administrative process and hearing) because the consequences can be severe, such as the loss of a career. The right to confront one’s accusers means that a student typically cannot make anonymous accusations about another student and expect the school to take action regarding that student (imagine a situation where you have been accused of cheating, and when you ask, *“Who made this accusation?”* the response is, *“That’s a secret.”*). As a result, many students are unwilling to come forward when they perceive that cheating has occurred. This is an important problem because, as mentioned previously, professions are expected to self-monitor and self-manage its members. In the same way that patients do not usually know when dentists are cheating them, faculty members do not typically know when students cheat. It would be optimal if the process of group self-monitoring began to take shape during dental school.

When a student is found guilty of an ethical violation, schools are likely to take an educational-remedial approach to punishment, seeking to turn the cheating episode into a potential life-enhancing developmental experience. This, of course, is not always the case, as some violations are occasionally so damning as to require dismissal from school.

Section 2.3: Peer Review

Peer review is designed to resolve disputes regarding the quality and appropriateness of dental treatment between a patient and member dentist, or a dentist and an insurance carrier.

*“Peer Review; A Membership Benefit”
CDA Document*

The [chart above](#) also lists something called “Peer Review,” an important benefit of membership in organized dentistry.

This service is provided mostly by local component (county) dental societies for [resolving disputes in a](#)

Peer Review has two important functions:

1. Resolve conflicts between doctors and patients (or between practitioners)
2. Manage member behavior.

[fair and impartial way that avoids legal intervention or board involvement.](#) Peer review may be able to resolve disputes between patients and doctors, between doctors and insurance companies, and between doctors and other doctors.

If a patient is unhappy with some aspect of your treatment, he or she can contact the local dental society and ask for help. From your point of view, this is a good thing, because other options are potentially more draconian and expensive. Patients could just drift away from your practice and grouse about you to their friends... or post a nasty Yelp review, and that’s not good, either. You certainly hope that they do not contact the dental board or call a lawyer, although you should never try to stop patients from doing so. There are almost certainly attorneys in your community who are looking for work, and their hourly fees are high.

The peer review process involves no fees for dentists or patients, and you can suggest that vehicle to patients. Peer review is a benefit of membership in the dental associations. In California the situation is investigated and adjudicated by a minimum of three other dentists (each with at least five years of practice experience), who may evaluate your treatment, records, and patient claims. The process tends to be faster than

legal interventions and tends to be fair. It does not necessarily shield you from a subsequent lawsuit, even though patients sign a form saying that they won't sue later. Peer review documents are not discoverable in a subsequent legal action. According to the CDA, outcomes have historically been evenly divided in favor of patients and dentists. Peer review is not a punitive system, so you do not have to worry about being punished if a claim is not resolved in your favor. It is possible that you will be asked to make amends of some sort, most likely financial.

Once again, this is an area where you can contribute to your profession. You can serve on the peer review committee once you have adequate practice experience yourself.

Reference

Chambers, D.W. (2014). Does the ADA have a code of ethics? *CDA Journal*, Vol 42 (12), 813.

Chapter 3: Commerce and Care

Peltier & Jenson

(12/26/17)

3.1: Incompatibilities and Tension (Theory)

Commerce and Care chart

Competition and cooperation

3.2: Making a Living in Dentistry

- Dentist owned and operated solo or group practice
- Dentist owned solo or group practice that hires a Dental Service Organization (DSO)
- Corporate DSO owned group practice
- Knox-Keene insurer/provider group practices
- Government agency group practice.

3.3: Specific Ethical Traps and Pitfalls in Business

3.4: Working with Third-Party Payers (“Insurance”)

Common legal and ethical traps in working with “insurance”

Conclusions

Reference

Key Concepts

- ✓ Dentistry is not simply a “regular” business like other businesses in the commercial marketplace.
- ✓ There are irreconcilable incompatibilities between a healthcare practice (such as dentistry) and a regular business in a market economy.
- ✓ The most important difference is that patients must trust doctors to look after their interests. Doctors and patients cooperate rather than compete.
- ✓ Private practice dentists have one foot in healthcare and the other foot in the business world. They must maintain a viable business in order to practice. Dental clinics typically must do the same.
- ✓ The need to make money creates a variety of ethical challenges.
- ✓ Corporate practice has its own set of ethical challenges.
- ✓ Dental plans (“insurance”) is a blessing and a curse, and are associated with many ethical issues.

Section 3.1: Incompatibilities and Tension (Theory)

American doctors have one foot in each of two conflicting worlds.

- Peltier & Giusti, 2008

From time to time you will hear someone remark, often in passing, that “Dentistry is a business” (more or less true) or that “Dentistry is just another business” (not true). The speaker is usually trying to make the simple point that a dentist must make ends meet. He or she must bring in more revenue than they spend to run the practice. That’s obvious.

Dentistry is not “just another business.”

But, there’s a less obvious component of that remark that must be challenged. The remark can also imply that a dental practice – first and foremost – must be run like any other business, and that the business components of practice are the most essential. This is wrong, as **there are core aspects of a healthcare practice that are incompatible with a “regular” business**, and while the “business” components might seem more important to the dentist, they certainly are not the most important to patients. **These incompatibilities are irreconcilable, and they create an ongoing tension in dental practice.** That tension never goes away. While some dentists do not seem to notice the tension, most do. The challenge is important enough in a small private practice, but the implications loom especially large in the emerging world of for-profit “corporate dentistry.”

The discussion begins with an acknowledgement that American dentistry is practiced in the context of a capitalist market economy characterized by competitive relationships between buyers and sellers. As with any system, there are distinct advantages and disadvantages associated with this system of conducting business. The main advantages derive from the ways that decisions by independent buyers and sellers set the proper price (and actual value) of goods and services in the marketplace. This

opens the door to competition, and such competition stimulates innovation and productivity. It also results in long hours, hard work, keen focus, risk-taking, and stress. Small business owners tend to get up early, stay late, work on weekends, and worry about the competition.

The chart below depicts key differences between the dynamics of the commercial marketplace in a capitalist economy and contrasts them with the ethics of healthcare (specifically, the doctor's office). The remainder of this section will discuss those differences, one by one. This matter is described in greater detail [here](#).

Commercial

- Profit is goal. (proprietary)
- Money is primary
- Customer as “means.”
- Competitive
 - between companies
 - between buyer & seller
- Caveat Emptor
- Create needs, wants
- Monopolies prohibited
- Endorsements, testimonials
- Things, commodities

Care

- Care is goal. (fiduciary)
- Money is derivative.
- Patient as “end”
- Cooperative
 - between doctors
 - between Doctor & Patient
- Buyer can't compete (trust)
- Prevention, education
- Monopoly
- Science, empiricism
- Life or death, health.

Here is an explanation of these differences, one by one:

Overarching goals. In a commercial enterprise, the main goal is profit. That's what a business is all about. In the small business arena, if you do not make a profit you will have to close your business. In fact, the IRS will not allow you to deduct the cost of doing business (rent, supplies) from your taxable revenue unless, at some point, you

make a profit. They will consider your “business” to be in reality, a hobby. In the corporate world, officers of a publicly held company view the task of “enhancing shareholder wealth” as an ethical duty. They must make a profit.

In healthcare, the whole point of the enterprise is different. The doctor’s office is focused, first and foremost on the well-being of the patient. Enhancing patient health is the goal. Patient needs *are the point*.

Money. In the commercial world, the acquisition and accumulation of money is central. It is the force that drives ideas and efforts, and it is the way that people keep score. You are doing “well” if you make more money; you are doing poorly if you do not. You focus your attention on making money. The vast majority of business owners would quit if there were no money to be made.

In the commercial world profit is the point.

In healthcare, the focus is on patient welfare and care. That is the point. If patients are doing better, you are doing well. Money, in this arena is derivative, meaning that when you take good care of patients, money will follow. This has certainly been the case in dentistry in the recent past. Whether it continues to hold true is an open question.

Customers and patients. In the commercial world customers are only of interest because they are the means by which money is made. Businesses need customers in order to succeed. *They are a means to an end.* Large corporations do not care deeply about you; they need you to purchase their goods and services so that they can succeed. They care about that. They are focused on producing things that you need or want, because that is how they make money. This is no secret; everyone knows it.

Customers are a means to an end.

In healthcare we don’t even call them “customers,” and we view patients differently. We care about them because, in a professional sense, they are what we are

all about. They are *the point*, not a means to something else (money). We don't need to place their interests above ours (if we consistently did so, we would probably burn out fast), but we do make them central to our practice. We do not use them to get something that we want or need. Our job is to take care of them.

Competition and cooperation. The most important difference between the worlds of commerce and care is in the dynamics of relationships. The essential nature of the American market economy is competitive. Competition is what makes it all work.

Businesses are competitive; healthcare is cooperative.

This competition exists in two dimensions: in relationships between businesses and also in relationships between buyers and sellers.

Businesses compete with each other to survive. If you do not compete well enough, other companies will take your customers and share of the market and your business will fail. You do not share information with competitors or do anything else that might help them succeed. In a sense, they are your enemy. They are surely a threat.

In the commercial arena there is a competitive relationship between buyers and sellers. Each has a duty to take care of their own interests and they cannot expect the other to do this. Buyers strive to get the most they can for the lowest price; they are trying to get the "best deal" they can get. Sellers do the opposite: they strive to give the least amount of product or service at the highest possible price. This is no secret, as everyone understands the rules and the game, and the tone of negotiations is usually friendly. But sellers do not do things just to be nice, and they do not "share." They always have an ulterior motive in mind, and everybody knows it. There is nothing wrong with any of this. It's how the system works, and as noted above, it has its clear and compelling benefits.

Healthcare services are cooperative, not competitive. Since the whole point is to serve patients to enhance health, doctors cooperate with each other on behalf of

patient needs. If another doctor can help with your case, they do so. This system becomes confusing when some doctors do not understand or buy into the need for cooperation. They view dentistry primarily as a business and see other dentists as competitors. This confuses patients and creates problems for the profession. Patients sometimes behave like consumers in response (shopping around, haggling over price), and dentists do not usually like this.

The most important lesson from the chart, however, is this: **the doctor-patient relationship is cooperative, not competitive (as is the buyer-seller relationship).** The doctor-patient relationship cannot be competitive because the buyer, in this case the patient, *is in no position to compete*. He or she does not have enough information or training to know what's going on. They do not understand the circumstances, the risks, the possible consequences, the alternatives, or even how the treatment is performed. They don't even know what to ask. It's not an even playing field or a fair fight. Competition won't work. Patients must rely on doctors to look after the interests of both parties, not just their own. This is a radically different relationship from that of the buyer and seller. It means that patients must trust doctors; therefore, doctors must be trustworthy.

Patients can't compete.

Creating demand vs. prevention. In the business world, it is perfectly OK to use marketing and advertising to increase demand for products or services. Companies must do a good job of making potential customers yearn for their goods. As consumers, sometimes it's difficult to discern the difference between what we "need" and what we want. Sellers love to convert wants into needs. We now all need a smart phone. More needs equate to more sales and more profit. The opposite is true in healthcare. Doctors actually strive to *decrease* needs through promotion of prevention practices and patient education (and fluoridation). We all know that prevention of disease is far more effective and efficient than restorations, even though such treatment enhances

Doctors don't try to increase the need for their services.

our bottom line. But, prevention is better for patients, so we focus on it, and we treat when we must, as something of a last resort. If dentists really treated their practices as a pure business, they would provide soda pop in the reception area and lolly pops on the way out the door. The conflict between these two worlds is clear in the following example: A large, complex treatment plan is not great for a patient (as compared to prevention), but is very good for a dentist's business. These issues are not simply abstract. They are a fact of everyday chairside interactions, especially with patients who do not understand prevention or view their teeth as the dentist's responsibility rather than their own. Dentists are face to face with this conflict whenever they help patients choose between treatments, especially when one treatment is more expensive than the other. The tension is real. Dentists make more money with one treatment rather than another, and patients don't know how to choose.

Monopoly status. For competition to work its magic in the economy there must be a level playing field, and government must serve as a referee in the game. If one company gets big and wealthy enough it can distort the natural competitive forces, and tilt the playing field. When one company has a monopoly, it does not have to lower its price in the face of competition (because there is none), so monopolies are prohibited. This is not the case in healthcare. Since cooperation and trust are norms, dentists essentially have a monopoly on dental practice. Only dentists can provide dental care. You must be licensed by the state, and you do not have to worry about non-dentists providing cut-rate, low quality care. Dentists often feel threatened when lower cost practitioners, such as denturists or dental therapists are permitted to practice.

Dentistry
has
monopoly
status.

Evidence. In the commercial world where advertising plays an important role, endorsements (when a famous person or celebrity touts a product) and testimonials (when a non-famous person does the same) serve as evidence of the value of a product or service. This is not the case in healthcare, where much more is at stake (life and limb). In healthcare we insist on empirical evidence; that is, science, not endorsements. We test things out under carefully controlled conditions to make certain that they are true. We do not rely on what celebrities say, nor do we use materials based upon testimonials. Science is our guide.

Dental practice relies on science.

Commodities vs. health. One final difference is in the actual services you provide and what's at stake in the outcomes. In the commercial world where everyday things are bought and sold, one can survive the purchase of a defective or crappy product. But in the healthcare arena, you may really suffer if you receive inadequate or poor care. You might even die. There's much more at stake. That's why trust and science are so important.

The stakes are high in healthcare, sometimes life or death.

