

ACD GIES ETHICS PROJECT

DO PATIENTS AND DENTISTS SEE ETHICS THE SAME WAY?

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

ABSTRACT

The most common approach to ethics in dentistry and bioethics generally is through principles. To be effective, principles must be interpreted in particular situations, and the skill of interpretation requires many years of practice with feedback. The opinions of 91 dentists and 54 patients regarding multiple potential actions and justifications for these actions were gathered for eight dental ethics cases. The summary responses of dentists and patients have been integrated as feedback in an online ethics education exercise that individual dentists can use (see www.dental-ethics.org/idea). The dataset of responses was also analyzed for general findings. It emerged that patients and dentists agree to a substantial extent on the average approaches, but they differ systematically on certain of the details. Some ethical issues stimulated a narrow range of responses while others, especially those of a nonclinical nature were regarded as ambiguous and are thus good candidates for future ethics training. A factor analysis revealed a five-dimension structure underlying dental ethics. Patients are most apt to view dentistry using a lens of oral health outcomes while practitioners prefer to stress the process and the technical dimensions of practice. The largest area of difference was patients' much greater interest in dentists assuming an active role as patient oral health advocates with their colleagues.

There are troubling situations in dentistry where there is reason to follow one course of action and also reason to pursue a contrary path. This is one of the characteristics of a profession that calls for the highest levels of skill and integrity. Doing the wrong thing for the wrong reason can undo beautiful technical work and biological acumen. Deciding whether to honor a patient request (respect for autonomy) for a treatment that is of questionable value (nonmaleficence) is a problem that arises from time to time. Deciding whether to take action, and if so what action, and for what real motives, when a colleague's work is pretty regularly seen to be below the standard of care is a test of loyalty—to the profession and to the public. These are called ethical dilemmas because there is something worthwhile to be said on both sides of the matter. Other times behavior is simply wrong but tempting. It is hard to think of circumstances that would justify overtreatment, upcoding insurance claims, or permitting a hostile work environment, but it happens. Although these are not dilemmas, we might still expect to see a range of behavior, supported by interpretations of particular circumstances and personal value systems.

Patients bring their own moral standards to the table. Some are likely to be sensitive to and speak up about particular tough choices that dentists face and overlook others. Some patients use highly personal ethical maps. Those who are not patients—including public

policymakers, bloggers, and those who vigorously avoid dentists—cannot be prevented from having opinions about what is right and wrong in dentistry.

In the past few decades, the professions have addressed these issues under the heading of “principles.” An ethical principle is an abstract standard for appropriate behavior. Veracity (truth telling) and justice (fair distribution of benefits and burdens) are examples. *The Belmont Report* (1979), the first comprehensive American statement of ethical policy in medicine, identified three principles: respect for persons, beneficence, and justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The field of bioethics exploded in the years following, and Tom Beauchamp and James Childress's *Principles of Biomedical Ethics* (2009) has become the fundamental expression of professional principles. Beauchamp and Childress's four cardinal principles are (a) respect for autonomy, (b) nonmaleficence, (c) beneficence, and (d) justice. The American Dental Association added a fifth principle, veracity, which accounts for about 40% of the Code of Professional Conduct and covers mostly dentist-to-dentist issues. The American Society for Bioethics and Humanities uses a code with seven principles. The American Bar Association identifies eight. The

American Medical Association Code of Ethics has nine principles.

Principles offer general guidance, but they are blunt instruments. Specific issues can often be categorized under more than one principle, and these sometimes “guide” action in contrary directions. The tension between conflicting principles is well known. Both the ADA, in their *Principles of Ethics and Code of Professional Conduct*, and Beauchamp and Childress (2009) acknowledge this, and professionals are usually counselled to “use their personal judgment to reach a ‘balanced’ resolution.” The problem is that there is no principle that determines when “balance” has been achieved (Thornton, 2005). Principles need some form of further support to finish the job (Jonsen, 1991).

The bulk of ethics training—both in dental schools and where it appears occasionally in CE formats—as well as codes of conduct—are intended as interpretations of the principles. This is sometimes called the Ethical Syllogism (MacIntyre, 1988). It works like this: Major Premise: Beneficence consists in doing what is best for the patient. Minor Premise: If patients are only informed of treatment options that I favor based on my training, they will always pick sound treatments. Conclusion: It is beneficent to steer patients in informed consent toward optimal oral health. There are no debates in dentistry over whether respect for autonomy or justice, for example, are sound ethical principles. They are. All of the discussion turns on whether specific behaviors are best interpreted as good examples of the principles. Learning to become a professional entails learning how one’s colleagues interpret the principles.

Despite their open-endedness, principles are a solid place to start in ethics training for professionals. Particular problems can be examined through the lens of multiple principles to give them depth and to reduce the chance of overlooking something important. Some interpretations of specific cases are clearly wrong and others are among the several alternative acceptable options. Interpretation is necessary, but all interpretations are not equally valid. Becoming a mature ethical professional means a long period of study of a wide range of concrete cases and gradually building interpretative skill. The principles can be memorized in less than a minute: becoming an ethical professional requires a lifetime of practice.

Not all practitioners interpret ethical principles the same way. A doctrinaire insistence on the letter of the law in the kingdom of one’s own office may satisfy the urge of consistency. Some dentists use a shallow grounding in ethics because they are confident that they can “just do the right thing.” It would be easy to maintain these positions if patients, staff, and associates can be dismissed for not seeing things as the owner-dentist does. In fact, principles may not even be necessary in such cases. Being a professional means contributing to and learning from the collective wisdom of one’s colleagues and other important people. Principles begin to play a useful purpose when dentists look to their colleagues and others to see whether better alternatives exist. Ethics becomes part of the language in the conversations that make it possible to grow professionally. Absent comparisons of specific ethical cases, practitioners are apt to stagnate at the level of moral maturity they had when leaving dental school or even earlier in their lives.

It may come as a surprise that there are no American journals for dental

ethics. Of the more than 20 in various professional fields, there are multiple examples in medicine, nursing, law, business, clergy, education, and even the military services. This is very likely a reflection of the fact that all of these professions are practiced in settings where professionals interact with each other in public. Since 1998, accreditation standards for U.S. dental schools require documented compliance with the standard that students “must be competent in the application of the principles of ethical decision making and professional responsibility” (Council on Dental Accreditation 2013; Standard 2-20). This is managed in some schools by an hour or sometimes several hours of seminar discussion of cases. This is not enough (Bertolami, 2004).

There are several theories of moral development. James Rest (1973) has extensively studied and modified Lawrence Kohlberg’s (1968) developmental stages model of moral reasoning. There are three levels in this characterization of ethics, each having to do with the reasons one uses in reaching moral decisions (and less so with the actions themselves). Rest identifies these levels as (a) “pre-conventional,” where the standard is to follow authority and do what is rewarded and avoid what is punished; (b) “conventional,” do what your peers expect of you; and (c) “post-conventional,” where abstract norms are weighted as a philosopher might. I will use the more descriptive labels: “self,” “group,” and “ethics” as these appear to capture where individuals orient for finding the ultimate standard for ethical decision making in various cases.

