2: Dentistry As an Ethical Context

Dentists share moral obligations with all humankind and especially those standards most cherished in their communities. These general moral norms include not harming or misleading others; hospitality and reciprocating kindnesses; confidence; respect for civil discourse; not taking, be clean; using, or destroying what is not one's own; contributing a reasonable amount to the common good; help others when we can; keeping one's promises, being fair or at least not conspicuously inconsistent; tolerating other's differences if no one is damaged in the process; not grabbing more than one's share of common resources; abstaining from torture or bullying. And there are more. Robert Fulghum's blockbuster, *All I really need to know I learned in kindergarten* [New York; Ballantine, 1986] expresses the correct sentiment that we learn a common core of what seem good and right without having to take a course in philosophy. It does not mean we know how to act ethically; that comes later. [See Thomas Donaldson and Thomas W. Dunfee's *Ties that bind: A social contracts approach to business ethics*, Boston, MA: Harvard Business School Press, 1999] for a brave attempt to enumerate a short list of universal ethical principles.] [Note on references: I follow the practice of inserting full bibliographic references at the point in the text where there are introduced. This reminds me of what has been documented and what needs further support. As the material goes through changes, the references travel with them, eliminating the need to manage text and references separately and reconcile them in the end. Material in blue will not appear in the final document. Material in red signals that more will be added at that point.]

The norms in the preceding paragraph are general, not universal. Each has exceptions. Circumstances dictate deviations, as in killing for self-defense or shading the truth to protect a friend's feelings. With so many norms, they are bound to collide with each other. Perhaps it is fine to underplay a treatment alternative if it violates other deeply help convictions. Catholic hospitals not performing abortions comes to mind. Nobody is ethical because he or she follows all the cultural norms all the time. Religions emphasize seeking over attaining perfection and forgiveness. In the civil domain, there are minimum standards and supererogatory opportunities: we may go for extra credit if we are in a position to do so but we are usually not faulted for failing to go beyond the norm.

Self-help books on ethics are a multimillion dollar industry. A few on the shelf behind me have titles such as *Moral prejudice* [Annette C. Baier. Cambridge, MA: Harvard University Press, 1994]; *The science of evil: On empathy and the origins of cruelty* [Simon Baron-Cohen. New York: Basic Books, 2011], *Does ethics have a chance in a world of consumerism?* [Zygmunt Baumna. Cambridge, MA: Harvard University Press, 2008], *Blind spots: Why we fail to do what's right and what to do about it* [Max H. Bazerman and Ann E. Tenbrunsel. Princeton, NJ: Princeton University Press, 2011]; *Lying: Moral choice in public and private life* [Sissela Bok. New York: Vantage Books, 1978]; *The great degeneration: How institutions decay and economies die* [Niall Ferguson. New York: Penguin, 2013]: *Moral hazard in American healthcare: Why we can't control our medical expenses* [Gary Fradin. No publisher, 2007]; *Everybody does it! Crime by the public* [Thomas Gabor. Toronto, ON: University of Toronto Press, 1995] *The righteous mind: Why good people are divided by politics and religion* [Johanthan Haidt. New York: Vintage, 2012]; *The arrogance of distance* [Stan Haski. New York: iUniverse, 2005]; *Absolute honesty* [Larry Johnson and Bob Phillips, New York, AMACOM, 2003]; *Coercion*. [Douglas Rushkoff, New York, Riverhead Books, 1999].) This is only a random sample, but two features stand out. First, most of this genera focuses on a single dimension of ethics; not ethics per se, but lying, crime, evil, or coercion and other evils one at a time. Second, most of the attention is on how others are misbehaving and we are victims.

The academic literature on the subject is quite different. There are more than 30 journals devoted to papers on moral behavior and ethical theory generally, and many additional ones that specialize in issues in context, such as nursing or management of public resources. These are technical and often define the problem to be solved so narrowly that the hoped-for solution emerges naturally, but few would ever be in exactly such a situation or have the time to work through the nuances before having to act. There is also a classical literature, mostly in the form of books by dead people, that works out general approaches to ethics. Aristotle's virtue ethics [The Nicomachean Ethics *in Aristotle, Writings,* Philip Wheelwright, ed, trans, New York: Odyssey, 1935], Bentham's utilitarianism [*An introduction to the principles of morals and legislation.* Mineola, NY. Dover, 1780/1909] and Kant's duty ethics [*Groundwork of the metaphysic of morals,* H. J. Patton trans. New York: Harper Torchbooks, 1785/1948] are the best-known examples. The academic field of ethics is divided between applied ethics and metaethics. In the former, the context is narrowly defined and a rule proposed: in situation X, do Y. In metaethics, philosophers are concerned to abstract general approaches that work across all, or nearly all, cases.