Summary

Commerce and health care are different in fundamental ways that most people do not clearly grasp. The basic principles and dynamics of the marketplace are incompatible with the ethics of a doctor's office. These differences are not reconcilable in any neat or complete way. As a result, doctors and other health care providers must be aware of the differences and prepared to live with the day-to-day tension that is always present. This tension must be managed. Many practitioners are not aware of these differences, resulting in confusion on the part of doctors and patients, as well. Dentists who work in corporate settings or in large clinics must be especially vigilant about potential abuses that can emerge when the norms of commerce prevail.

The “bottom line” in healthcare is that patients must be able to trust doctors and other care providers. Patients are not customers who can readily or effectively compete in a caveat emptor (let the buyer beware) arrangement. Doctors look after patient interests as well as their own. The patient’s health is the primary concern of a dental practice.

Patients must rely on doctors to look after patient interests, not just their own.

Section 3.2: Making a Living in Dentistry

Dentists must attend to the economic realities of practice or risk failing at business and being of no service to anyone.

While the practice of dentistry may be satisfying and even exhilarating at times, it is generally not viewed by practitioners as a hobby. The work is challenging and sometimes risky, and no one expects you to do it for free. Dental faculty members and dental patients hope that you will make a very good living at it.

While things are changing rapidly now, there are currently five main business models plus a variety of hybrids that you will encounter in the real world. Hopefully, your practice management class will prepare you to effectively engage with them and make your way into the one with the best fit. They are:

(Natasha Lee, personal communication, email of February 7, 2016)

- 1) **Dentist owned and operated solo or group practice** where the dental practice is owned and operated by a practicing dentist or dentists. The dentist-owner does it all and takes all the risk and all the profit, and he or she must become a competent business practitioner and marketer as well as an excellent clinician. Some of these practices hire young dentists to serve as “associates,” occasionally with the purpose of grooming them to purchase the practice in the future.

Current business models in dental practice.

- 2) **Dentist owned solo or group practice that hires a Dental Service Organization (DSO)** for management support. In this model, the dentist-owner hires professional managers to take care of the essential business components of practice. This allows the dentist to focus almost exclusively on oral health treatment. Hopefully, the DSO is really good at the management of the practice.
- 3) **Corporate DSO owned group practice** that employs dentists and sometimes offers opportunity for partial ownership in one or more locations in the form of employee stock shares (e.g., Heartland, Pacific Dental Services).
- 4) **Knox-Keene insurer/provider group practices** that own and operate the practice, act as the dental managed care plan and provider, and hire dentists as employees (e.g., Western Dental, Kaiser). The term "employee" has important and complex legal implications in the business and tax world. Clinicians work on a structured "nine-to-five" kind of basis with occasional weekend work and vacation time that is guaranteed. Work days and times are negotiated and negotiable. Employees are likely to be paid a salary with benefits such as matching retirement contributions, health care, and disability insurance. They carry less day-to-day responsibility to make ends meet, and substantially less risk. Employees tend to share after-hours responsibilities.
- 5) **Government agency group practice.** In this setting dentists are members of the agency (e.g., military personnel in the case of the Armed Forces). Their work is supervised by the agency and its rules, and they typically receive significant benefit packages. These agencies are often committed to societal or educational goals that extend beyond making a profit (e.g., Indian Health Services).

"Corporate" practices like to call their practices "private" in the same way that traditional dentist-owned practices call themselves "private." The word "private" is now often used to differentiate a "private practice" from a "public health practice."

Ethical challenges in each model

Regardless of the type of dental practice all the models share a common demand: revenues generated by dental care must exceed the expense of providing that care.

While each practice configuration poses special challenges, dentists in a private practice situation are often in the best position to fulfill their ethical duties and obligations. The more control a dentist has over their work environment the more control they have in decisions that directly affect patient care. In an institutional setting, the dentist loses some control over treatment decisions, but may have considerable input in how the organization sets patient care policies. In most situations, a dentist in a corporate setting has the least personal control over policies and procedures that are typically designed to maximize profits.

The ethical challenges of solo private practice. Many people choose a career in dentistry so that they can “be their own boss” and run their dental practice as they choose. For these entrepreneurial types, a private practice situation is the obvious best choice. Let’s look at some of the ethical challenges being such an entrepreneur presents.

As with any business the formula for success is rather simple: revenues must exceed expenses (the dentist’s desired salary being one of those expenses). The dentist is then presented with two strategies for success: increasing revenue and decreasing expenses. Both strategies can present ethical challenges, but each can be managed in such a way that ethics are not compromised.

First, the pressure to make money can be intense in a private practice, especially in a new practice. Sometimes a practice must accept debt at the beginning, on the premise that a loyal patient base takes time to develop. Even with a loyal base, practices must endure occasional dry spells, soft months that recur each year, and national or regional economic downturns. The pressure can become intense, especially when others (such as staff members and family) are depending on the practice for their financial survival.

Unethical practices can seem attractive under these conditions, and humans are capable of powerful rationalization in the face of crisis.

One of the most powerful challenges lies in the fact that solo practice is just that: solo. This means that the dentist-owner may be so independent as to be isolated. Essential business decisions are made alone, without consultation with others who may advise restraint or a view that might result in higher expense or lower revenue. As a solo practitioner feeling the intense pressures of a high-stakes small business, it is easy to rationalize effective business decisions that are – in a clinical sense – unethical. And there is no one to check you. Unethical practices can go on for years if they are not scrutinized or challenged, until a crisis evolves. The solo dentist is surprised because he or she thinks that the thing they were doing was fine simply because they've been doing it so long, with zero consequences. This problem is less likely to happen in group practices or large organizations where many people are involved in decisions and daily practice.

Another challenge in solo practice is this: if the practitioner cannot create leverage by hiring another dentist, there are two obvious ways to increase revenue. The first is to personally work more hours and see more patients. This is stressful and exhausting, and can set one up for poor decisions. The second is to ask auxiliary team members to do more. This can cause them to cross legal and ethical lines to do things that are outside of their scope of practice.

Some solo practices address this challenge by creating incentive plans, and these plans usually establish financial goals for specific time periods (days, weeks, and months). While they certainly help to focus everyone's attention on efficiency, they can have the effect of focusing the practice on money ahead of real patient needs. Team members sometimes become uncomfortable "selling" dentistry. Others, especially when they have been taught dentistry by a dentist who is aggressive, may naively embrace selling without understanding the ethical implications.

The ethical challenges of corporate practice. It is easy to see that the dentist in a corporate setting typically faces significant ethical challenges. That said, there are corporate dental entities that do an exceptionally good job of creating clinical environments that support the values and ethics of the profession. In fact, a well-run corporation can provide better access to care and more consistent and efficient care for their clients than many non-profit and private practices. Large entities have the advantage of economy of scale, and they can use their size to institute quality control measures and can often afford the most modern instruments and equipment. They can also provide ongoing training that might be prohibitively expensive for a solo practice. Small dental practices must shut down for a day if serious continuing education for team members is to take place.

The most important thing to know about working in a corporate situation is that the dentist cannot defer to any illegal or unethical policies of the company. The ultimate legal and ethical responsibility for patient care is always that of the individual provider. “Company policy” is no defense in the case of malpractice or ethical breaches. While the corporation might provide legal defense for their employees, they have no obligation to do so, and the fate of the individual’s license to practice and any malpractice losses are entirely placed on the treating dentist. The risk is yours. It is always your license that is at risk, even though you work for a large company that directs your work.

Young practitioners should carefully investigate (before signing into) any potential employment contract or practice environment, and decline to join any business that does not uphold the values and ethics of the profession. Your professional organizations, such as the CDA may offer guidance to young members. One cannot sign away one’s professional responsibilities no matter what the contract states, so always obtain legal advice before signing, and always review a contract for clauses that may compromise your ability to practice ethically. For example, if the corporate situation takes away your right to diagnose and treatment-plan the patient as you see fit, then you are already at high risk

for a legal or ethical breach. Treatment plans that are profit-oriented are rarely in the best interest of the patient. As we know, patient autonomy is of utmost importance in dental ethics and autonomy is violated when all reasonable alternative treatment plans are not offered. “Selling” an ill-suited treatment plan is unethical and often illegal, as well. While expensive treatment plans are better for the practice or company, they are not always best for a patient. Corporate practices commonly use formal incentive systems to motivate and track clinician behavior (such as how long each appointment takes). Such systems can cause significant conflict and stress for practitioners. Extracting one’s self from such situations is usually more difficult than avoiding them in the first place.

Section 3.3: Specific Ethical Traps and Pitfalls in Business

Businesses succeed by increasing revenue and/or decreasing expenses.

Here is a partial list of general and specific ways that dentists encounter potential ethical challenges on the business side. They are divided into two types, those involved in efforts to decrease expenses and those aimed at increasing revenue.

Efforts to decrease expenses:

- Negotiate favorable lease conditions or invest in a physical facility.

Ethical Pitfall: It is the dentist’s responsibility to ensure that the facility in which they offer treatment is safe, up to date with regulations, and accessible to all patients.

- Control or reduce the costs of materials used.

Ethical Pitfall: The dentist is responsible for the outcomes of the care provided. If excellent results cannot be obtained with cheaper materials, equipment, or techniques then they must be avoided.

Ethical challenges when cutting costs.

- Maximize the life span of equipment.

Ethical Pitfall: Dentists are expected to have up-to-date equipment, especially if treatment outcomes and patient safety are at risk. Old or outdated instruments and equipment must be renovated or replaced in a timely manner.

- Control or reduce the costs of labor.

Ethical Pitfall: Dentists are responsible for all care provided by staff members. It is the dentist's responsibility to determine if a staff member has the appropriate training, experience, and licenses to provide care. All clinical work must be properly supervised, and work done by assistants and hygienists must be within their scope of practice.

- Control or reduce the costs of dental laboratory fees.

Ethical Pitfall: Utilizing a dental laboratory that produces inferior quality restorations or uses questionable restorative materials is unethical. The dentist is ultimately responsible for the fit, appearance, and quality of the final restoration.

- Limit the number of patients who demand more time or who cannot afford extensive or expensive care.

Ethical Pitfall: Dentists have an obligation to make their services available to all people. Every dentist has an ethical obligation to accept patients with limited ability to pay and patients who present physical and behavioral challenges. Such patients cannot be systematically avoided and left for "other" dentists to treat.

Efforts to increase revenue:

Ethical challenges when enhancing revenue.

- Attracting new patients.

Ethical Pitfall: Advertising must not be false or misleading in any way.

Ethical Pitfall: Fee splitting is not allowed. You can't pay someone to send you patients, because it creates a conflict of interest. Offering discounts in exchange for patient referrals is illegal.

Ethical Pitfall: Claiming superior treatment or technique.

Ethical Pitfall: Claiming to be specialized in areas without the proper training and experience.

Ethical Pitfall: Claiming to be a “specialist” in areas that are not recognized as specialties.

- Encouraging patients to buy more services.

Ethical Pitfall: Encouraging patients to consent to services that are either not necessary, not in their best interest, or inappropriate considering their values.

- Expand the number of different services offered (e.g., implants, Invisalign).

Ethical Pitfall: Attempting procedures without the proper training and experience.

- Maximize the insurance benefits of third party payers.

Ethical Pitfall: Submitting an insurance form that does not accurately represent the diagnosis made; this is both illegal and unethical. Adapting or recommending treatment plans based mostly on insurance compensation.

- Increase office efficiency to provide more care in less time.

Ethical Pitfall: Increasing efficiency by delegating tasks to dental assistants and hygienists that are not within the scope of their practice.

Ethical Pitfall: Ordering radiographs without interviewing or examining the patient.

Ethical Pitfall: Allowing the hygienist to begin treatment before the dentist examines the patient and makes a diagnosis and treatment plan.

Ethical Pitfall: Allowing associate dentists to perform treatment that they did not treatment plan.

Ethical Pitfall: Loosening or ignoring rules about General and Direct Supervision of assistants.

- Maximize the use of the clinical facility.

Ethical Pitfall: Including specialists within the general practice, creating a conflict of interest when the patient is not given a choice of specialists elsewhere.

Ethical Pitfall: Allowing staff members to conduct inappropriate treatments or procedures when the dentist is not present.

- Incentivizing staff.

Ethical Pitfall: Creating a business system and culture that emphasizes financial goals ahead of clinical goals.

Ethical Pitfall: Creating specific incentives that encourage team members to sell dentistry rather than treat patient needs and wants.

Section 3.4: **Working with Third-Party Payers (“Insurance”)**

This is an area rife with potential for legal and ethical challenges. The main source of these problems derives from differences in the basic goals and values of dental practice versus third-party payers. As noted at the beginning of this chapter, the goal of dentistry is care (of patients), while the goal of third-party payers (who live in the world of commerce) is profit.

Dentists and insurance plans live in different worlds.

We will use the term “insurance company” in this chapter because that term is synonymous with “third-party payers” in dentistry. The word “insurance” is not technically accurate because these dental companies do not actually provide insurance. They provide dental benefits agreed-upon by patients and their employers, often for regular, expectable, ongoing care. Unlike real insurance they are not in place to help clients recover from an unlikely disaster, such as an auto collision or flood or fire in their home. They are a “plan,” typically tied to one’s job, offered as a benefit of employment.

These dental plan companies provide a valuable service to patients and society, as they allow dental expenses to be spread across large numbers of people over long periods of time, making dental care affordable to many people who could not or would not pay for the care they need at the time they need it.

Dentists and plans are trapped in a treacherous game.