The challenge is to create a safe environment for all dentists who traditionally work in isolation to compare notes, try alternatives, and get feedback to build moral skill. We need a platform

for interaction, and it needs to be pretty large, open to all, and easily available 24/7 for extended periods of time.

As a step toward creating an opportunity for dentists to engage in public interpretation of prototypical ethics cases, the American College of Dentists has created a set of eight cases for discussion. These are available in written form and will soon be available in video format. But there is a significant limitation to the effectiveness of reading about ethics. There should be some way of experimenting with options and learning what one's colleagues would do. Perhaps it would even be useful to know what a representative sample of patients thinks of these situations.

Okay, let's find out. There are two goals in this report: (a) introduce a platform for building interpretative skills in practical ethics for practitioners that can be accessed conveniently from one's office and (b) begin to understand the norms patients and dentists hold regarding various aspects of dental practice.

MATERIALS AND METHODS

Eight cases were developed, representing a range of problematic situations that could arise in dentistry. There are existing collections of cases in various styles, but I have followed the model of the late Jim Rule in his wonderful book *Ethical Questions in Dentistry* (2004). Rule's cases are longer and more detailed than many in circulation, but they were not written to illustrate predetermined theoretical positions. Although length slows down the reader, it also reduces the chance that one will imagine unstated facts or screen out inconvenient particulars from "skeletal" cases to make them fit abstract principles or personal preferences.

A little of life's messiness is necessary to be realistic. Although all the cases have multiple dimensions and interesting paths to follow, they are not all dilemmas. The goal is to involve readers in the cases, not for them to be theoretical commentators. The full text of the cases can be seen at www.dentaethics.org/idea. The stem theme for each case and the actions and reasons are shown here in Table 1.

Each case is followed by four to six potential actions, and readers are invited to indicate on a five-point Likert scale how appropriate each action would be. The scale has anchor points of "absolutely," "probably," "50:50," "doubtful," and "no way." The actions are not mutually exclusive. It might be "absolutely" appropriate to initiate two or more actions at the same time and give just a little possible credence to a third that is similar to a choice that should be avoided entirely. There is seldom exactly one response to an ethical challenge. Usually there are several appropriate things that could be done and more than one way to get it wrong. But a forced selection on behavior is important in ethical situations. Too often we mistake performing an analysis of the situation and an enumeration of relevant principles for an ethical choice. They are not. The only way others will know whether we are ethical is by watching what we do.

Each case is also accompanied by from four to six "reasons" or important considerations or ethical goals. The reasons are similarly graded on a Likert scale as "decisive," "important," "not clear," "little importance," or "irrelevant." One could think of the reasons as "justifications" or things that might be said in defense if questioned about what we had done. These reasons represent some of the goals one has in mind when taking action. Again, the reasons are not mutually exclusive. Much of our action is

intended to simultaneously optimize several goals and stay out of trouble everywhere it might turn up. The structure of the actions and reasons is intended to place respondents in a realistic situation rather than as an academic exercise of picking the right answer on the best theoretical grounds. Dental school may be like that, but life is not.

Norms were constructed from a sample of dentists and patients, each of which reported what they would do and why for all eight cases. The sample of dentists consisted of 91 national and section officers of the American College of Dentists who were surveyed by mail. The sample of patients was taken from the attendees of two churches in Sonoma, California, totaling 54 responses.

In addition to full descriptive tabulation of the results, t-tests were performed for differences between groups (dentists vs. patients), F-ratios were calculated for homogeneity of variances between multiple groups, a factor analysis with varimax rotation was performed to identify the latent structure in respondents' views of oral health, and correlation matrices were created to reveal associations among the variables.

This project was approved in the exempt category by the IRB at the University of the Pacific, #13-63.

RESULTS

Both dentists and patients were able to use the cases in the format presented. The results are summarized in Table 1 and have been converted to feedback available in the online version of the cases. Additionally, these data have

TABLE 1. RESPONSES OF PATIENTS AND DENTISTS TO EIGHT ETHICS CASES

1. **Service (Robin Hood):** Patient who has immediate need and has used current insurance eligibility requests that dentist perform work but date the insurance claim a month later so as to qualify for coverage.

<i>Mean</i>	<i>SD</i>	<i>%Strong Support</i>	<i>%Neutral</i>	<i>%Strong Reject</i>			
Actions							
1.41#	1.39*	10	16	18	20	37	[TF] Perform the needed work and submit the claims with later date
.30	.88	4	2	0	9	85	
1.60#	1.25	7	22	18	31	22	Perform the work only if Professor X can pay the cash
2.50	1.29	30	23	24	18	8	
3.08#	.84	35	41	20	4	0	[TF] Offer to perform the work at a reduced rate as a public service
2.52	1.03	17	39	28	13	4	
2.00	1.23	13	18	42	11	16	Make inquiries concerning other dentist said to postdate claims
1.72	1.22	11	18	19	39	14	
Reasons							
2.82*	.83	18	52	26	2	2	[S] Legal, contractual arrangements with insurance companies
3.27	1.05	51	39	1	3	6	
3.41	.50*	41	59	0	0	0	[G] Patient's oral needs and pressing circumstances
3.21	.79	37	53	6	3	1	
3.15	.81	37	45	14	4	0	[E] Dentist's personal values regarding service
2.77	.92	45	42	7	4	2	
1.93	1.42	14	27	27	4	29	[S] Potential inaccurate dating of the procedure will be detected
2.19	1.71	26	19	6	9	40	
2.62	1.26	23	45	15	4	13	[E] Dental codes and standards in the community
2.52	1.39	28	36	14	6	17	
3.66*	.47+	66	34	0	0	0	Overall sense of what is right
3.86	.35	86	14	0	0	0	

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

<i>Mean</i>	<i>SD</i>	<i>%Strong Support</i>	<i>%Neutral</i>	<i>%Strong Reject</i>			
Actions							
3.06	1.18	46	33	8	8	6	Contact dentist who did the work to get his or her side of the story
2.93	1.27	44	30	8	11	7	
2.32#	.96	11	34	32	23	0	[PE] Lodge a formal complaint with the dental society or dental board
1.44	.93	2	8	35	40	15	
1.83	1.32	11	28	15	28	19	[PE] Suggest patient return to first dentist, do nothing else
1.92	1.29	17	18	19	35	12	
3.80	.45	82	16	2	0	0	Inform the patient of her present condition, as you see it
3.80	.48	84	13	3	0	0	
1.18#	1.30#	7	14	11	27	41	[TF] Suggest indirectly to colleagues unnamed dentist not up to par
.29	.53	0	0	4	21	75	
Reasons							
2.96*	.52*	12	73	15	0	0	[S] Patient's recollection of what was done and when
2.69	.85	10	62	17	8	52	
2.26*	1.07	11	32	38	11	9	[G] Professional code against unjustifiable colleague criticism
2.64	1.06	20	45	20	10	5	

(Table 1, CONTINUED)

Mean	SD	%Strong Support	%Neutral	%Strong Reject			
1.22	1.20	2	18	18	24	38	[S] Dentists are independent; their practices are their business
.92	1.08	1	11	14	26	48	
3.78	.42	78	22	0	0	0	[E] Current health needs of the patient
3.69	.46	69	31	0	0	0	
1.82	1.17	5	27	32	18	18	[S] Complexity and uncertainty of interpersonal relationships
2.00	1.16	7	32	32	16	15	
1.78	1.16	2	28	30	20	20	[S] Patient personality and motives
2.05	1.06	3	35	36	13	13	
3.65	.52	67	31	2	0	0	[E] Dentists have obligation to all patients and profession generally
3.56	.52	57	42	1	0	0	

3. Who Cares (Generalist-Specialist Relations): Two periodontists in town suddenly both stop returning patients to the referring general dentist and advise patients that they all need "advanced care" that only they can provide.

Actions

1.71+	1.34	13	16	22	27	22	Confine comments to reinforcing the desirability of optimal care
2.32	1.25	20	27	27	14	11	
2.84	.92	24	43	27	4	2	Suggest that patient make an appointment to be seen by specialist
2.82	1.19	32	41	8	13	6	
2.33#	1.03	8	45	22	20	4	[TF] Invite specialists to lunch to discuss apparent change in referrals
3.40	.83	55	35	5	3	1	
3.13#	.89+	42	33	21	4	0	[TF] Explore GP-specialist roles with component ethics committee
1.86	1.21	11	22	23	31	13	[PE]

Reasons

2.43+	1.17	8	59	14	4	14	[S] Patient's financial situation
2.00	1.14	0	50	15	21	14	
2.67#	.97+	19	44	26	9	2	[S] Implication that generalist is not competent to maintain patient
3.25	.69	38	50	11	1	0	
2.96	.81	26	49	21	4	0	[G] Changing trust levels between patient and generalist
3.04	.81	28	54	13	3	1	
3.57#	.57*	61	35	4	0	0	[S] Accuracy of informed consent so patient understands all choices
3.02	.90	29	53	12	2	3	
3.48*	.58+	52	44	4	0	0	[E] Patient's freedom to choose the level of care they desire
3.16	.79	32	59	4	2	2	
3.21	.76	35	55	8	0	2	[E] Importance of optimal oral care
3.37	.62	41	57	1	0	1	

4. Fair Payment (Patient attempts to renege on payment): Patient attempts to renege on part of payment for large completed treatment plan based on failure of part of it that the dentist recommended against.

Actions

.35	.79#	0	6	0	17	77	Agree to patient's suggestion to cut payment
.16	.40	0	0	1	14	85	
2.06	1.22	15	26	17	36	6	Dismiss patient through a formal process and write off the bad debt
1.94	1.16	8	26	29	25	12	

(CONTINUED)

(Table 1, CONTINUED)

<i>Mean</i>	<i>SD</i>	<i>%Strong Support</i>	<i>%Neutral</i>	<i>%Strong Reject</i>			
2.88	.96	26	48	16	8	2	[PE] Refer patient to peer review for adjudication of disagreement
2.67	1.13	28	33	22	14	3	
2.01#	1.30+	14	27	20	23	16	[TF] Negotiate compromise treatment, partial, extended payments
1.19	1.03	1	15	11	47	26	
Reasons							
2.73+	1.06+	16	63	8	6	8	[G] Dentist's reputation in town
2.26	1.17	9	47	16	18	10	
3.14	.82	33	53	10	2	2	[E] Get patient to accept responsibility for both financial and health issues
3.35	.73	43	52	1	2	1	
3.46+	.58	50	46	4	0	0	[S] Chart notes of options presented, written financial arrangements
3.67	.56	71	27	1	1	0	
2.49	.86	2	60	30	2	6	[S] Potential for protracted dispute and lost time in the office
2.17	1.05	2	51	15	25	7	
3.08	.82	29	57	6	8	0	[E] Addressing patient's compromised dental condition
3.02	.74	22	65	9	3	1	
2.09	1.15	6	40	23	19	13	[G] What other dentists might do in a similar situation
2.16	1.14	6	44	24	14	13	

5. Coach (Hostile Work Environment): Hygienist complains that patient ("Coach") is verbally sexually harassing her.

Actions

1.19	1.10+	6	4	21	40	29	Registered letter dismissing Coach, citing illegality of harassment
1.06	.82	1	4	18	54	23	
3.20	.95	46	36	12	4	2	Talk to Coach, explain perceptions, warn of possible termination
3.37	.74	48	45	2	4	0	
2.73	.95	33	31	17	13	6	Encourage hygienist to talk with Coach, help her be assertive
2.53	1.23	23	38	16	16	8	
2.40	1.31	26	30	11	28	6	Call a staff meeting to discuss the issue
2.68	1.26	32	31	17	12	8	
.29	.59*	0	2	0	22	76	[RA] Dentist does nothing; this is an employee-customer relationship
.16	.40	0	0	1	13	86	

Reasons

2.70+	1.02	12	66	10	4	8	[G] Reputation of the profession in the community
2.30	1.28	12	48	12	11	16	
2.49+	1.20	16	47	22	2	13	[R] Civil liberties and personal autonomy
2.84	1.00	25	49	15	8	3	
3.18	.44+	20	78	2	0	0	[G] Employee morale
3.34	.60	40	56	3	1	0	
3.06+	.85	31	51	14	2	2	[S] Legal considerations
3.40	.73	52	38	8	2	0	
2.88	.94	21	58	13	4	4	[S] Verbal skills and confidence of the dentist and the hygienist
3.06	.77	28	54	13	4	0	
3.35	.75	49	39	10	2	0	[E] Dentist's personal standards of interpersonal respect
3.36	.90	54	37	2	4	2	

(Table 1, CONTINUED)

<i>Mean</i>	<i>SD</i>	<i>%Strong Support</i>	<i>%Neutral</i>	<i>%Strong Reject</i>			
6. Tooth Colored Restorations (Informed Consent): Three dentists compare different philosophies regarding treatment presentation of amalgam or composite on posterior restorations. Dr. A aggressively steers all patients toward composite; Dr. B explains both options and lets patients decide; Dr. C simply does what he thinks is best in each case without engaging the patient in the decision.							
Actions							
3.33*	1.03#	61	22	12	2	4	[Pt] Off base to offer only composite and replacing sound amalgams
3.82	.47	85	12	3	0	0	
3.31+	.95#	56	27	8	8	0	[Pt] "Selling" perhaps unneeded dentistry as "patient education"
3.63	.53	66	32	2	0	0	
.66	.77	0	2	12	36	50	[RA] Patients asked to decide when not really qualified to judge
.58	.82	0	2	14	23	60	
.60	.96	2	4	8	23	63	[RA] Carrying informed consent too far
.66	.85	0	4	11	30	54	
3.08	1.12	44	36	10	4	6	[PE] Off base to consider only dentist's values
3.25	1.01	56	25	12	3	4	
.96	1.22	8	4	10	31	47	Informed consent is unnecessary in such cases
.76	1.16	7	3	8	23	59	
Reasons							
3.38	.72	46	50	2	0	2	[E] Patient autonomy: patients have ultimate say over their own care
3.53	.58	57	39	4	0	0	
2.19*	.95	2	42	37	12	8	[E] Dentist autonomy: dentists allowed to practice as they think best
2.72	1.00	12	68	7	7	7	
.77	.94	2	4	12	35	48	[G] Patients question dentist damages the professional relationship
.73	.92	0	4	19	22	54	
.68+	.92*	4	2	2	43	49	[S] Dentists should only offer the most esthetic and expensive care
.37	.62	1	0	1	27	71	
2.23	1.38	12	46	12	8	22	[S] Dentist's comfort level talking about alternatives and costs with patients
1.89	1.29	8	35	14	24	19	
1.60	1.24	0	28	26	16	30	[S] Whether patient seems intelligent and to value high-end care
1.46	1.19	3	20	22	27	28	
2.81	1.04	19	62	8	4	8	[S] Amount of experience dentist has with the procedures
2.66	.95	10	64	14	7	6	
7. Full Care (Pro bono Work): As a member of a local service organization that does charitable work, the dentist visits a nursing home is town and discovers substantial unmet need.							
Actions							
.49	.79	2	0	6	29	63	[OH] No action—society and insurance have set compensation too low
.73	.86	0	5	13	33	49	
.28+	.50+	0	0	2	23	74	[OH] No action—no lasting impact, might be seen as interference
.51	.67	0	1	6	36	57	
3.42+	.66	49	45	4	2	0	[OH] Work to start program that involving other local dentists in care
3.11	.83	36	44	16	4	0	
3.24#	.74	40	46	12	2	0	[OH] Volunteer one day a month in the nursing home, no matter what
2.57	.97	17	39	31	11	2	