Despite this service, and because of the difference in values (between dentists and insurances) dentists sometimes feel victimized, and they vilify insurance plans and their rules and behavior. Sometimes the behavior of dental plans tempts dentists to cut corners or to take actions to deceive those plans. Some dentists feel justified in doing so, thinking that dental plans are out to cheat patients and

dentists. It becomes a bit of a game, with dentists trying to retaliate for what they perceive as unfair treatment by the insurance company, which causes insurance companies to create rules to prevent this from happening, which in turn makes dental care more difficult. It becomes a circle of distrust. This is a very dangerous game, because insurance companies typically follow strict (and legal) rules of engagement, and are unhappy when dentists do not follow them, especially since dentists have signed formal agreements to participate.

There are several areas where this creates ethical (and typically legal) problems.

Common
legal and
ethical traps.

- **Waiving the co-payment.** This tactic is illegal and insurance companies make this fact crystal clear. They even send notices to patients about it. In their view, when dentists waive the copay they are actually reducing their fee. Therefore (in the view of payers) dentists have falsely billed the insurance company, causing the company to pay out more than they should. That said, patients usually love to have their copay waived, and some even expect it (or worse—demand it as a condition of treatment acceptance).
- **Jiggering the treatment plan.** In response to a perception that plans are not paying a “fair” amount for treatments, some dentists adjust their treatment plans to cause the dollar amount of treatment to be higher, in effect making up for the amount that they feel the insurance plan should pay. In addition to the ethical and legal problems involved, this behavior is, to put it simply, crazy (and dangerous).
- **Altering dates of service.** Patients are often the ones initiating or requesting this behavior, and it is obviously illegal and unethical (and crazy, too). But it can be surprisingly tempting when a patient has lost his or her job or just gotten a new job, or when their employer has made a unilateral change in benefit plans. If you just perform the treatment now and submit a claim stating that the treatment was done on a different date, the patient can take advantage of a plan that will allow them to “afford” the proper treatment. Patients will sit in your chair and plead with you to “help” them in this way. While it can make for a difficult discussion, the bottom line answer is that: 1) you do not do dishonest things

such as writing falsehoods on documents; and 2) you could lose your license to practice if you were to do so. Many patients are not aware of the severe consequences attached to this behavior and view it all as simply facilitating maximum use of the benefits they have earned or deserve. Some may even have had previous dentists offer to do this. Other patients figure that *“it never hurts to ask.”*

- **Treating to the insurance plan rather than (clinical) patient needs.** This is another tempting but very problematic behavior, and it represents something of a conspiracy between patients and dentists. Patients open the bidding with a comment like this: *“Does my insurance cover it?”* or even *“Just treat what the plan covers.”* All dentists have heard these questions and comments, and they are completely understandable. Who can blame a person for trying to minimize out of pocket expenses? But, some patients have been covered by excellent dental plans for so long that they really don’t expect to have to pay *anything* for their care. In a sense, they have been “spoiled.” Others are living from paycheck to paycheck, are striving hard to make ends meet, and complex dental treatments can seem very expensive to average Americans.

This scenario becomes especially problematic when the ideal or proper treatment is not “covered.” The dentist is clear about what should be done, and the insurance plan does not reimburse for it. This seems strange to the well-trained, conscientious practitioner, and makes no sense from a “care” point of view. Sometimes dentists get angry and feel justified in breaking the rules (see the examples above), and sometimes they are tempted to only perform procedures condoned by the insurance (especially when patients assert that they will only consent for treatment that is covered by the plan). The picture gets even more complicated when a dentist perceives that their patient might decline a treatment plan or even disappear without any treatment at all.

Of course, it is unlikely to be a good idea to “treat to the plan” or treat to the specifications of the insurance company, especially if such a path would not conform to the standard of care. While it is relatively easy to rationalize and conclude that some care is better than none at all, even if this is true, a doctor must still be able to justify treatment based upon the standard of care.

When doctors are unwilling to conform to the plan’s dictates, they then must assertively explain their reasoning to a disappointed patient.

Conclusions

The fact that American dentistry (and all of healthcare) operates in a competitive, market-based economic environment causes intractable conflict. This conflict is unavoidable, confusing to practitioners and patients, and the source of many ethical challenges. Doctors must resist market forces to provide good ethical care to patients, to stay out of legal trouble, and they must effectively manage market forces to run a financially healthy practice.

Reference

Peltier, B. & Giusti, L (2008). Commerce and care: The irreconcilable tension between selling and caring. *McGeorge Law Review*, University of the Pacific, Vol 39 (3), p. 785-800. (http://www.mcgeorge.edu/Documents/Publications/08_Peltier_MasterMLR39.pdf).

Chapter 4: Informed Consent

Peltier & Jenson

(12/26/17)

4.1 The Basic Concept: The Patient's Right to Choose

The Autonomy-Paternalism Spectrum

General Components of the Informed Consent discussion

4.2 What to Do and How to Do It

Specific components of the discussion

4.3 Who Can Consent for What?

Adults Who Cannot Consent for their Own Treatment

Summary

References

Key Concepts

- ✓ The informed consent duty derives from the principle of Autonomy.
- ✓ Patients and practitioners both have autonomy. They can both say "No." Neither can prevail on the other.
- ✓ Informed consent is a process of communication that results in agreement.
- ✓ Signatures on paperwork are not "Informed Consent." They are documentation.
- ✓ The practical meaning of autonomy varies from culture to culture.
- ✓ Minors (and several categories of others) cannot typically consent for their own treatment.

Section 4.1 The Basic Concept: The Patient's Right to Choose

Informed consent is a process of communication; of informing and getting permission. It is a person's voluntary authorization for a procedure based upon that patient's understanding of all necessary and relevant information. The patient grants consent for treatment.

To adequately understand informed consent, you must endure a brief history lesson combined with a little philosophy and some law.

Consent in medicine and dental practice is relatively new (Faden & Beauchamp, 1986). Doctors have historically practiced paternalistically, meaning: *Father knows best*. This notion seems more ridiculous with each passing day, but it wasn't long ago when that mode of practicing was dominant in dentistry. It still happens in some places and some practices. Baby boomers such as the authors of this text can clearly recall the way that care was administered when they were young: The dentist typically said something like this: *"OK. Today we're going to do a couple of fillings, so open wide and let's get started."* That was the extent of the "discussion," if any discussion took place at all. This is not to criticize or paint the dentist as a bad guy (they were, actually, almost all men). It was the way things were done, and for the most part, nobody complained. If the dentist was earnest, competent, and trustworthy, things went pretty well.

But society and American culture has evolved, and paternalism has fallen out of favor, especially among younger people. Still, informed consent is relatively new in healthcare, and some practitioners find it hard to fathom. Some seem to view it as an "inconvenience," like a speed bump.

The requirement for consent derives from the normative principle of *autonomy*, the right of people to govern themselves (“agency”), and to choose for themselves what they will volunteer for among the available options. While paternalism was common practice in the 20th century, the legal right to autonomy in healthcare is not especially new.

Informed consent is derived from the principle of patient autonomy.

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault

Justice Cardozo, 1914
Schloendorff v. Society of NY Hospitals

The moral definition of individual autonomy is clear and helpful:

Individual autonomy is generally understood to refer to the capacity to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces.

Stanford Encyclopedia of Philosophy
Christman, 2015

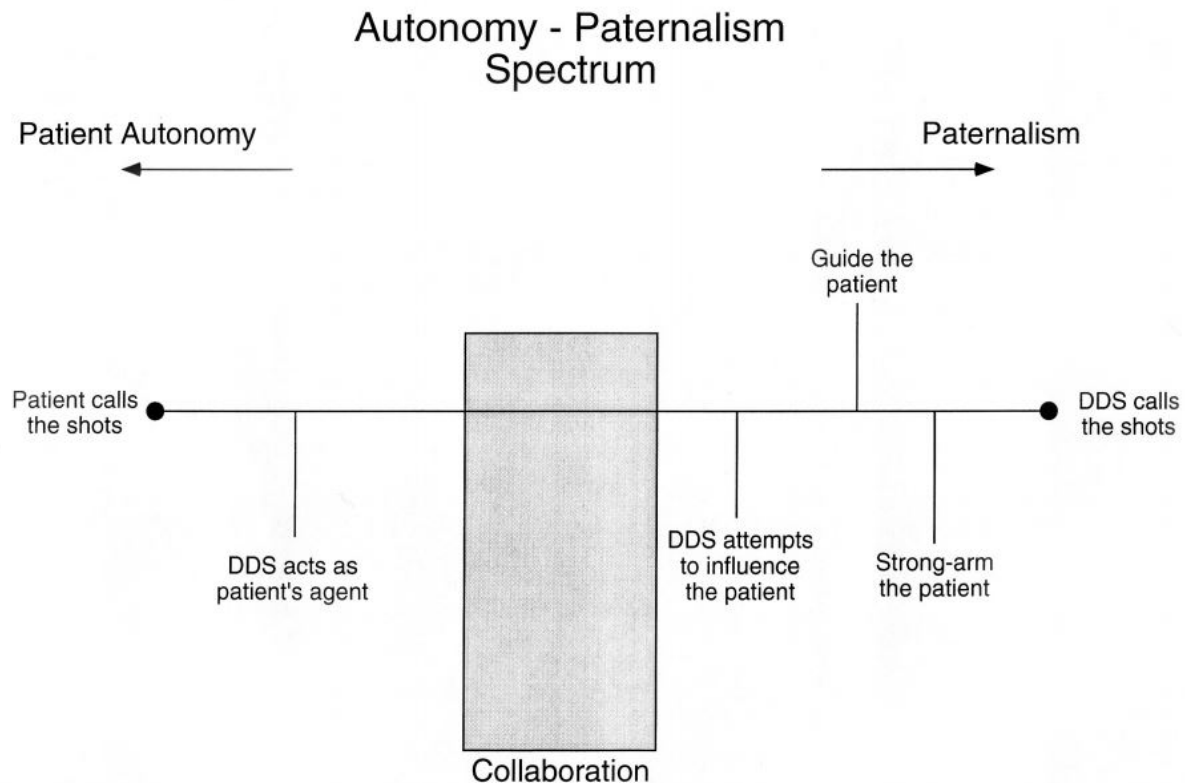
Paternalism, on the other hand is somewhat the opposite. It interferes with a person's capacity to choose things for their own reasons, and it acts on behalf of someone without their knowledge or perhaps against their wishes. Paternalistic action is justified by the claim that the paternalistic choice will be better for that person. No malevolence is intended. It's just that the paternalistic one knows what's good for the other person. To some extent this is true in dental care. The dentist *does* know better, at least in some ways. The dentist knows much more about dentistry, teeth, oral health, disease, and the consequences of everything involved.

Dentists know about dentistry; patients know about themselves.

Patients know very little of this. But, patients have their own special knowledge domain: that of themselves, their lives, their families, their history, their values, their

resources, their habits, their dreams, and their responsibilities. Both sets of expertise must be included in treatment decisions.

The chart below may help sort this out.



The issue of autonomy vs. paternalism is not as simple as the chart implies, as there are philosophical categories of paternalism such as hard and soft, weak and strong, broad and narrow, pure vs. impure, and moral vs. welfare paternalism. Paternalism is not universally bad. As an example, is it wrong to stop a person from walking in front of a bus while they are texting, or to stop a person from jumping from the Golden Gate Bridge, or to insist that people wear helmets or seatbelts and to install buzzers that annoy them when they do not buckle up? It's complex, like most ethical issues.

The matter is further complicated by the fact that individual autonomy is not universally embraced or seen as the ideal. It is a modern, humanistic, and western concept, for the most part. Different cultures view autonomy and even the idea of “self” differently, and American culture (especially the white, northern European components) tends to prioritize individual rights and personal autonomy. Alternative views assert that the self and identity are intrinsically connected to others, to family, and to community. For many people, the essential decision-making unit is family rather than self. This difference is not just an abstraction, as you will encounter clinical dental situations where a treatment decision is viewed as a family matter. Often a person cannot and will not consent to a treatment without checking with their spouse—or an elder.

In many cultures, important decisions are not made without familial involvement.

That said, the legal requirement for consent is an individual one, based on the premise that it is the individual person who must live with the discomfort of the procedure, the outcome of treatment, and is held responsible for payment.

The matter is even more complicated when you factor age and competency into the mix. The legal age of consent is, of course, eighteen. But the matter of getting consent for and from minors can be frustratingly complex. And there are adults between the ages of 18 and 65 who are “developmentally disabled” or “intellectually disabled,” in ways that impair their capacity to understand and consent.

Section 4.2 What to Do and How to Do It

“The dentist should obtain the patient's informed consent through a face-to-face discussion that allows the patient sufficient time to make an informed decision. The discussion should be appropriate to the patient's level of understanding.” – California Dental Association (CDA Online)

The Informed Consent Exchange

Most people do not really understand the consent process, and few healthcare practitioners do a really good job of it. Most patients don't help much either, partly because they do not know what to expect and partly because they trust you and would rather not make the effort to understand the big picture or the details. Some are so nervous that they just want to get the process over with. Others feel that they would bother their doctor if they asked too many questions. Some don't generally understand what they are reading or hearing and do not want to seem dumb. Many patients just want to seem cooperative and nice. Some doctors and patients treat informed consent in the same way that they deal with the process of downloading software from the Internet. They just hit "Agee."

Some patients aren't all that interested in the informed consent discussion.

Doctors are often unaware when their patient does not adequately understand the situation and the implications of treatment (Peltier, 1998).

Doctors are often unaware that patients don't understand.

The first thing to remember about informed consent is that it is a discussion, an exchange of information. Obviously, you the dentist or dental student know far more about teeth, gums, and oral health and disease than almost any patient. Less obvious is the fact that your patient knows much more about his or her life than you do. So, you both must exchange information about your respective areas of expertise. Informed

Informed consent is a process of communication.