(Table 1, CONTINUED)

<i>Mean</i>	<i>SD</i>	<i>%Strong Support</i>	<i>%Neutral</i>	<i>%Strong Reject</i>			
Reasons							
2.71	1.08	16	61	12	2	10	[G] Reputation of the profession in the community
2.88	.96	23	56	10	8	3	
3.70	.46	70	30	0	0	0	[E] Patient's oral needs
3.57	.50	57	44	0	0	0	
1.67	1.09	0	29	29	24	18	[S] Each provider community and funder functions independently
1.93	1.05	6	24	40	20	11	

8. Who Decides? (Patient Autonomy): Patient indicates strong preference for veneers in aesthetic region and a disinclination to have needed restorative and periodontal work done first.

Actions

1.66#	1.15+	6	18	30	28	18	[OH] Convince patient that veneers are not always the best choice here
.73	.86	0	5	13	33	49	
3.26#	.84	42	51	2	4	2	[OH] Try to convince patient of dentist's plan for long-term oral health
.51	.67	0	1	6	36	57	
2.70*	.82	13	53	25	9	0	Suggest cleaning, replacement filling; postpone full treatment plan
3.11	.83	36	44	16	4	0	
1.92#	1.13	8	23	37	19	13	[OH] Say you value needs above wants and suggest another dentist
2.57	.97	17	39	31	11	2	[Pt]
2.11#	1.10	8	34	30	19	9	Begin work while continuing to educate patient during treatment
1.44	1.21	5	21	16	33	26	

Reasons

2.87	.79	13	70	9	6	2	[E] Patient autonomy (right to choose what they feel is best)
2.84	.82	14	69	9	7	2	
3.44	.63	52	40	8	0	0	[E] Patient's comprehensive oral needs
3.55	.52	56	43	1	0	0	
2.75	.57*	4	67	27	2	0	[E] Dentist's autonomy (right to choose what they feel is best)
2.85	.89	17	65	7	9	2	
1.98#	1.13	6	29	38	12	15	[S] Legal considerations
2.88	1.06	27	52	9	7	6	
2.74	1.00	15	56	21	0	8	[S] Verbal skills and confidence of the dentist and the hygienist
2.72	.90	12	62	14	8	3	
1.55#	1.14	4	14	41	16	25	[S] Prospect that such a patient will become a management problem
2.56	1.08	14	54	15	11	7	

NB: The top line in each pair describes patients' responses; the bottom line describes dentists' responses. The means and standard deviations are shown in the first two columns of each set. Higher numbers represent greater agreement with the action or reason or larger standard deviations. Differences between patients and dentists that are significant at $p < .05$ are marked with a +; *represents differences at $p < .01$; # identifies differences significant at $p < .001$. The numbers in italic are percentages in each group choosing each of the five possible responses, with strongly agree on the right. The single letters in square brackets designate level of reasoning: [S] = self, [G] = group, and [E] = ethical. The double letters in square brackets refer to a five-dimension structure derived from factor analysis to characterize the various types of ethical actions. [OH] = oral health outcomes, [TF] = technical focus, [PE] = professional engagement, [RA] = respect for autonomy, and [Pt] = paternalism.

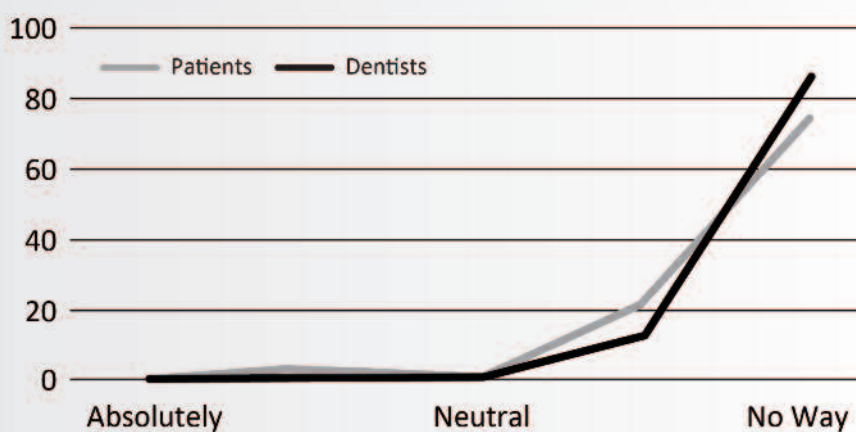
been analyzed by various statistical means to reveal the structure of dentists' and patients' views of ethical issues in dentistry, as reported below.

Skill Building

In the computerized version of the cases, dentist and patient norms appear on the screen as soon as the reader makes his or her choices for the case. This provides instant feedback that takes the place of group discussion in live seminar settings. Currently, the feedback is presented as percentages of patients and dentists selecting each position on the Likert scales for each action and for each reason. Those using the online form of these cases can see how their choices would be viewed by the public and by colleagues.

Consider an example from the case on hostile workplace environment (Coach). One of the actions offered to respondents was to ignore the hygienist's complaint that a patient was making inappropriate remarks on the grounds that such matters are personal between the staff and the patient. Dentists overwhelmingly rejected this as a way of handling the matter, 86% saying "no way" and 13% saying "probably not." Any dentist working through this case who thought seriously about ducking the issue would have to be nimble in creating an excuse for why he or she is different from others in the profession. As it happens, patients see this situation the same way. Among patients, 76% said do not avoid the issue in the strongest possible terms and another 22% considered this a doubtful alternative. Any dentist still thinking that the problem should be left to sort itself out on its own now has to fabricate a justification for the public. Dentists and patients also tended to agree on the

FIGURE 1. DENTIST IS JUSTIFIED IN OVERLOOKING HARRASSMENT OF EMPLOYEE BY PATIENT AS THIS IS A PRIVATE MATTER.



reasons various actions should or should not be taken when hostile workplace environments occur. This patterns is shown in graphic format in Figure 1.

Patients and dentists were of a common mind that employee morale, the law, value in good interpersonal communication skills, and the dentist's sense of integrity are strong reasons for confronting the issue. Slightly less important were reasons such as abstract matters of civil liberties and the dentist's reputation in the community.

There are examples such as this throughout the cases where patients and dentists agree that certain actions and reasons are obviously correct. There are also situations that are more challenging. For example, patients and dentists often disagree regarding a dentist's responsibility for challenging colleagues who are doing faulty work. Not all issues are ones where there is near uniformity on the right action or right reason. For example, dentists are of mix mind regarding whether to dismiss a patient who reneges on payments; the entire range from "absolutely" to "no way" being advocated by many respondents. All of these outcomes where there is no consensus can be valuable for stimulating reflection.

Principles are like a handpiece: they are a tool for doing better dentistry. Knowing about principles is like knowing about handpieces. The real result comes from repeated practice in individual situations. The eight ethics cases in this program are like the mannequins that students used in preclinical technical. They are a good place to start learning.

UNDERSTANDING THE NORMS

This database can also be studied to learn about patients' and dentists' views of dental ethics. Are there patterns in the way the public or practitioners expect dentists to behave generally or what reasons are appropriate for the way dentists should act? Do patients place more or less weight on ethics and do they see particular situations the same way dentists do? Do we need CE courses on personnel law or on inter-professional management of patients? This is a rich dataset in which to explore such questions.

The full descriptive results are displayed in Table 1. Patients' responses

are on the top line and dentists' responses are below them in each pair. The highest score possible is 4.0, the lowest is 0.0, and the midpoint is 2.0. Means and standard deviations are shown, and symbols are used to flag statistical significance differences between groups. The symbol * indicates that the difference between patients and dentists is significant at the conventional $p < .05$ level; + denotes higher significance ($p < .01$); and # indicates significance at $p < .001$. The absence of a symbol means that no statistically significant difference was detected. Differences between standard deviations were also tested for significance because large ranges may indicate ambiguity or disagreement within each community of respondents. Thus, it matters both where the center of opinion is on each issue (whether the peak of the curve moves right or left) and how widely

spread the opinions are (how flat the curve is). The double initials in square brackets signal classifications of actions into one of five categories based on the factor analysis to be described below. Single initials ([S], [G], or [E]) are for given reasons using the relabeled Rest Three-factor Model of moral reasoning.

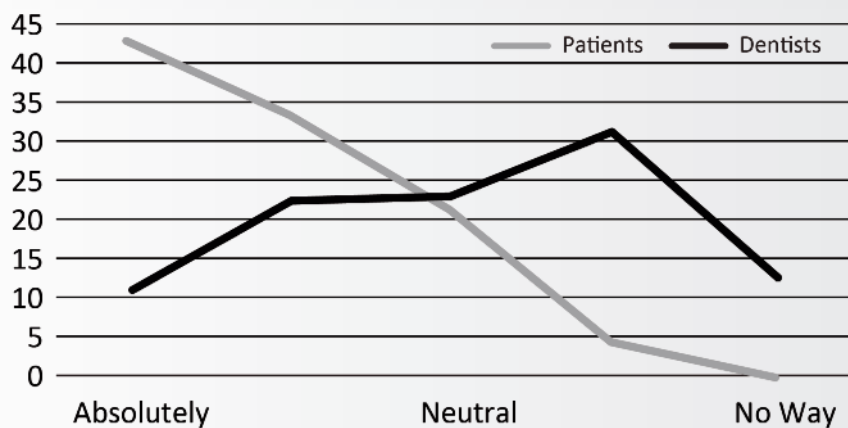
Figure 2 is a graphic representation of one of the 84 elements in Table 1, Case 3, "Who Cares", action alternative 4. It shows the percentage of respondents selecting each of the five options from strongly favorable to strongly unfavorable for taking up with the component society the issue of specialists not returning patients to the referring general practitioner. On average, patients tend to favor raising the concern at the professional level (3.13, where 2.00 is neutral) while dentists shy away from that (1.86). This difference is statistically significant at $p < .001$.

Further, the standard deviation for patients is .89 compared to the statistically significantly larger standard deviation of 1.21 for dentists. Dentists are more divided in their opinions than are patients. Graphically, the differences in appropriateness of the action is clear as a shift in the two peaks on the curve. Graphically, the difference in consensus of opinion is represented by the overall flatter curve for the dentists.

In the set of 37 possible ethical actions, the most prominent differences between patients and dentists include the following. Dentists are more apt to favor upfront payment, comprehensive treatment plans, limited informed consent, and confidential management of differences among colleagues. Patients value adjustments of payment alternatives and spacing of treatment, full informed consent, better education, active and open engagement of colleagues who are not practicing at the standard of care, and greater involvement of dentists in the general oral health needs of the community.

A striking illustration of the divergence in valued actions concerns a patient who requests veneers on teeth with questionable anatomical support. Should the dentists educate the patient regarding a long-term treatment plan based on health instead? Ninety-three percent of patients say "yes" while 93% of dentists say "no," the apparent reason being partially related to suspicions that this is an "independently minded" patient. More than half the dentists (56%) would refer such patients out of their practices, a policy endorsed by only 31% of patients. Another such example of divergent opinions regarding management of patients whose expectations differ from those of the practitioner involves renegotiating treatment and payment for a patient who is dissatisfied with the initial

FIGURE 2. INVOLVE COMPONENT SOCIETY WITH EVIDENCE OF DENTIST NOT TREATING TO STANDARD OF CARE



work performed by the dentist and not inclined to pay for it. Both patients and dentists agree strongly that letting the patient off the financial hook is inappropriate. But the typical response among patients is to explore breaking treatment plans and payments into segments. Among dentists almost 75% would look unfavorably on this action. Patients are more apt than dentists to favor referring the patient to peer review for adjudication of the disagreement.

Agreement between Dentists and Patients

The Likert responses on each item were converted to a 4-to-0 scale and the average was taken for each item for patients and for dentists, collapsing the dataset to 37 actions and 47 reasons. The correlation between patient and dentist *average* scores for actions was $r = .806$. The correlation across *averages* for the reasons was $r = .911$. There is very high global agreement between dentists and patients in how to act and why across the eight cases studied.

Is There One Best Answer (Issue Ambiguity)?

There was consensus on some actions and reasons contrasted with a range of responses on others. Only a dentist who was outside the tight range would need to worry about these ethical issues, and by definition there will be few of them. The profession needs to turn its attention first to those issues where there is little settled opinion. Those challenges where dentists agree with each other and patients are in agreement that something else should be done are also critical and will be discussed below. How wide is the range of preferred responses?

Table 2 presents the results of the first of several analyses intended to show

TABLE 2. RANGE OF REASONS GIVEN FOR VARIOUS ETHICAL ACTIONS CHOSEN BY PATIENTS AND DENTISTS.