Informed consent is a discussion that includes these elements:

1. The doctor (or assistant) provides information and offers treatment choices.
2. The patient asks questions.
3. The doctor answers those questions.
4. The patient makes choices and gives consent.

consent involves a discussion, and it is not a one-sided discussion with the dentist mechanically reciting a long list of things that could go “wrong.”

This process is best done with the use of visual aids such as models, pictures, diagrams, radiographs, or even videos. It is hard to imagine an effective informed consent process without some use of visual aids. Many dentists do not use visual aids, partly because they were not taught to do so, and did not have teachers who modeled such behavior. Some busy dentists may feel that the use of visual aids would slow them down, but the benefits of visual aids far outweigh the cost in time and effort. While the informed consent discussion can be done by dental assistants or other staff, and videos are very helpful, the doctor must be involved in the process and take ultimate responsibility for it.

Use visual aids

- Photos
- Radiographs
- Drawing
- Cast models
- Internet

The point, of course, is that patients understand the situation so that they can make an informed decision. This means that the discussion must be done in language that is comprehensible to them. There are two types of language usage that must be considered. First, patients and doctors don’t always speak the same “native” language. The United States has always been an immigrant nation, and many languages are spoken here. In California dental schools one can expect to regularly encounter patients who speak one of five different languages. A quick internet search indicates that more than 100 languages are spoken in California and roughly half of Californians grew up in a family that spoke a language other than English. (This trend is common throughout the United States now.) The language challenge must be dealt with successfully, involving the use of interpreters and translation as necessary (interpretation is an oral process; translation is a written one). Family members can serve this purpose, but there are complications that can make this strategy problematic. Personal health information can be sensitive and very personal, and

family dynamics complex. No matter: the problem must be solved. There is no informed consent when patients do not comprehend what they are being told.

Second, dentists have their own special technical language that they use to communicate with each other which includes terms such as *periapical, buccal, vestibule, mesial, and tori*. Patients have no idea what these terms mean, and they are mystifying. Because they do not want to seem “dumb,” unsophisticated, or bothersome, many patients will not ask you to define your terms. They simply nod and allow you to move on to the next topic. This means that you must track their understanding, checking along the way to ensure that they really know what’s going on and what you intend to do to them. This is an important component of informed consent...and it’s only fair. This means that you must develop two different vocabularies, one for colleagues and faculty members, the other for patients and their families. And you must pay attention to the language you use with each audience. Do not assume that patients understand what you told them.

The Role of Documentation

While documentation of informed consent is extremely important, it is widely misunderstood. Many, if not most patients and healthcare practitioners mistakenly think that the signing of complicated forms is the central focus and essential part of consent. It is not.

The central task of informed consent is not to simply get a patient's signature.
(That's "documentation.")

Take a look at the form below:

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages (exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partner, associates, association, corporation or partnership, and the employees, agents and estates of any of them, shall be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including expert fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. The immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 342.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1253.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services: 4/10/01

Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ (Date: 4/11/01)
Patient or Patient Representative's Signature (Date)

By: _____ (Date: 4/11/01)
Print Patient's Name

Print or Stamp Name of Physician,
Medical Group or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Ask yourself this question: Does a signature on a form like this constitute informed consent? Many healthcare practitioners seem to feel that when they get a patient's signature, they've done their job and all is well, so they focus their energy on getting that signature.

This is the way it is supposed to work:



This means that the most important component of the process is the interaction between doctor and patient that results in a truly informed choice on the part of the patient. Once this choice is made, the choice and the process are

documented in writing. The information is for the benefit of the patient; the documentation is for the benefit of the doctor or practice.

Both parts are essential. That said, the interaction benefits both parties, as a good discussion enhances trust and rapport, and connects patient and doctor in a collaboration. Be wary of patients who are unwilling to participate in an informed

consent discussion. It is simply not healthy for patients to ignore essential treatment information. Such patients may not feel ownership of the process, may not feel responsible for their own health and homecare, and may not feel that they have any important role in their treatment or follow-up. They may not follow through with medications, home care, or even payments.

The three-block diagram above also points out that it is the patient who gives consent. Sometimes you will hear healthcare practitioners say that they “gave (the patient) informed consent.” This is a misguided use of language, because it is the patient’s right and duty to “give” (or decline) consent to the practitioner. So, doctors “get” informed consent from patients. They don’t give it. They give information and (hopefully) get consent in return.

Two parts of the informed consent process:

1. Discussion
2. Documentation

What’s Included in the Consent Discussion?

The overall concept is that patients should be provided with all the necessary information needed to make an informed decision about their treatment. This is generally thought to include:

- ✓ the nature of the pathology and treatment
- ✓ the pros and cons of proposed treatment
- ✓ alternatives, including no treatment
- ✓ risks and implications (for the future)
- ✓ possible side effects of medications
- ✓ costs

As you can see, there is more to be discussed than just RBA's (risks, benefits, alternatives), and costs are to be discussed ahead of time, mostly because patients frequently make treatment decisions that are influenced by cost, especially when they are paying "out of pocket." The alternative of no treatment should be discussed as well. Doctors should describe a prediction of what is likely to happen if no treatment is performed or the treatment is postponed. The most challenging task is often the discussion of the "cons" or negative aspects of the recommended treatment. This can be hard because it requires that you inform your patient about the downsides of the treatment you are proposing. That said, such a discussion can really save the day if the downside rears its ugly head. As an example, if you have warned your patient that preparing a tooth for a filling might result in the need for root canal treatment, you seem smart and competent when you announce that RCT is indeed required. If you failed to mention that possibility ahead of time, and your patient is surprised, and you may end up with egg on your face...along with a confused and annoyed patient. Such a patient is likely to lose faith in you.

Patients must be informed of the risks and negatives associated with each treatment.

This does not mean that a dentist must discuss every single possible risk or side effect. The legal question of "how much information?" was resolved in the classic case of [Cobbs v. Grant](#) in 1972. The court found the following:

- disclosure need not be made if the procedure is simple and any danger is remote, or the harm is quite minor.
- doctors need not disclose risks when the patient requests not to be informed. (This means that a practitioner can skip the informed consent discussion when patients insist that they do not want to participate. As you might imagine, this is a bit risky, and you should carefully document things in the record. It's probably wise to insist that your patient hear at least the most compelling aspect or risk involved in the proposed treatment.)

- doctors need not disclose risks when disclosure would so seriously upset the patient that the patient would not be able to dispassionately weigh the risks of refusing to undergo the recommended treatment. (If disclosure would frighten them so much that they would not be able to respond rationally or might even flee treatment). This is called the “therapeutic exception” or “therapeutic privilege.”

Section 4.3 Who Can Consent for What?

Typically, patients give consent for their own treatment.

Minors

Despite the above, patients are not always allowed to consent for their own treatment. The most common exception is when your patient is a minor (someone under the age of 18, the age of “majority”). In that situation it is the parent who must grant formal consent...and sign documentation. When this happens, it is a good idea for you to get the minor patient’s *assent*, which is their explicit or implicit agreement to the treatment. Assent is generally informal, and it involves a disclosure discussion with the young patient, conducted at an intellectual level appropriate to the patient’s age. It’s never fun or optimal to provide treatment to someone who objects to that treatment, although it is occasionally done (with parental consent, of course). If parents are divorced and do not share custody, then the custodial parent must give formal legal consent. The exact rules about parental consent get quite complicated when parents of a child are not married to each other, or are deceased or not involved, so check local law before you treat a minor in this situation.

Most states (California included) have laws that allow minors to consent to some treatments without parental permission, consent, or knowledge. Parents balk and cringe

Minors can consent to several kinds of care (depending on state law), but not for dental treatment.

at the thought of such a situation, but these laws serve to protect minors when it is in the minor's best interest to be able to receive care without parental involvement. All states allow emancipated minors (under the age of 18 who have a court's finding that it is in their best interest) to live self-sufficiently and without parental constraint. Non-emancipated minors have some [rights to consent for their own care](#), as well. In California for example, minors (over the age of 12) are [permitted to consent to an abortion](#) (*American Academy of Pediatrics v. Lungren* 16 Cal.4th 307, 1997 and (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11) without parental notification, to consent for mental health care, for alcohol and drug treatment, for contraception and treatment of sexually transmitted infections, and for HIV testing. While these exceptional situations do not include dental care they can complicate discussions with minor patients. The case of an adolescent who is pregnant can precipitate a complex legal and ethical situation when decisions about radiographs are concerned (study the current standard of care regarding x-rays and pregnancy as it evolves). It is conceivable that a dentist might not be permitted to discuss the situation with parents of the pregnant minor. Obviously, dentists need to know when their patients are taking oral contraceptives, and youthful patients may be reluctant to share that information if they suspect that dentists will inform their parents.

Adults Who Cannot Consent for their Own Treatment

Here are some other complicated areas where someone other than the patient can provide consent for treatment. These situations are quite rare in general practice, often associated with developmentally disabled, intellectually disabled, or "incompetent" patients, and one should consider legal advice before proceeding.

- Legal guardian
- Public guardian
- Regional Center Director
- Prior power of attorney

- Judge (Court order)
- Next of kin
- Two uninvolved physicians or dentists (in emergency)

Summary

While everyone in healthcare knows about Informed Consent, it is not always conducted properly, especially when viewed from an ethical point of view. Many practitioners think of it as a “paperwork” requirement, which is a misunderstanding. Informed consent honors patient autonomy and requires a clear and thorough give-and-take discussion between doctors and patients. Documentation is important, but it follows the verbal exchange. Absent such an exchange, patient understanding, and verbal agreement, informed consent has not taken place.

References

[American Academy of Pediatrics v. Lungren 16 Cal.4th 307, 1997.](#)

[California Health & Safety Code §§ 123110\(a\), 123115\(a\); Cal. Civ. 56.10, 56.11.](#)

Christman, J. (2015), "Autonomy in Moral and Political Philosophy," *The Stanford Encyclopedia of Philosophy* (Spring Edition), Edward N. Zalta (ed.), URL = (<http://plato.stanford.edu/archives/spr2015/entries/autonomy-moral/>).

Cobbs v. Grant (8 Cal. 3d 229). California State Supreme Court, 1972.

Faden, R. and Beauchamp, T. (1986). *A History and Theory of Informed Consent*. NY: Oxford University Press.

Peltier, B. (1998). Ethics and psychology: Informed consent. *Contact Point* (August).

Schloendorff v. The Society of the New York Hospital, Court of Appeals of New York 211 N.Y. 125; 105 N.E. 92. Decided April 14, 1914.

Chapter 5: Professional Relationships

Peltier & Jenson

(12/26/17)

Cooperation and Self-Regulation

- Sharing patients
- Error
- The work of other dentists
- Gross or continual faulty treatment
- Impaired colleagues

References

Key Concepts

- ✓ Dentists cooperate and collaborate (rather than compete) with patients and other practitioners.
- ✓ Professionals self-regulate in order to protect the public.
- ✓ Dentists are obligated to inform patients of their current oral health status (the result of the dentist's examination) without disparaging comment about prior dental services.
- ✓ Patients cannot tell the difference between bad outcomes and bad work.
- ✓ Dentists have a duty to take action when a colleague produces "gross or continual faulty treatment."
- ✓ Dentist have a duty to take action when a colleague is impaired.

Cooperation and Self-Regulation

You may recall from Chapters 1 and 3 the idea that cooperation is an essential component of the professional's identity. Doctors are members of a profession, a group of people committed to the care of other people who are in a vulnerable position because of their maladies, pain, and relative lack of information about dentistry. Doctors cooperate and self-regulate the profession because the public is ill-equipped to do so. Remember that your professional autonomy, the ability to conduct your practice in ways that suit you, is granted to you by the public. It is not a right or a given. When the public loses faith, legislation and regulation follow. Therefore, it is in dentistry's best interest to maintain high standards so that it is perceived as trustworthy by the public.

Doctors cooperate on behalf of patient needs.

Dentists cooperate with patients and they collaborate with other healthcare providers on behalf of the needs of patients. It is unprofessional to compete with others in your profession, especially if patients lose as a result. Doctors share information and expertise, and to a considerable extent, they look after each other.

It is unprofessional to compete with other practitioners, especially when patients are deceived or harmed.

This chapter explores some of the specific guidelines and behaviors associated with intraprofessional cooperation, including:

- How do you handle referrals (sharing patient care with another dentist)?
- What do you do when treatments (done by others) are sub-optimal? What do you say to patients?
- What do you do when you think that a colleague is behaving poorly?
- What do you do when you perceive that a colleague is impaired in some way?

Sharing patients

Obviously, no single dentist can provide all the services that every patient needs. Your scope of practice dictates that you refer patients to other dentists from time to time, so that patients get the best possible treatment. Dentists refer to other generalists and to specialists depending on patient needs. If you decide to perform a root canal treatment, you must be able to do it to the standard expected of a specialist. If not, refer to one. This situation becomes ethically complex when a patient rejects your referral. Sometimes patients balk at the cost of specialty care, sometimes they do not want to drive a longer distance for treatment, and sometimes they simply trust and like you, their current dentist.

When a patient is referred to you, communicate with the referring doctor to ensure that you understand your proper role. Return that patient back to the referring doctor for ongoing care as appropriate (unless the patient volunteers that they do not wish to return), and do your best to support the relationship that this patient has with his or her current dentist.

Error

Dentistry is a very challenging profession. Dentists, hygienists, and assistants perform difficult, intricate tasks in the mouths of live human beings who move and jolt, produce saliva, and feel what is being done to them by hand pieces and burrs that rotate at 400,000 RPM. Variations in anatomy and patients are common. Mouths and tongues are large and small, pain tolerances high and low, patient responses to anesthesia differ, and tooth and nerve anatomy vary from person to person. Some patients are super cooperative while others, not so much. The list goes on. Dentists treat fifteen to twenty patients a day, sometimes more. Orthodontists treat thirty to one hundred patients in a single day, day after day.