	Actions		Reasons	
	Patients	Dentists	Patients	Dentists
Alternatives used (%)				
1	0	0	0	0
2	0	0	9	6
3	11	16	15	6
4	24	24	21	19
5	65	59	55	68
Mean modal response (%)	46.2	50.1	52.2	53.5
Mean SD	1.00	.93	.89	.89

NB: "Alternatives used" designates proportion of the five available alternatives selected by any respondent per item. For example, 5 means that at least one person chose each alternative; 3 means that two of the alternatives were not used; 1 would indicate complete unanimity. The average modal response is the percentage of respondents selecting the commonly chosen alternative. This number would range from 20% if all five responses were chosen by an equal number of respondents to 100% in the case of unanimity. By paired-comparison t-tests, dentists tended to be more concentrated in their most preferred action than were patients ($t = 1.79$), but there were no differences between dentists and patients on reasons ($t = .80$). Reasons were more concentrated than were actions in patients' minds ($t = 1.98$, two group t-test), but not for dentists ($t = 1.01$). Mean standard deviation across items was not different across patient or dentist groups or for actions compared with reasons (F-test all under 1.75).

the underlying structure in these data. Of the 37 action items and the 47 reason items, there were none where a single one of the five scale values was agreed by either patients or dentists. In 55% of actions and 68% of reasons, *all five* alternatives from "absolutely/decisive" all the way to "no way/irrelevant" were selected by somebody. This diffuse pattern was also reflected in the modal responses. Where there was consensus, the distribution will be peaked and a large proportion of the responses will be in the mode (most commonly chosen alternative). The mode could range from a low of 20% (meaning that all five alternatives were chosen an equal number of times) to 100% (meaning that one alternative was always selected). Across all 84 items, the average modal response clustered near 50%, meaning that the most popular action or reason was favored by roughly

half of the respondents. Alternatively, patients or dentists who chose the response favored by most of their peers were in disagreement with half of those in their group. Patients and dentists were equally spread on both actions and reasons. Dentists were equally spread on their choices of actions and reasons, but patients were slightly more concentrated on reasons than on actions. Items with large standard deviations tended to have larger numbers of missing values, $r = .197$. This can also be interpreted as a sign of ambiguity—respondents simply chose not to register an opinion and, presumably, would try to avoid rather than address such challenges.

Table 3. AVERAGE (STANDARD DEVIATION) of ENDORSED REASONS FOR ACTIONS CLASSIFIED by MORAL REASONING LEVEL

	Self	Group	Ethical	F	p
Total Sample	2.35 ^a (.80)	2.53 ^a (.71)	3.20 ^b (.45)	7.67	.001
Patients	2.30 ^a (.75)	2.54 ^a (.73)	3.21 ^b (.45)	8.77	.001
Dentists	2.39 ^a (.89)	2.50 ^a (.75)	3.19 ^b (.51)	5.50	.007
Patient-Dentist Difference					
t	.34	.11	.10		

NB: Types of action were identified from a factor analysis and only those actions with significant loadings were scored for each action type. In some cases, the direction of scoring was reversed based on factor loadings. The three levels of moral reasoning were categorized based on an approximation of Rest's typology. The F- and p-values on the right reflect one-way ANOVA tests across action types of moral reasoning levels. The t-values at the bottom of each column represent t-tests for differences between patient and dentists. Values having the same superscripted letter cannot be distinguished based on post-hoc Duncan multiple-range tests across types of actions or levels of moral reasoning. There were no significant differences between patients and dentists.

The issues that drew the widest range of opinions for both patients and dentists (standards deviations above 1.25) included truthfulness in filing insurance claims, taking action regarding other dentists' questionable behavior, involving all staff in the hostile workplace matter, and extent of informed consent deemed appropriate. Providing care when the patient is making irregular payments was more of an unsettled issue for dentists than for patients.

Matching Actions to Reasons

It is possible that there are tight connections between actions and the reasons used to justify them—each action based on a dominant reason. It is also possible that reasons support multiple actions. To explore this possibility, all

correlations were calculated between actions and reasons and the average taken on a case-by-case basis. The average across all eight cases was $r = .104$. This means that reasons were not specific to actions. Further evidence for negligible action-reason pairing was found by locating those cases where a single reason was associated with a single action. Only 26% of the reasons motivated a single action (operationalized as a correlation significant at the $p < .05$ level), while 40% motivated multiple actions and 34% were not systematically associated with any action. Analyzed from the opposite perspective, 31% of the actions were significantly associated with a single reason, while 44% had multiple motivations, and 25% had none. This finding raises questions about grounding ethical analysis in principles, or at least in expecting to find that principles lead predictably to actions.

Level of Ethical Justification

Forty-seven different reasons for ethics in dentistry is too many to work with. We need to find meaningful groupings. When psychologists, rather than philosophers, study ethics, they look to levels of reasoning or to the sources of these standards. A well-established classification system is James Rest's three categories, which I have modified slightly to emphasize the location of the standard for making ethical choice. Each of the reasons for actions in this study was assigned to one of the categories of Self, Group, or Ethics, and the results are summarized in Table 3.

Self and Group justifications were valued to about the same extent, but the Ethical reasoning category was preferred or given stronger credibility. This grouping was statistically significant. There were no differences between patients and dentists on this score. The literature generally reports that individuals seldom come up with fully Ethical justifications on their own (McNeel, 1994). This study found that where such reasons are provided, they carry weight.

Underlying Structure, Ethical Dimensions of Dentistry

Thirty-seven different courses of action is also too many to work with individually. It is human nature to look for patterns. One might be tempted to say, for example, some dentists are master technicians and others are born salesman. Some are both and some are neither, but the typology still makes sense. Some office staff have names for certain kinds of patients. Every case does not fit perfectly in such systems, but we keep using them because on the whole they guide action with few surprises. There is a formal statistical procedure called factor analysis that uses the computer to identify natural dimensions

TABLE 4. FACTOR STRUCTURE AMONG 37 ACTIONS ON EIGHT CASES, 148 COMBINED PATIENTS AND DENTISTS.

	Factors	Oral Health	Technical Focus	Professional Engagement	Respect for Autonomy	Paternalism
	Variance (%)	17%	16%	9%	8%	7%
Action	Case					
No action; society and insurance have set compensation too low	Full care	- .813				
No action; no lasting impact; might be seen as interference	Full care	- .723				
Work to start program that involves other local dentists in care	Full care	.681				
Volunteer one day a month in the nursing home, no matter what	Full care	.648				
Convince patient that veneers are not always the best choice here	Who decides	- .614				
Say you value needs above wants and suggest another dentist	Who decides	.512				.527
Try to convince patient of dentist's plan for long-term oral health	Who decides	- .762				
Perform the needed work and submit the claims with later date	Service		- .424			
Offer to perform the work at a reduced rate as a public service	Service		- .526			
Negotiate compromise treatment with partial or extended payments	Fair payment		- .669			
Suggest indirectly to colleagues that unnamed dentist is not up to par	Third opinion		- .594			
Invite specialists to lunch and discuss apparent change in referrals	Who cares		.602			
Explore GP-specialist roles with component ethics committee	Who cares		- .426	.530		
Lodge a formal complaint with the dental society or dental board	Third opinion			.701		
Suggest patient return to first dentist, do nothing else	Third opinion			- .604		
Refer patient to peer review for adjudication of disagreement	Fair payment			.681		
Dentist does nothing; this is an employee-customer relationship	Coach				- .485	
Patients asked to decide when not really qualified to judge	Tooth colored				- .782	
Carrying informed consent too far	Tooth colored				- .811	
Off base to offer only composite and replacing sound amalgams	Tooth colored					.760
"Selling" perhaps unneeded dentistry as "patient education"	Tooth colored					.717

in data based on how respondents group their responses. Factor analysis calls out dimension rather than clusters, so a particular item can “load” (have common properties) on several factors. Combined patient and dentist responses for all 37 actions were submitted to principle components factor analysis with a varimax rotation. Factors were retained based on analysis of scree plots, eigenvalues above 1.0, and meaningfulness of suggested interpretations. Table 4 shows the five factors that were extracted, which together account for 57% of the variance. Only items with significant factor loadings are reported.

Table 4 shows a very clean, five-factor structure. Most actions load on a single one of the five underlying dimensions. The most prominent factor is labeled Oral Health orientation. Items loading on this factor mention positive

patient health status independent of treatment activity. The second most prominent factor (Technical Focus) selected for specific treatment, appropriateness of selected treatment, or managing work flow or financial relationships. Professional Engagement, the third factor, included items describing dentist-to-dentist relationships. The fourth factor was the classical ethical principle of Respect for Autonomy. A final dimension has been included for the sometimes mentioned practice of Paternalism. Actions loading on this factor involved behavior where the dentist alone determines what is in the patients’ best interests. The same factor structure emerged when separate factor analyses were conducted for patients and for dentists.

Occasionally in such situations, a global factor emerges in a preemptive position that explains most of the

variance. This was not the case here, but had that been so, it would have supported the view that there is a global construct—“being ethical”—which characterizes some dentists but not others. This analysis suggests that ethical dental practice is more nuanced and situation-specific.

Ethical Dimensions of Dentistry as Seen by Dentists and Patients

More than half the variation (57%) in the actions chosen by patients and dentists in these ethical dental situations was explained by a five-factor structure. If we know where people stand on these dimensions, we will be able to predict with some confidence how they will act when presented with ethical challenges. It would be helpful to know whether this five-factor structure is applicable to both patients and dentists independently. The answer is sketched in Table 5.

Table 5. AVERAGE PREFERENCES (STANDARD DEVIATIONS) FOR ACTIONS OF VARIOUS TYPES AMONG PATIENTS AND DENTISTS (ONLY ITEMS IDENTIFIED IN FACTOR ANALYSIS INCLUDED).

	Oral Health	Technical Focus	Professional Engagement	Respect Autonomy	Paternalism	F	p
Total Sample	2.80 ^a (1.01)	3.23 ^a (.96)	2.44 ^a (.67)	4.48 ^b (.17)	3.10 ^a (.72)	3.97	.008
Patients	3.37 ^{ab} (1.14)	2.75 ^a (.84)	2.88 ^a (.39)	4.48 ^b (.20)	2.86 ^a (.81)	2.52	.08
Dentists	2.22 ^a (.89)	3.71 ^{ab} (.89)	2.34 ^a (.62)	4.48 ^b (.18)	3.34 ^{ab} (.67)	4.09	.02
Patient–Dentist Difference							
t	1.72	1.91	2.34	.02	.80		
P	.04	.03	.01				

Higher numbers represent greater endorsement. Only items significantly loading on the identified five-factor structure were included in the calculations.

Table 6. ASSOCIATIONS BETWEEN ACTION TYPES AND MORAL REASONING LEVEL.

	Patients			Dentists		
	<i>Self</i>	<i>Group</i>	<i>Ethical</i>	<i>Self</i>	<i>Group</i>	<i>Ethical</i>
Oral Health	-.365+					
Treatment Focus		-.302*		.222*		
Professional Engagement				-.312*		
Respect for Autonomy	-.378+		.269*			
Paternalism						-.265*

Only significant correlation coefficients are shown.

* = $p < .05$ + = $p < .01$

Respect for autonomy, willingness to include others in the decision making process, appeared as a leading ethical dimension for both patients and dentists. After that, some differences begin to emerge. Patients placed a greater salience on behavior that ensures positive oral health outcomes than did dentists. Dentists focus more on the technical aspects of dental treatment. Patients were very significantly more concerned that dentists should engage in professional interactions with colleagues on patients' behalf than were dentists.

Ethical Dimensions of Dentistry and Levels of Ethical Reasoning

Table 6 shows the correlation coefficients between moral reasoning level and types of actions most valued by patients and by dentists. This is a summary of the extracted five dimensions of actions and the three levels of reasons instead of the nearly 400 relationships in Table 1. Patients favoring Self-focused, rule-based approaches over other types of ethical reasoning tended to devalue both oral health outcomes and respect for autonomy. Those with Group orientations were what might be called "casual" with regard to the way dentists preferred to run their practices. The general norm

in the patient community contains ambivalent expectations. Those patients who placed a high value on understanding issues from the Ethical point of view were keen on respect for autonomy, they want to be independent moral agents.

Dentists presented a slightly different picture of the relationship between level of ethical reasoning and their structuring of ethical actions. Self-focused reasoning was associated with actions keeping practitioners out of engagement with their colleagues or the professional generally. Group thinking was associated with attention to the business of dentistry and technical performance. The dominant norm by which dentists judge each other appears to be performing technically fine treatment and running a successful practice. Higher Ethical reasoning was negatively associated with paternalism. Seeking the grounds for ethical practice in general standards was considered inconsistent with acting as one's own standard.

DISCUSSION

Eight detailed cases of ethical situations that arise in and around dental practice were reviewed by 54 patients and 91 dentists. The respondents indicated their degree of agreement with multiple courses of actions and justificatory reasons in each case. This dataset was

used to create an online interactive ethics learning platform where individual dentists can compare their considered actions and reason against norms from their peers and from a sample of patients. The dataset has also been analyzed in detail to identify the underlying structure of ethics in dental practice.

Although there is substantial agreement on actions and reasons at the aggregate level (patients as a cohort and dentists as a cohort), there are patterns of particular differences that deserve further exploration. Such topics as justifiable criticism, informed consent, financial arrangements and patient responsibility, and dentists' role in oral health beyond the purely technical tasks suggest themselves as very promising for policy discussion and education. These are areas where wide differences of opinion appear and where a range of opinions exists among dentists. The public and the profession seem to have different perspectives on the primacy of technical procedures and oral health outcomes and on how far paternalism should be carried. Another place where patients and dentists seem to be looking

in different directions is on the dentists' obligation to engage colleagues or the profession as a whole on the patients' behalf.

Policy discussions, code revision, and continuing education should focus on those issues where there are material differences in the courses of action preferred by patients and dentists and where dentists exhibit a range of opinions on situations. Practical dental ethics is complex. There is little evidence in this study for grounding dental ethics in theories of ethics. There was no evidence for a general construct—"ethical dentist"—that applies across the boards or for courses of actions to flow directly from principles. John Stuart Mill (1863/1910, p. 24) seems to have been correct in noting "there is no case of moral obligation in which some secondary principle is not involved." The fact that a factor structure with five dimensions emerged rather than a global "ethical/not ethical" dichotomy is consistent with the literature, including the classical Hartshorne and May (1928) study showing that children would steal a lunch but not a pencil or cheat on a test but not in a game, and various individual combinations.