Everyone makes mistakes. No one likes to think about doctor error, and as a result medical error sometimes does not get the attention and recognition it deserves. Doctors and hospitals are not immune to error, and this presents a significant challenge. For a chilling analysis of medical error and its prevalence, click [here](#).

Everyone makes mistakes.

What follows are some thoughts about your own errors. First, do everything you can to prevent or minimize error in your work. There are four main ways to do this:

1. **Continuously grow your knowledge and skills.** Get as much continuing education as you can. Stay involved with study groups, organized dentistry, and professional inquiry. Real doctors never stop learning. Refresh your professional joy by expanding yourself. That said, do not stretch yourself beyond your capacities, especially when tempted by the chance to make more money. Be sure that you know what you are doing before you start a treatment.
2. **Prepare for each appointment adequately.** Mistakes are sometimes made when a doctor is not prepared for a treatment or has not studied the patient's chart.
3. **Put systems in place to minimize error.** Use routines and checklists that require safe practice, including double-checking by at least two sets of eyes. Do not assume that you will naturally notice or catch every possible error. Do not assume that you will not make mistakes; assume the opposite.
4. **Slow down.** Many errors are made by clinicians who are simply moving too fast. There are many forces in daily dental practice that tend to push practitioners to move too fast.

When you make a mistake, own it. Be truthful to patients about the situation. This is often embarrassing and truly difficult to do. Do not make the situation worse by offering

Take responsibility for mistakes or sub-optimal outcomes. Tell the truth.

misinformation or a lie, even though it may be tempting to do so. In the end most people will respect you for stepping up and taking responsibility, even though it can be awkward and distressing. You may lose a patient, but when you step back and think about it, isn't that better in the bigger picture than telling a professional lie? It may help to know that state dental boards are unlikely to severely discipline practitioners for one simple mistake. They do, however, punish providers who cover mistakes up. Never alter or falsify records. Contact your malpractice insurance provider for help with error as necessary.

The work of other dentists

All dental practitioners encounter dental work that appears suboptimal. Sometimes a restoration looks wrong or even strange. How should you respond? What are the ethics involved in this everyday situation?

Bad work versus bad outcome. The first step in sorting things out requires a look at the distinctions between a restoration that was poorly done and one that was done properly (or as well as could be done under the circumstances), but did not result in an optimal outcome (Ozar & Sokol, 2002).

Bad Work
vs
Bad Outcome

Bad work is defined as

Diagnosis, treatment, or communication that falls below the standard of care. Poorly, improperly done, or a "mistake."

There are several possible causes of bad work.

- ⊖ poor or inadequate technique
- ⊖ wrong diagnosis
- ⊖ mistakes in preparation or restoration of a tooth
- ⊖ poor lab work
- ⊖ inadequate quality control and follow-up
- ⊖ speed and greed

Bad outcome:

Work that fails to accomplish a benefit to the patient or involves harm or risk; not the result of “bad work.” May be the best that could be accomplished under the circumstances.

There are many possible causes of bad outcome.

- ⊖ difficult or challenging patient conditions
 - small oral opening
 - patient could not sit still
 - patient could not get numb
- ⊖ temporary restorations still in place; the patient did not follow through to receive the permanent restoration
- ⊖ patient had limited resources and dentist provided a less good treatment, perhaps as a stop-gap or temporary measure
- ⊖ restoration did not work out well, patient did not return for re-do
- ⊖ patient did not employ adequate home care

Patients typically cannot tell the difference between bad work and bad outcome. Sometimes—especially when clinical rapport is not good—patients assume that a bad outcome is bad work, “the doctor’s fault.” Other times, especially when rapport is good, patients give their dentist the benefit of the doubt, excusing bad work and figuring that “*it was just one of those things*” or “*everyone makes mistakes.*”

Patients cannot tell the difference between bad work and bad outcome.

An ethical response to sub-optimal work requires great care and skillful communication. The ADA’s Code provides the key to such communication:

Patients should be informed of their present oral health status without disparaging comment about prior services.

This implies that **a)** you must comment on the condition of a patient’s oral health, including any work that seems problematic; and **b)** you should do so without

criticizing. This can seem hard to do when you encounter a restoration that looks horrible, but no matter what you assume, there is almost always an alternative explanation. Sure, bad work exists. It's out there in patients' mouths. But, for every restoration that looks terrible, there is a possible exculpatory explanation that would make it a bad outcome. You just don't know because you weren't there when it all went down. For example, there's always the possibility that the treating dentist placed a crown or bridge, realized that it was inadequate, informed the patient, and instructed them to come back in a week to have that restoration replaced with a "good" one. The patient never came back and then forgot about it completely after a couple of years. Now, it certainly looks like bad work, but it's really a case of bad outcome, compounded by patient indifference or misunderstanding.

Your ethics codes say that:

...when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed and justifiable. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable.

This means that dental providers must come up with scripts and phrases to use in such situations, and the phrases need to be truthful. First, describe what you see in objective terms rather than judgmental ones.

Judgmental:

*"This crown was poorly done.
This is a poorly constructed bridge.
Wow! Where did you get this bridge done?"*

Objective, without disparaging comments:

"The crown on tooth number 14, the first molar on your upper left side, has an open margin. We really need to replace it, because there's a

space around the gum line that is likely to allow bacteria to get inside the crown and damage the tooth. (Let me show you with this picture)."

If your patient asks why or how this happened, you can answer:

"It's impossible for me to tell. I can tell you that at this point it's important that we remove the crown, inspect the tooth structure underneath, and replace it."

These conversations can be difficult, especially when patients (understandably) ask probing questions about prior services or assert that the restoration was done recently, and that they paid a significant amount of money for it. You can certainly recommend that your patient contact the previous dentist, and you could even offer to do this for them. But, refrain from speculation about how that open margin came about. The Golden Rule applies here: remember that there are probably restorations out there in the world that you placed that are not working out perfectly. Think about how you would like a colleague to handle *that* situation.

Gross or continual faulty treatment.

All of this is not to infer that you should cover up for colleagues. A profession is not a group of people who circle the wagons and simply look out for each other, reflexively protecting themselves from patient criticism. Remember that the point of a profession is to use your special knowledge and skills to look after the interests of people who are vulnerable because they cannot evaluate your recommendations or treatments. In fact, ethics codes also say this about the work of colleagues:

Gross or continual faulty treatment.

"Dentists shall be obliged to report to the appropriate reviewing agency ... instances of gross or continual faulty treatment by other dentists."

This means that you have a professional obligation (to the public) to monitor and help manage colleagues who are practicing below the standard of care. This could include:

- colleagues who have inadequate training or skills
- colleagues who are attempting treatments that are beyond their skill set
- colleagues experiencing a loss of skills due to medical or cognitive conditions or age-related deterioration of abilities
- colleagues who suffer from substance abuse or addiction

Impaired Colleagues. Often dentists in the above categories do not or will not recognize their limitations, and need outside help to adjust or retire. Patients depend on professional colleagues to intervene. There are several possible actions to be taken.

Confronting
impaired
colleagues.

1. Meet with the colleague in person and discuss your observations
2. Contact your local peer review committee for help
3. Contact the state dental board

Such interventions are mandatory. Ethics codes require some kind of appropriate action. Gossiping or grouching to colleagues without taking action is professionally inadequate and unacceptable. The ADA Code also says this:

It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

Most if not all states offer diversion programs for addicted healthcare providers. California has two, one run by the dental board, the other by the California Dental Association. Diversion programs typically allow a practitioner to enter treatment

and continue to practice with a license (while being monitored for compliance and sobriety).

Summary. Dentists are expected to cooperate with each other on behalf of patient welfare. This means that they accurately and objectively inform patients of their oral health status without criticizing colleagues. This constraint is not in place simply for members of the profession to protect each other, but is necessary because one never really knows what happened or why a restoration looks “bad.” That said, dentists do have a duty to act when a colleague is impaired and likely to harm future patients.

References

- American Dental Association (2016). *Principles of Ethics and Code of Professional Conduct*.
http://www.ada.org/~media/ADA/Publications/Files/ADA_Code_of_Ethics_2016.pdf?la=en .
- California Dental Association (2012). *CDA Code of Ethics*.
https://www.cda.org/Portals/0/pdfs/code_of_ethics.pdf
- Leape, L. (1994). Error in medicine. *JAMA*, Vol 272 (23), 1851-1857.
http://www.uphs.upenn.edu/gme/pdfs/Leape_Error%20in%20Medicine_JAMA.pdf
- Ozar, D. & Sokol, D. (2002). *Dental Ethics at Chairside. Professional Principles and Practical Applications*. (2nd Ed). Washington, DC: Georgetown University Press.

Chapter 6: Confidentiality and Mandatory Reporting

Peltier & Jenson

(12/26/17)

6.1: The Nature and Importance of Confidentiality

6.2: Managing Confidential Information

- Record-keeping and record management

6.3: Exceptions and Mandatory Reports

- Categories of abuse

 - Child abuse

 - Elder abuse

 - Domestic violence and abuse

 - Developmentally disabled adults

6.4: Other responsibilities related to confidentiality

- Dangerous or suicidal patients

- Criminal patients

- Patients with infectious diseases

- Adolescent patients

Summary

References

Additional Resources

Key Concepts

- ✓ Start with the premise that everything you learn about your patient is confidential.
- ✓ Patients generally expect a confidential relationship. This allows them to be open and honest with you.
- ✓ Electronic communication, while generally favored by patients, is problematic. Assume that an electronic message is public – or could be.
- ✓ While doctors and clinics essentially “own” patient records, patients typically hold the legal privilege (regarding who can access them).
- ✓ Patients have a right to access their own records.
- ✓ Dentists, hygienists, and assistants are mandated reporters in several important areas such as child abuse, elder abuse, and domestic violence. There is an epidemic of abuse in these areas in the United States, much of it hidden or kept secret.

Section 6.1: The Nature and Importance of Confidentiality

Whatsoever I shall hear in the course of my profession...I will never divulge, holding such things to be holy secrets. - Hippocratic Oath

Confidentiality is important for at least two reasons:

1. Absent a confidential relationship patients are **unlikely to share** essential information accurately with their doctors, because
 - Some patients have a medical, dental, or a health history that is embarrassing to them (HIV, Hep C, herpes, mental health, phobias, addictions, seizures, allergies, pregnancy), and patients are quite private about their bodies, their maladies, and treatments. In many cases you absolutely need accurate medical information. Most people prefer not to feel judged about these things. Some fear that a new doctor might reject them if they know about their extensive and challenging health history.
 - You also need to know about patient values, especially what they care about in dental care.
 - You need a certain amount of (accurate) information about their finances when you discuss treatment options.
2. Disclosure of private information to third parties can cause real harm. People can be embarrassed or ashamed, and disclosure could damage a marital or intimate partner relationship, might cause job loss, or loss of prestige in the community. Friends and family can be hurt by previously undisclosed sensitive information. Business deals could be damaged or undone.

Without confidentiality, patients won't provide accurate and complete information.

The expectation of confidentiality is central to a patient's trust in their dentist and dental team.

- theyoungdentist.com

Patient expectations of a confidential doctor-patient relationship run along a broad spectrum. Some patients (likely a small number) have never thought about confidentiality when they visit their dentist. Some may expect confidentiality from their physician, but not their dentist. Others could not care less in any case. But most patients do care, and they enter the relationship with an expectation that the things they tell their doctor will be kept private. That private relationship is vitally

connected to trust, which is central to dental care and treatment. Absent a confidential relationship, treatment is fundamentally limited.

Here's a cautionary tale. Many dentists have had this experience or something like it.

A new patient comes into the practice, and during the initial examination informs the dentist that he or she cannot tell the patient's spouse that the patient wears dentures. It's a secret.

While this scenario can be difficult to imagine, it happens, which means that you never know what people consider private and what's public for them. Some patients are deeply distressed about something you consider trivial. You cannot apply your own standards and values to the situation. You must simply treat everything that you discover in your professional practice to be confidential. Err on the side of caution when it comes to confidentiality. This includes

Err on the side of caution in maintaining confidentiality.

- Everything that your patient tells you
- Everything that you read in their records
- Everything that you discover in your examinations
- Everything that you do for them
- The fact that they are a patient in your practice

Section 6.2: Managing Confidential Information

This requirement of confidentiality constrains your behavior when you need to communicate with other healthcare providers in the following ways:

1. If you can get a consultation without revealing the identity of your patient, you are free to do that as you wish. This means that you can get advice about how to treat a "34-year-old female with a blood pressure of 160/100 and a resting pulse rate of 80."
2. If the information you would like to share will necessarily reveal the identity of your patient, you should get your patient's explicit permission first. Be sure to document that you did this. Although it is generally acceptable in healthcare to get verbal permission and then document that conversation in the records, dental schools have a form for patients to sign, and practitioners are safer (from a risk management point of view) when they have

You can get anonymous consultations about patients without their consent.

such documentation. Sometimes patients forget that they previously gave you permission over the phone. That said, most patients are happy to find out that you are consulting with other doctors, or others who can help with their care.

In a dental school or large clinic, you can consult with other members of the clinical team in the same organization without special permission from your patient, and it is a good idea to inform patients that this is liable to happen by stating it in written intake forms. This means that you can share information with dental faculty members and get advice to enhance care or advance your learning.

When you share confidential information, reveal only relevant information needed to get the job done. Do not “overshare.” A discussion about a patient’s treatment plan should not include extraneous gossip.

The last item on the bulleted list above is called “contact confidentiality,” and it requires you to keep your list of patients confidential. You should not reveal the fact that a person is a patient in your practice (without permission of your patient). Occasionally people do not want others to know that they are visiting an orthodontist, “esthetic dentist,” prosthodontist (for denture care), or other specialist, for example. They may not want their previous dentist to know that they are seeking advice or treatment from a new dentist, especially if they felt mistreated by the first one.

Contact confidentiality: The fact that your patient is your patient is confidential.

At first glance the requirement of confidentiality seems simple. But, in real life, it is often complicated and sometimes vexing. For example, what do you do when a spouse calls to inquire about his or her partner’s treatment...or their attendance at appointments? Some spouses push their partner into dental care (for their own good), then call to make sure that their partner is complying. Sometimes spouses wonder where their partner spends their time. Sometimes high schools request documentation that a student was at your office when they missed class (were they actually at your

office?). What do you do if a patient's employer or HR department calls to find out about your patient's treatments? The answer to these questions is generally something like *"We can't answer that sort of question....HIPAA regulations don't allow us to do that. I'm sorry I can't help you."*

But, what about a patient who is HIV or hepatitis positive and has not told his or her partner? Or a pregnant teenager who begs you not to tell her parents that she's taking birth control pills or is pregnant. Those are challenging topics for ethics discussions, to be sure.

Emails and texts pose significant privacy risks.

Texts and email communication pose a significant threat to confidentiality, and a good general rule is to avoid these media except for routine messages regarding scheduling, cancellation, and basic administrative functions. There is surely a slippery slope in this area, as administrative messaging can easily slide into confidential treatment content over time. This can be a challenge to patient privacy and confidentiality. Electronic messages to patients and to colleagues are extremely convenient, but bear in mind that an electronic message is basically a public message. Assume that everyone in the world can and will see it someday. That said, you will find that many patients, especially younger ones, seem quite happy to share private information in text or email messages. When this happens, you should caution your patient, and you need to post a cautionary boilerplate message on your own email messages. We recommend a short, clear message that people might actually read.

Confidential treatment also requires a modicum of physical privacy. Operatories are problematic if they are not private, and when that is the case, practitioners must take necessary steps to enhance patient privacy. This matter is typically resolved – for better or for worse – on a case by case basis depending on the circumstances and practitioner resourcefulness. As an example, sometimes state dental associations such

as the CDA offer free dental care to large numbers of people in an open area such as a gymnasium. Sometimes dental school operatories are quite close together. It is important to lower one's voice and take sensitive conversations to a private place in these compromised situations.

It is a good idea to take special care of information or records related to sensitive issues, such as HIV seropositivity, chemical dependency, or sexual orientation and gender identity. Work closely with your patient and align closely to their preferences for sharing. If they are open about these issues, do not necessarily assume that you can be open about them.

These requirements are legal as well as ethical. The legal nature of patient privacy has been codified in HIPAA, the Health Insurance Portability and Accountability Act of 1996. That federal law – designed to protect insurance coverage for people who change or lose their job – also created standards for electronic billing, and along the way created formal rules for the handling of “PHI,” protected health information. The law really got the attention of dentistry, and it sets out strict rules for record-keeping and information sharing. Among other things, the law requires practices to appoint a privacy officer and post privacy practices.

Record-keeping and record management

Patient records are written and maintained for two clinical reasons and several business ones. The clinical reasons are:

Keep good records for:

- Continuity of care
- Risk management

1. **Continuity of care.** To help clinicians recall and integrate consistent treatment planning and safe practices regarding medication, allergies, radiographs, and other findings (for the benefit of the patient).
2. **Risk management.** Documentation can protect a practice from false or erroneous claims (for the benefit of the doctor and practice).

To understand how to manage records confidentially and properly, it is important to understand the legal concept of “privilege.” Privilege is a legal term which generally means “a special right, advantage, or immunity granted or available only to a particular person or group of people.” In healthcare the doctor or the clinic “owns” the records. They write and manage them on behalf of the patient who holds the privilege. This means that it is the patient who has the privilege to control legal access to their records (not the doctor). Doctors physically manage those records on behalf of the patient, and they must (typically) get their patient’s permission to allow any third-party access. This is true even after a patient has died, and you must get permission from an authorized party in order to share the deceased patient’s information.

Patients typically hold the privilege.

Records must be maintained carefully and stored safely. When they are paper records, they must be kept in a secure place. When they are electronic, various safeguards must be used (such as encryption, passwords, and malware protection). These practices should be established and published in the practice’s privacy policy, and patients should have access to them.

It is not only the doctor who must honor the privacy and confidentiality of patient information. All members of the dental treatment team must do so, as well. It is the responsibility of the doctor or practice owner to ensure that everyone in the office understands the importance of confidentiality and privacy, and new team members must be trained. Create and maintain a culture of confidentiality in your practice. Do not expect that people hired to work in a dental practice understand and appreciate healthcare confidentiality.

Patient access to records. If patients hold the privilege, then it follows that they have access to their own records. A doctor or

Patients have a right to access their records.

practice cannot refuse a patient's request for records. While state laws no doubt vary, in California a patient is allowed:

- a copy of the records, sent within 15 days of a written request (never relinquish the original records)
- opportunity to inspect the records within 5 business days (and patients can bring one other person with them)
- receive a summary of record content related to the patient's request (within 10 to 30 days depending on the size of the task)

Patients can request that their records be sent to a third party, such as another dentist. Dentists must comply with patient requests for records whether or not there is an outstanding account balance (the patient owes money). Practices can charge a "reasonable cost-based fee" for providing the records or summary.

The idea that patients could access and read their records should always be on your mind when you are writing charts and notes. Write nothing that you could not objectively defend, and avoid negative behavioral judgments. For example, instead of writing "patient was drunk," write "*patient's breath smelled of alcohol, gait was unsteady, and speech slurred.*" Do not offer assessments that are outside of your scope of practice such as, "patient seemed depressed," or judgments such as "patient was hostile." (You do not know that for a fact.).

From time to time you will receive a subpoena or court order for patient records. You may also receive a request for information from a licensing board. Do not panic. The rules are complicated, so respond immediately by contacting your malpractice insurance company or your attorney for advice about how to proceed. There are many kinds of subpoenas, and each should be dealt with somewhat differently. Even so, never ignore a subpoena. Respond in a timely manner in some way.

Section 6.3: Exceptions and Mandatory Reports

Now that it is clear that everything you know about your patient is confidential and private, it is time to learn about a series of exceptions to that rule. The basis for these exceptions is that there are times and circumstances when the good of the public (or third parties) conflicts with a patient's right to confidential treatment. While there are several types of exceptions, they are exceptions, not the norm. But these exceptions require that you break or violate the confidential relationship you have with your patients.

Laws require that you break confidentiality from time to time.

Dentists, hygienists, and assistants are mandated reporters in the following situations in all fifty states:

- child abuse
- elder abuse
- domestic violence

"Because 65 percent of all physical child abuse and 75 percent of all physical domestic violence results in injuries to the head, neck, and/or mouth, the dental professional is often the first person to render treatment to abuse victims as well as being their first line of defense. The dental community can make a difference."

- Dental Professionals Against Violence

The demand for a mandatory report is a challenging one, and dentistry has historically fallen short in its duty to report (ADA, 1998). Statistics indicate that while 65% of all child abuse injuries occurred to the head, face, and neck, only 1% of reports have historically come from dentistry. Dentists sometimes do not know the law or reporting requirements, sometimes do not want to alienate a patient, perhaps do not truly embrace the duty to report, and sometimes are just fearful about conflict. The situation has no doubt improved since 1998, partly because dental

There is an epidemic of domestic violence and child and elder abuse in the United States.

students typically receive at least some training in this area. Some states mandate regular continuing education on abuse and reporting as a licensure requirement.

This matter is important for at least two reasons: 1) There is a lot at stake. Children, elders, and spouses or partners die sometimes when they are abused or neglected. The emotional costs to victims are extremely high and long-lasting; and 2) There is an epidemic of abuse in each of these three reporting areas, mostly unrecognized because of the shame, fear, and secrecy surrounding them. For example, statistics indicate that there are at least 40,000 intimate partner relationships in every major city that could be characterized by “regular, severe violence,” and that physical assault is widespread in American society: 51.9 percent of surveyed women and 66.4 percent of surveyed men said they have been physically assaulted at some time in their life by an adult caretaker as a child and/or by another adult as an adult (CDC, 2000). “Overall, lifetime and one-year estimates for sexual violence, stalking, and intimate partner violence are alarmingly high for adult Americans; with intimate partner violence alone affecting more than 12 million people.” (CDC, 2010).

While specific laws vary from state to state, ethics codes encourage reporting. The ADA’s Code says that

Dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities, consistent with state laws.
- ADA, 2016

Laws in California (and most states) require dental practitioners to report when they have “reasonable suspicion” that abuse has occurred.

Reasonable suspicion means that you must consider whether the hypothetical reasonable practitioner would have suspicion. If they would, you should. A “reasonable practitioner” is someone who has adequate training and mainstream judgment. You do not need to investigate, you just report your

Every dentist will encounter abused patients.

professional suspicion and let the investigative officers do their job. You are allowed to take photographs or radiographs to document or track your suspicion. Dental records sometimes play an important role in abuse cases, so document carefully. You are immune from liability if you make an earnest report. While investigators will not reveal your identity, you do have to provide your name on reporting forms. Patients are likely to be able to figure out that it was you who made the report, so you must be prepared for that to happen, although it is very unlikely that anything bad will happen to you as a result. Patients sometimes even thank their doctor for reporting. The reason for reporting is not to arrest perpetrators (although this could happen). The reason is to protect people who are in a vulnerable position (children, elders, victims of domestic abuse).

Dental hygienists and assistants are also mandated reporters, independent of their dentist. They are required to report even if their doctor does not agree that such a report is necessary.

There are several types of abuse in each category

Child abuse. A child is anyone under the age of 18.

There are four categories of child abuse including emotional abuse, sexual abuse, physical abuse, and neglect. Dentists are likely to encounter physical

abuse, defined as “non-accidental physical injury caused by another.” Corporal punishment such as spanking is allowed in California and many other states, but with narrow restrictions. Parents are the only ones allow to administer corporal punishment. It must be reasonable, applied to the buttocks and back of the legs, and not to the face and head. Any punishment that requires dental or medical treatment is almost certainly to be against the law in California (see [Gonzalez vs. Santa Clara County, 2014](#)).

Types of Child Abuse:

- Physical
- Neglect (including dental neglect)
- Sexual
- Emotional-psychological

Neglect is a very significant issue for dentistry, as many American children are dentally neglected. The law requires parents to provide adequate dental care for their children, and many children do not receive that care. It is important to note that a report of neglect to Child Protective Services is not likely to instigate police action. CPS workers aim to solve the problem of neglect, not punish the parents.

The law (in California) requires an immediate phone call to CPS, followed by a written report within 36 hours, using a form that can be found at the end of this chapter.

Elder abuse. An “elder” is anyone over the age of 65. Types of elder abuse include physical abuse, neglect, abandonment, abduction, isolation, mental suffering, and fiduciary-financial abuse. Mandated reporters can call the police, local elder abuse services, and in California (when the abuse takes place in a care facility) you should call the county Ombudsperson (<https://www.aging.ca.gov/programs/litcop/>).

Domestic violence and abuse. While there are several types of domestic abuse, dental practitioners (and many other healthcare providers in California) are required to make a report to local law enforcement if he or she “*provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is suffering from any wound or other physical injury that is the result of assaultive or abusive conduct.*” This requirement applies to domestic violence only (not to injuries incurred in a bar fight between strangers). It does, however, require reporting of sexual assault and spousal rape. ([California Penal Code 11160 - 11163.6](#)).

Developmentally disabled adults. These are people between the ages of 18 and 65 who are unable to take care of themselves because of cognitive-intellectual disability. Dentists are mandated reporters of the abuse of developmentally disabled adults in California. Categories and reporting requirements are basically the same as for the above groups of people. California is divided into regions, each having a “Regional

Center” that administers and coordinates state services to developmentally disabled adults.

Section 6.4: Other responsibilities related to confidentiality

Dangerous or suicidal patients. Occasionally dentists encounter a patient who is suicidal or dangerous to others. You will be surprised sometimes at how open your patients will be when they visit you for care. They frequently reveal very personal information, and this implies that they trust you. It probably means that you have done a good job with rapport, although it could also imply that they have no one else to confide in.

Dental law and ethics codes have little or nothing to say about such patients, so we will extrapolate from how other healthcare professions handle these things, and make some calculated speculations. Obviously, a dentist ought to do what is in the best interest of a patient’s (and the public’s) well-being, so ignoring a suicidal or homicidal patient makes no practical or ethical sense.

Psychotherapy law provides some guidance. The first principle is to protect a patient’s privacy and the confidential relationship between doctor and patient. If a patient poses an active danger to self or others, the least intrusive effective intervention is preferred. When contacting third parties, provide just enough information required to resolve the problem at hand.

The rules for psychotherapists require them to conduct an adequate assessment for suicide and then respond appropriate to the results. In actual practice this usually means that they must take some kind of action, and such action may mean breaking confidentiality by warning or the enlisting help of a family member or the police. No one expects dentists to conduct a suicide assessment or a psychological intervention, but dentists should consider calling a patient’s family member, a suicide prevention line,

or the police, who might implement an involuntary psychiatric hospitalization (for 72 hours). If there is time, a professional consultation with a psychologist or malpractice attorney is a very good idea, from a practical and risk management perspective. While it is certainly risky to call a third party to warn them about a suicidal patient, imagine how you might feel if your patient did kill themselves shortly after their appointment with you. Risk aversion seems unethical when a patient's life is genuinely at stake. It is hard to imagine that you would lose much if a suicidal patient complained that you called his or her family member, especially if you have properly documented the discussions of suicide.