It is not customary for professions to include patients or the public in the development, interpretation, or implementation of their ethics codes. Jürgen Habermas (1990) offers a helpful rule in this regard: all competent individuals who are affected by a decision should be allowed to participate in the decision. Competence in the case

of individuals in need of oral health care obviously extends beyond the technical aspects of treatment, as evidenced by the content of most professional codes, and participation can certainly be representative. To the best of my knowledge, no lay individuals were involved in the development of the ADA code and its exact shape and use are strictly controlled by the House of Delegates. By contrast, Institutional Review Boards which are required to pass on all research involving human subjects in America are not permitted by federal regulation to take a vote on any specific proposed project unless there is at least one lay committee member among the quorum (See Code of Federal Regulations, 45 CFR 46).

The level of justification or touchstone source of deciding what is right to do that was supported by the data in this analysis seems intuitively correct. The Self as standard was associated with unattractive actions for both patients and dentists. These included diminished concern for oral health outcomes, limited professional engagements, and low respect for autonomy. Accepting the norms of one's reference Group appeared to be matched with focus on technical and business aspects of practice for dentists and with some distancing from these characteristics by patients. There is a sense in which this is the public face of dentistry, with practitioners focused on aspects of delivery while patients accept this without enthusiasm and wanting more attention on oral health outcomes. A high level of Ethical reasoning emerged as antithetical to paternalism or the imposing of ones views on others.

The five-factor structure of dental ethics issues produced by the factor analysis approach seems face valid. Oral health outcomes and technical and practice excellence should be on everyone's list as highly valued signs of

the best practices and as reflections of the fundamental integrity of dentists. These concepts are present in various places in the ADA code and the codes of specialty and other dental groups.

Paternalism (or more properly limited appeal to it) and individual members and the profession's active self-policing on behalf of patients appeared as dimensions of both patient and dentist's ethical framework. It seems as though this matters a bit more to patients than to dentists. There is research evidence suggesting that Professional Engagement, especially among the most ethical members of the profession, is a more powerful influence on the ethical character of dentistry than are enforcement actions against those who bend or break the rules (Chambers, 2014a). This is an area the profession will find fruitful to explore.

Respect for autonomy was the only ethical dimension that emerged prominently in the present dataset of ethical concerns that is also one of the five organizing principles in the ADA Principles of Ethics. But the fit is not as tight as we would hope. This is the first of the Belmont principles ("Respect for Persons"). The ADA version was changed to feature "Patient Autonomy" (Chambers, 2014b). Certainly respect is implied if not stated, but there are significant differences between patients and persons. Much of the public would not consider itself currently to be patients of record of a dentists, and some of the ethical issues studied here, such as agreement on treatment plans, care for institutionalize individuals in need of treatment, and agreement on payment and selecting and following treatment plans, are exactly about who should be considered a patient. I have long argued

(Chambers, 2003; 2013) that dentists are entitled to exactly the same respect that patients and the public at large have. I would prefer the Belmont language of persons, not patients.

Finally we must return to the beginning and see what has been learned about the role of principles in dental ethics. Philosophers have shown clearly that we can get the job of ethics done just as well without as with principles (Hooker, 1999; Dancy, 2004; Rorty, 1999). A case can be made that patients and dentists can agree with each other generally in practice without sharing a common language or use of principles. There was very little support in these data for a direct connection between reasons for ethical behavior and the actual actions chosen. The five-factor structure for ethics that emerged from analyzing the choices patients and dentists actually made did not match well with systems of principles derived by philosophers.

Aristotle seems to have held reservations about the usefulness of ethical principles. "If theories were sufficient of themselves to make men good, they would deserve to receive any number of handsome rewards.... But it appears in fact that, although they are strong enough to encourage and stimulate the young who are already liberally minded, although they are capable of bringing a soul which is generous and enamored of nobleness under the spell of virtue, they are impotent to inspire the mass of men" (Aristotle, 1920; 343-344).

Principles are useful as theoretical organizers, as the carrying cases for examples of the behavior dentists expect of each other and the public expects of dentists. But they are not the behavior itself or even possibly not the best characterization of the patterns of that behavior.

Further work is needed along these lines to clarify what will most improve oral health and how dentists can know they are on the right path. Working with cases, lots of them over a long time frame and with feedback from colleagues and the public, bid fair to serve this need. ■

REFERENCES

- Aristotle (1920). *The Nicomachean Ethics*. J. E. C. Welldon, Trans. London: Macmillan.
- Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics*, 6th ed. New York, NY: Oxford University Press.
- Bertolami, C. (2004). Why our dental ethics curricula don't work. *Journal of Dental Education*, 68(4), 414-425.
- Chambers, D. W. (2003). Standards. *Journal of the American College of Dentists*, 70, 61-64.
- Chambers, D. W. (2013). Would someone please explain what it means to be ethical? *CDA Journal* 41(7), 493-497.
- Chambers, D. W. (2014a). Computer simulation of dental professionals as a moral community. *Medicine Health Care and Philosophy*, 17, 467-476.
- Chambers, D. W. (2014b). Does the ADA have a code of ethics? *CDA Journal*, 42(12), 813.
- Council on Dental Accreditation (2013). *Predoctoral dental education standards*. Chicago, IL: American Dental Association.
- Dancy, J. (2004). *Ethics without principles*. Oxford, UK: Oxford University Press.
- Habermas, J. 1990). *Moral consciousness and communicative action*. C. Lenhart & S. W. Nichol森, Trans., T. McCarthy, Intro. Cambridge, MA: MIT Press.
- Hartshorne, H., & May, M. A. (1928). *Studies in the nature of character*. New York, NY: Macmillan.
- Hooker, B. (1999). Rule-consequentialism. In H. LaFollette, Ed. *The Blackwell guide to ethical theory*. Oxford, UK: Blackwell, 183-204.
- Jonsen, A. R. (1991). Casuistry as methodology in clinical ethics. *Theory and Medicine*, 295-307.
- Kohlberg, L. (1968). The child as a moral philosopher. *Psychology Today*, 7, 25-30.
- MacIntyre, A. (1988). *Whose justice? Which rationality?* Notre Dame, IN: University of Notre Dame Press.
- McNeel, S. P. (1994). College teaching and student moral development. In J. R. Rest, & D. Narváez, Eds. *Moral development in the professions: Psychology and applied ethics*. Hillsdale, NJ: Lawrence Erlbaum Associates, 27-49.
- Mill, J. S. (1863/1920). *Utilitarianism*. A. D. Lindsay, Intro. London, UK: J. M. Dent & Sons.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979). *The Belmont Report: Ethical principles and guidelines for the protection of human subjects in research*. Washington, DC: Department of Health, Education, and Welfare.
- Rest, J. (1973). The hierarchical nature of stages of moral judgment. *Journal of Personality*, 41, 86-109.
- Rest, J., Narvaez, D., Bebeau, M. J., & Thoma, S. J. (1999). *Postconventional moral thinking: A neo-Kohlbergian approach*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Rorty R. (1999). Ethics without principles. In R. Rorty, *Philosophy and social hope*. London, UK: Penguin, Books, 72-90.
- Rule, J. T. & Veatch, R. M. (2004). *Ethical questions in dentistry, 2nd ed*. Chicago, IL: Quintessence Publishing.
- Thornton, T. (2005). Judgment and the role of the metaphysics of values in medical ethics. *Journal of Medical Ethics*, 32(6), 365-370.