Psychotherapists have a duty to act to protect third parties from patients they know to be dangerous. As mentioned above, no one expects dentists to perform the duties of psychologists, but if a patient is clearly dangerous to another person or to the public, it is highly unlikely that you would "get in trouble" (whatever that is) by alerting authorities of the danger. Be careful, however, and get consultation if time permits. You certainly do not want to violate the confidential doctor-patient relationship based upon a "hunch" that your patient is a bad actor. Such a violation could be legally construed as slander. But, if you have credible evidence or reasonable suspicion that your patient intends to physically harm others you ought to consider action, such as calling the police or warning a third party. Excellent documentation is, of course, essential.

Criminal patients. This area is unclear, and regulated on a state by state basis. While the law tends to require third party warnings of intended dangerous conduct in the future, previous criminal conduct is likely to be viewed as confidential (Applebaum & Meisel, 1986). The law discriminates between actively concealing a crime (illegal), and simply not reporting one. Laws in this area typically focus on felonies, implying that misdemeanors need not be reported. Actively helping to conceal a crime is illegal

(“misprision”). Asserting privilege (reminding authorities that the relationship with your patient is confidential) seems unlikely to be considered concealment. Remember that your professional role is that of a healthcare provider, not an officer of the law. Your patients probably expect you to keep things confidential. Applebaum and Meisel assert that *“fear of prosecution for failure to report a past crime should not be a factor in deciding on a course of action”* (p. 221). (Please do not construe anything in this text to be legal advice. The authors are not attorneys, and much of the above is speculation. Contact an attorney for legal advice.)

Patients with infectious diseases. According to the AIDS.gov website (2017):

“Many states and some cities have partner-notification laws—meaning that, if you test positive for HIV, you (or your healthcare provider) may be legally obligated to tell your sex or needle-sharing partner(s). In some states, if you are HIV-positive and don’t tell your partner(s), you can be charged with a crime. Some health departments require healthcare providers to report the name of your sex and needle-sharing partner(s) if they know that information—even if you refuse to report that information yourself.

Some states also have laws that require clinic staff to notify a “third party” if they know that person has a significant risk for exposure to HIV from a patient the staff member knows is infected with HIV. This is called duty to warn. The Ryan White HIV/AIDS Program requires that health departments receiving money from the Ryan White program show “good faith” efforts to notify the marriage partners of a patient with HIV/AIDS.”

The Centers for Disease Control and Prevention offers a compendium of state laws related to this issue: <https://www.cdc.gov/hiv/policies/law/states/index.html> .

Adolescent patients. As mentioned in Chapter 4, minors (typically thought of as over the age of 12) can consent for certain kinds of medical treatments, such as treatments related to pregnancy and substance abuse. As an example, regarding pregnancy, contraception, HIV testing, and substance abuse treatment, California law states:

Adolescents can consent for their own treatment in several arenas other than dental care. Laws vary from state to state.

*“The health care provider is **not** permitted to inform a parent or legal guardian (that they provided such treatment) without the minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor.”*

- (Cal. Health & Safety Code §§ 123110(a), 123115(a) (1); Cal. Civ. Code §§ 56.10, 56.11)

When you become aware of these conditions in your youthful patients (as you should), it is probably a good idea to discuss confidentiality with the minor patient. (It’s optimal to discuss confidential arrangements and conditions before a complicated crisis unfolds.) Find out how they want you to handle information related to their treatments and conditions, specifically whether they would like you to inform their parents or not. While dental law is not especially clear in this area, it is probably wise to start from the premise that the information is private and should be kept confidential, between patient and doctor. That said, parents generally hold the legal privilege regarding treatment of their children, and when that is true, have a right to access records and information. As a dentist you must document your findings, diagnoses, and treatments (or decisions not to treat), and parents generally have a right to view those records. It is sometimes possible to have parts or all of your records shielded under certain circumstances (e.g., if revealing the records would harm the patient), so seek legal advice right away. It is also possible to make (and document) arrangements with parents that allow you to treat their children more or less confidentially.

Summary

While patient care is generally confidential, there are several situations where dentists (and assistants and hygienists) are required to make reports to authorities when abuse or danger are present. This duty is complicated and challenging, but must be taken seriously, as there is currently an epidemic of domestic abuse and neglect that places many vulnerable people at risk. Dentists are often the first to notice abuse and neglect. Consultation in this area is often indicated.

References

AIDS.gov (2017). HIV disclosure policies and procedures.

<https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/your-legal-rights/legal-disclosure/> (Accessed on 3/5/17).

American Dental Association (1998). *Proceedings: Dentists C.A.R.E. (Child Abuse Recognition and Education)* Conference Report, July 31 – August 1, 1998.

(<http://www.mchoralhealth.org/PDFs/ADAProceedings.pdf>)

American Dental Association (2016). *Principles of Ethics and Code of Professional Conduct*.

(http://www.ada.org/~media/ADA/Publications/Files/ADA_Code_of_Ethics_2016.pdf?la=en).

Applebaum, PS & Meisel, JD (1986). Therapists' Obligations to Report Their Patients' Criminal Acts. *Bull Am Acad Psychiatric Law*, V 14 (3), 221-230.

Centers for Disease Control (2010). *National Intimate Partner and Sexual Violence Survey*. (<http://www.cdc.gov/violenceprevention/nisvs>)

Centers for Disease Control (2000). *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women*.

(<https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>)

Dental Professionals Against Violence (DPAV). Family violence is a social and healthcare issue. (http://www.cdafoundation.org/portals/0/pdfs/dpav_ref_manual.pdf)

Additional Resources (California)

Child Abuse & Neglect Reporting -- Penal Code sections 11164 - 11174.3

leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=1.&part=4.&chapter=2.&article=2.5.

Domestic Violence -- Penal Code sections 11160-11163.6

leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=1.&part=4.&chapter=2.&article=2.

Dependent/Elder Abuse & Neglect Reporting -- Welfare & Institutions Code sections 15630-15632

leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=11.&article=3.

Child Abuse Mandated Reporter Training – California Department of Social Services
<http://mandatedreporterca.com/training/generaltraining.htm>

Childhelp: USA National Child Abuse Hotline – (800) 422-4453 <http://www.childhelpusa.org/>

The National Domestic Violence Hotline – (800) 799-7233 <http://www.ndvh.org>

California Elder & Dependent Adult Abuse/Neglect Hotline – (888) 436-3600
<http://www.aging.ca.gov>

Training for dental offices:

[P.A.N.D.A. \(Prevent Abuse and Neglect through Dental Awareness\)](#). Nation-wide public-private partnership designed to train dentists, dental hygienists and other professionals to recognize and report or refer suspected cases of abuse and neglect.

Reporting forms (California) can be found here:

- Elder Abuse Reporting –

https://www.smchealth.org/sites/main/files/file-attachments/soc_341.pdf

- Suspected Child Abuse Report Form –

<http://ag.ca.gov/childabuse/forms.php>

or http://ag.ca.gov/childabuse/pdf/ss_8572.pdf

- Suspicious Injury Report –

<http://www.publichealth.lacounty.gov/mch/cpsp/forms/Suspicious%20Injury%20Report%20&%20Instructions.pdf>

Chapter 7: Challenges in the Doctor-Patient Relationship

Peltier & Jenson

(12/26/17)

7.1: Doctor Values and Patient Values

7.2: Dual Relationships

7.3: Unacceptable Patient Behavior

7.4: Ending the Doctor-Patient Relationship

7.5: Harassment and Hostile Environment

7.6: Gifts

Why do patients give gifts?

Potential problems

How to decide?

How to respond?

Summary

References

Key Concepts

- ✓ Dentists and patients do not always share the same values regarding dentition. This can challenge treatment decision-making, where patients do not desire the same treatments that dentists prefer.
- ✓ Dual relationships (where doctors and patients have more than one relationship) tend to complicate treatment and create ethical challenges.
- ✓ Dual relationships are not illegal, not necessarily unethical, and are sometimes unavoidable.
- ✓ Problems in dual relationships are typically not obvious at the onset of treatment.
- ✓ Patients are generally unaware of potential dual relationship problems, so dentists must take professional responsibility.
- ✓ Sexual interaction between dentists and patients is explicitly illegal (in California).
- ✓ All dentists must learn how to say “No” and to end the doctor-patient relationship appropriately.
- ✓ You must complete all invasive treatments or phases of treatments that you begin.
- ✓ Dentists must be familiar with sexual harassment law and dynamics and manage their office environment in a healthy way.
- ✓ Gifts from patients can complicate the doctor-patient relationship and must be managed appropriately.

While treatment relationships are often positive and gratifying to both patients and doctors, dentistry can present challenges, many because of differences between the two main parties. Patients are at a clear disadvantage, as dentists know so much more about oral health and disease, and patients are typically uneasy or even terrified and disoriented in the operatory. Few people look forward to dental appointments.

Section 7.1: **Doctor Values and Patient Values**

Everyone has values. Differences between the values of dentists and those of patients in the oral health arena can cause distressing challenges. Dentists typically value dentition, and the loss of a tooth is a big deal to them. Some teeth are somewhat more important than others, but to a dentist they are all important. You might even say that dentists orient their entire professional life toward saving and maintaining teeth, gums, and bone structure. Patients sometimes do not share these values. For example, many patients seem to place a pretty low value on teeth relative to their financial circumstances and decision-making. Some prefer their flat-panel TV or historically restored car – or even their drug of choice. Others may be financing the first person in their extended family to ever attend college, while others live from paycheck to paycheck. When a patient has a tooth that is dead, dying, or infected, dentists strive to save that tooth. They may recommend root canal therapy, and patients naturally inquire about the cost. Sometimes they gasp at the price of a root canal and crown. They ask if anything else can be done to remedy the situation. Extraction is often an option, and when told the price of that procedure, they choose it without much reflection. They do not value that tooth as much as the amount of money it would cost to repair and keep it. This breaks dentists' hearts, because they perceive the value of that tooth differently, while most non-dentists do not think

Dentists and patients do not value oral health in the same way.

much about teeth and gums. These differing values cause all kinds of challenges, and they highlight the importance of effective informed consent discussions.

It is best to remain non-judgmental about the way that patients think about their teeth and remember that all patients have strengths in other areas that you don't have. Frequently, very smart and competent people don't know much about their teeth, and some don't even seem to care.

What follows are some relationship challenges commonly found in the dental office along with ethical implications.

Section 7.2: Dual Relationships

A “dual relationship” exists when a doctor and patient have a second, different relationship outside of the treatment relationship. A dual relationship exists when you have more than one relationship with a patient at the same time ... another relationship in addition to the doctor-patient relationship. When you treat the owner of the local hardware store, you have a merchant-customer relationship at the same time that you have a doctor-patient relationship. When you treat your spouse, you are involved in a spousal relationship while you have a doctor-patient relationship.

Dual relationship:
When a doctor and patient have an “outside” or second relationship in addition to the treatment relationship.

Examples include:

- a business relationship outside of dentistry
- a customer relationship where the dentist is the customer of the patient
- a friendship
- a family relationship (mother, father, sister, brother, cousin, aunt or uncle)
- friendships or romantic relationships that evolve from the doctor-patient relationship
- a bartering relationship

Many such relationships exist, and there are few rules that prohibit them. They are generally quite legal, except when sex is involved. **Sexual interaction between dentists and patients is explicitly illegal** in California and no doubt other states, as well.

Dual relationships are generally not illegal or unethical, but can become a nightmare.

Many dual relationships are innocuous or even mutually beneficial. Sometimes trust has been established in the outside relationship and it enhances the treatment relationship. Many patients would prefer to be treated by someone they already know rather than a stranger. On the other hand, there are many potential ethical and legal problems lurking behind the curtains, and young, inexperienced practitioners are especially vulnerable. Dual relationships seem so convenient at first, and so friendly. Who doesn't want to help friends or family members in need?

But, the **problems associated with dual relationships are not obvious at the onset of treatment** or the beginning of a new relationship. They pop up suddenly when it is sometimes too late to "go back." Here's an example:

You offer to treat your Aunt Mildred after you graduate from dental school. When she arrives for treatment your office staff hands her a health history checklist on a clipboard. As she fills it out she suddenly notices questions about her medications and health conditions. Sadly, she has suffered from a bipolar disorder for years, and it has been well-managed with Lithium and Depakote. She also has Hepatitis-C, and that malady is also being treated medically. She absolutely does not want you or other family members to know these things, so she is now faced with a terrible decision: tell the truth and reveal her secrets to her nephew, or lie on healthcare documents. As her treating dentist you need to know this information to properly treat her.

Obviously, Aunt Mildred does not want you to know her medical history. She is now in the very awkward position of having to decide whether to lie on her health history form. You

All patients must provide their relevant medical history.

are in the unfortunate position of potentially treating someone who has relevant medical conditions you are not aware of.

Health history forms obviously must be completed fully and accurately. If your doctor is also your friend or your tennis partner, do you want him or her to know all about your health history? If you go to church with your patient, do you really want to know about their history of substance abuse problems, or herpes, or hyperlipidemia? If you treat your friends' children, do you want to be the first one to find out that a daughter is secretly pregnant and thinking of an abortion? Or that she is taking birth control pills that her parents are not aware of? Maybe so...but maybe not.

The doctor-patient relationship is special. At its best, it creates a trance state that results in trust, treatment adherence, and healing. When it goes bad, it can result in nightmares for both doctor and patient. Both parties must deeply engage in their respective roles for treatment to go well. Doctors must think and behave like doctors; patients must think and behave like patients. Doctors must be able to confidently and decisively produce mandibular blocks, cut deeply into gingival tissue, and carve out technically precise preparations while looking into a small mirror. Patients must be able to trust in the judgment of their doctors to make good decisions, to take care of their patients' interests, and to do the best work they possibly can. Both parties must be able to disagree with each other. Patients must think that their doctor is special, patients must be treated as if they are special. It is a "special" relationship.

Protect the special nature of the treatment relationship.

There are several formal areas of ethical concern regarding dual relationships:

- Are arrangements in the best interest of the patient – or does they unduly favor the dentist? Bartering relationships, for example, are legal (when income is posted as revenue on tax forms) but can result in patient exploitation, especially when the fees charged by the patient are significantly lower than those of the dentist. The arrangement can

become akin to indentured servitude. How does a person who generally works for \$30 per hour barter with someone who charges \$3,000 for a root canal and crown on one tooth? The dental treatment is equivalent to 100 hours of patient labor.

- Justice (each person gets their fair share; equal parties are treated equally) is threatened by dual relationships. **Are all patients treated equally?** Do some get extra-special treatment and care? Is this justified by familial bonds? Shouldn't you treat your parents better than others?
- **Is confidentiality – or the perception of confidentiality – threatened or damaged?** Sometimes entire families become aware of the details of treatment when the dentist is a family member.
- **What happens when the dentist makes an error, or when treatment fails?** How does this impact the future second relationship? What if a patient experiences a significant negative health outcome subsequent to dental care (such as a cardiac event)? What if your treatment harms a parent or friend?
- What should dentists do about the **inherent power differential** in various relationships, such as the doctor-patient relationship and the parent-child relationship? How do you feel when your mother or father is in your chair? Are they able to let you do your job?

There is a variation of Murphy's Law that sometimes applies here. Many experienced dentists do not treat family or friends because they discovered that something always seemed to go wrong. The pattern was almost magical, and they became superstitious about it, and simply stopped. Similarly, family members can be "difficult" patients for various complicated reasons, while colleagues have absolutely no trouble treating your mother (even though you can't seem to make it work).

Many experienced dentists do not treat family or friends because they discovered that something always seemed to go wrong.

Dual relationships usually start out in a simple and harmless manner. A patient asks you out for coffee, a friend refers a friend, or your accountant asks you if you would help them with their dental care. It is later in the relationship that unforeseen events unfold. For example, how do you treat your accountant if he misses a filing deadline? How does he think you will treat him after that? Will there be tension in the air? Such tension is avoidable if the accountant-patient sees a different dentist for his or her care.

How do you charge your friends and family? Do you simply show them your fee schedule and, being fair, charge everyone in your practice the same fees? Do you treat your family for free? Do you charge them for the lab fees? Patients typically do not consider lab fees. How could you charge your husband or your wife? What about your brother? How could you charge him money? What about your cousin? She didn't charge you when she took your son to Disneyland! What about the differences between good friends and acquaintances, especially people who think they are better friends than they really are? If you don't charge some family members for treatment, where do you draw the line? Your sister talks to your cousins, of course, and they might figure that they are lucky to have a dentist in the family.

What about hygiene and dental habits? Do you get tired of treating a friend who just won't pick up a toothbrush? When you notice a friend clenching his jaws during a social conversation, do you think of all the hard work you put into those lovely crowns you made for him? What do you do when one of those crowns wears out after a couple of years?

Small towns pose a special problem for health care practitioners. When there are only a few dentists in town, it is inevitable that dentists and patients maintain multiple relationships. You treat the mayor and play tennis with her.

Rural dentists must expect to encounter dual relationships.

You take care of your Internist and he coaches your daughter's soccer team. Dentists in small towns must learn to navigate through the dual relationship mine field. As a result, some dentists choose not to reside in the same town where they practice.

Dual relationships highlight the importance of assertive communication skills and the capacity of dentists to say "No" appropriately and skillfully. Remember that patients cannot be expected to have a sophisticated view of dentistry or the treatment relationship, so it is incumbent upon the dentist to raise the issue of dual relationship complications. Do not expect friends, family members, and other non-dentists to be aware of all the possible complications related to dual relationships. Dentists must raise the issues and make sure that the risks are clear upfront.

Respect the complexity of dual relationships

Section 7.3: **Unacceptable Patient Behavior**

Not all patients are alike. Some are angels; pleasant, positive, impeccably reliable, completely cooperative, and eager to please. They make your work easy. Others, not so much. Remember that dentistry scares most people, and some react to their fear by behaving poorly. Competent people become unreliable, they show up late, they seem grumpy and disagreeable. They don't listen very well and can't remember what you said. A few patients lack integrity, some are disorganized, others have political views that clash with yours and offend you. Some are racist or sexist.

As you will see in the text below, you do not have to put up with offensive behavior or even patients that you do not like. But you cannot decline to treat every patient who misses an occasional appointment or tells a joke that makes you squirm. You must decide how far your duty to treat the public takes you. It's a personal, moral decision that you get to make. You do not have to put up with

offensive behavior or harassment as you will see in the pages that follow, but you certainly have some duty as a licensed doctor to provide care to people with difficult personalities and suboptimal habits. Remember your ethics codes' call to [service](#).

That said, everyone who works in a dental office or practice has the right to work in an environment that is not offensive or hostile, and that issue will be covered below. In the end, the owner of the practice has a duty to protect his or her team from harm, humiliation, discrimination, abuse, and offensive patient (or staff) behavior. This means, of course, that you must occasionally speak with and confront those whose behavior causes problems: patients, colleagues, team members, and others who visit the practice (vendors or delivery people).

Section 7.4: **Ending the Doctor-Patient Relationship**

While you have few formal obligations to people who are not patients in your practice, once a person becomes a “patient of record” you cannot simply walk away or abandon them. There are specific legal and ethical rules to guide you in this area.

Do not abandon
“patients of record.”

- ✓ You are not obligated to provide emergency treatment to someone who is not a patient of record. You may provide emergency treatment for “strangers” if you choose, and this can be a great way to build a practice. You are required by ethics codes to “make reasonable arrangements” for people who have dental emergencies but are not patients of your practice. While this does not mean that you must treat them, you should not ignore them, either. (You must step in to handle any life-death emergencies that you encounter, but those are very rare in dental practice). While it is not entirely clear what the term “reasonable arrangements” means, it clearly does not mean that you can simply tell them to go away.
- ✓ You must finish all invasive treatments that you start. If you have placed temporary crowns, for example, you can only leave those “temps” in place as long as the standard of care dictates that it is safe and reasonable to do so.

If the standard of care implies that it would be unsafe or even bad for a patient to leave temporary crowns on for one more day, they must be replaced whether or not that patient has paid their bill. You cannot terminate care for a patient unless you have completed the treatments you have started or arranged for that to be done. Treatments can be phased, and you do not need to start a new phase of treatment.

- ✓ You do not need to continue to treat someone you've come to dread. If a patient's behavior is problematic or if the doctor-patient relationship has soured, you are free to end it (as is your patient). You cannot simply walk away, but there is a legal process (send them a letter that includes a description of their oral health situation along with referral information, and offer emergency care for thirty days). You do not need to provide a reason for the termination of care.

Section 7.5: Harassment and Hostile Environment

American workers have a legal right to a workplace that is not hostile or offensive to them. This means that employers have a duty to protect that right. When patients or staff members behave offensively, the dentist must take appropriate action. Such action is hard enough when the offensive behavior is clear and obvious; it gets more challenging when the behavior is subtle or when parties disagree about what's appropriate and what's not (such as a joke with sexual content or comments that include innuendo). The duty is also complicated when a legal level of harm is not met, but subtly offensive behavior threatens the good morale of an office. These situations are somewhat common in dental practice, and they ought not to be ignored (even though it is tempting to do exactly that).

Sexual harassment generally involves unwelcome sexual behavior and other unwelcome verbal or physical conduct. There are two forms, and they are both illegal:

1. The **quid pro quo**, when compliance with a request impacts future benefit or opportunity

Two types of Sexual Harassment:

- ✓ Quid pro Quo
- ✓ Hostile environment

(an exchange of some sort, such as sex in exchange for better work situations). This does not necessarily require overt sex, but can include toleration of sexually charged behavior such as lewd comments or jokes or informal touching that has sexual connotations.

2. Sexualized behavior that creates an intimidating, offensive, or **hostile work environment.**

Patients, as well as staff members and dentists can be perpetrators of harassing behavior, and it is the practice owner's legal and ethical duty to notice it, stop it, and to prevent it.

Section 7.6: **Gifts**

Patients frequently gift their doctors, and while such gifts represent lovely gestures and sentiments, they are not without problems.

Why do patients give gifts?

There are several different reasons that patients give gifts to doctors or their office team.

Sometimes they are given to simply thank the doctor for providing excellent care while showing kindness. The gesture is simple and gracious, without ulterior motives or subtext. Many patients are greatly relieved when the care is finished and has gone well. Some patients are just generous people who are good at expressing gratitude. Others may have difficulty speaking their thanks, so they express it with a physical gift.

Occasionally, the gift is more complicated. Another motive is to level the interactional playing field. Some patients are uncomfortable with the power relationship of the doctor-patient relationship, and seek to "level the playing field." Their gift, especially if it is an expensive one, tends to even things out or even tilt things in the patient's direction. Both parties have given, and both have received. The patient can then feel just as

Gifts can complicate things.

good as the dentist might feel about his or her contribution. The patient might feel a little less in a “one-down” position.

Some patients give gifts to explicitly or subtly enhance future care. The doctor now owes them something, if not something tangible at least some special attention. The doctor cannot simply treat that patient as just another anonymous name on the day’s appointment list.

Lastly, gifts are sometimes a result of cultural tradition and expectation. In some cultures and countries, a visit to the doctor includes a small gift or dish of food. Some patients could not imagine going to the doctor empty-handed.

Potential problems.

There are known **problems** with gift-giving and receiving in the doctor-patient relationship. They include:

- **Changes in the relationship.** The exchange shifts from a simple provider-receiver-of-services relationship and can become complicated. Sometimes the receiver of the gift struggles to determine whether the gift creates a demand in the future. It can be difficult to discern whether a patient expects anything different because of the gift. That patient may perceive that the relationship is suddenly closer than the doctor would like it to be. The relationship can really change if the doctor decides to decline the gift.
- The gift might be accompanied by an **expectation for special treatment in the future.** Should that patient expect more timely or convenient appointment times? Longer or shorter appointments? More attention – or worse, fudging on insurance forms to benefit the patient?
- It is possible that a nice gift might even **change the clinical judgment of the dentist.**

- If other patients become aware of the gift they might logically wonder if they need to also give a gift in order to get more attention or the highest level of care. They might wonder what benefits the gift-giver is receiving or what else might be involved in the exchange.

How to decide?

While there is disagreement in the profession regarding the acceptance of gifts, there is general agreement that accepting all gifts is not appropriate or smart (Caddell & Hazelton, 2013). There are two relatively clear criteria for acceptance. First, the gift should not be too expensive or valuable. The general standard in American industry is that a gift must be “of non-lasting value.” It is not always easy to determine what the term “lasting” actually means. Even a small amount of money (like a tip) is of non-lasting value, but any cash gift is typically understood to be unacceptable in healthcare. The patient is already paying a fee for the service, and most doctors wouldn’t feel great about accepting a “tip.” A larger amount of money begins to smell like a bribe. When you accept a valuable gift – even of non-lasting value such as a ticket to a special sporting event – you are at risk for being “on the hook” to provide favorable service in the future.

Gifts must be of “non-lasting value.”

A second useful standard is appropriateness. While this criterion is vague, it is still of value at the extremes. Some gifts are clearly problematic. When a gift has overt sexual tones, is way too personal, or has troubling political or ethnic overtones, it must be rejected.

How to respond?

There are three general ways to respond to a gift from a patient.

1. Accept the gift gratefully.
2. Accept the gift on behalf of the office team and share it openly with team members.
3. Reject the gift graciously.

When you accept a gift, it is a good idea to do so in the open rather than behind closed doors. If you are uncomfortable with the gift, it's probably not a good idea to accept it in the first place. Consider whether it's a good idea to display the gift in the office (considering what other patients might think). Thank your patient appropriately and promptly, perhaps with a short note.

Consult with a trusted colleague when you are unsure about what to do. If you accept a gift, don't let it go to your head, and avoid providing inappropriate special care to that patient in the future.

If you decide to reject a gift, do so – as best you can – without rejecting the patient or the sentiment involved.

“Thanks very much for the lovely offer. That’s really nice of you, and it’s great that you are happy with the care we’ve provided. But our policy doesn’t allow me to accept gifts like this. It’s really nice of you, and I hope you understand.”

(For a more detailed discussion of these issues, see Chapter 25 in Bernard Lo's *Resolving Ethical Dilemmas*, 2013).

Summary

The dentist-patient relationship is of consummate importance to a dental practice and while it is often positive and friendly, it can offer challenges. Patients are

typically nervous about office visits and procedures, and they know little about dentistry and oral pathology. Many have had previous life experiences that were traumatic or unsatisfactory in some significant way. Attention to these potential challenges can head off problems and enhance your practice. It is the doctor's duty to anticipate challenges and confront them appropriately.

References

Caddell, A. & Hazelton, L (2013). Accepting gifts from patients. *Canadian Family Physician*. Dec; 59(12): 1259-1260.
(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860914/>).

Lo, B. (2013). *Resolving Ethical Issues*. 5th Ed. Philadelphia: Lippincott, Williams, & Wilkins.