To the extent possible, this report will avoid all of these approaches to ethics. The popular press is choppy and sensationalistic. Metaethics operates at 30,000 feet and is subject to diverse personal interpretation when a practical decision needs to be made. Applied ethics is such a large and loose collection of theoretical papers, that not even faculty who cover this field are able to master much of it.

My favorite is the rather large literature known as the "trolley problem" [Joshua Greene, Moral tribes: Emotion, reason, and the gap between us and them. New York: Penguin, 2013]. Readers are asked to imagine that he or she is on a bridge across a track with a rapidly approaching trolley that is bound to run over and kill three folks tied on the track. The potential moral agent is in a leg cast and cannot jump onto the track to save the three unfortunates. As luck would have it, standing next to the moral agent is a 350-pound drunk who for some reason is trying to get on the railing of the overpass. The moral question is whether to "nudge" the large person and thus trade three lives for one. Or closer to home, should an emergency physician allow the speedy demise of an accident victim with a donor card that would afford transplants to three patients who would otherwise expire. There are about eight versions of the trolley problem: as philosophers seem to be narrowing in on a solution, the problem is altered to may it more difficult. The odds of anyone reading this report being in this situation are very small.

But are there not moral obligations that are unique to dentists? Informed consent is expected to compensate for asymmetries in knowledge. But this standard is uncommon in a grocery store. A very high standard of cleanliness is expected because of possible exposure to saliva and blood. Because patients must reveal personal information on their health histories, confidentiality is mandatory. Because oral disease is a process and not an event, dentists are expected to engage patients in a continuous and comprehensive relationship. By contrast, we go to a big box store to buy replacement filters for our furnace, until the furnace poops out, then we go to an HVAC vendor. A high level of technical skill covered by trust compensates for patients' inability to judge quality of treatment. Dentists have obligations to their staff for a fair and safe work environment. Overtreatment, improper billing, and sloppy records are unprofessional.

The nature of dental practice and the unique relationship between dentists and patients imposes a special set of ethical requirements. The relationship between dentists and staff, dentists and third parties such as benefits carriers, commercial organizations, and regulators carry strong ethical dimension. The relationship among dentists themselves will get special attention in this report.

The character of dentistry creates set of ethical expectations that no one else has. Thus it is necessary to understand the nature of dentistry to fully appreciate dental ethics.

Context matters. This chapter is about what makes dentistry different from virtually all other human relationships. Dental ethics must fit within the context of dental practice. Dentistry faces two ethical challenges. If dentists act outside the generally accepted social standards or contrary to what dentistry stands for, the individual dentists is unethical. If dentistry as a profession strays from what the public accepts as appropriate, embraces the values of other, commercial groups, or fails to respond to the changing context in which the profession is practiced, the profession is off base ethically, even when individual dentists think they are behaving appropriately.

Dental Practice

Four folks are carpooling. Able says, "Boy, I have had this most awful intermittent pain in my jaw. Five or six days. Comes and goes but it is really distracting." Baker says," You should lay off the sugary stuff. My wife had something like that." Charlie added, "Nothing much you can do about things like that. My wife had a problem. It cost us a bundle and she lost the tooth anyway." The fourth passenger, a dentist, was silent.

Baker and Charley gave bad advice, but they were not unethical. Dentist was. All those who hold themselves out to the public have a moral obligation to help others with their oral health. A referral would be the least expected of an ethical dentist. Dentistry is a characteristic of the relationship between special people and others; practice is the name for this relationship, not for the location with a lot of scary equipment.

The contemporary philosopher Alasdair MacIntrye [*After Virtue: A Study in Moral Theory*. London, England: Duckworth, 1981] says "A practice involves standards of excellence and obedience to as well as the achievement of goods. To enter into practice is to accept the authority of those standards and the inadequacy of my own performance as judged by them. It is to subject my own attitudes, choices, preferences, and tastes to the standards which currently and partially define the practice" (178).

MacIntrye is making the case that no dentist is his or her own standard; if they hold themselves out as dentists they will be judged by the standards common to all dentists. Even more to the point, MacIntrye holds that dentistry is not a transaction where the dentists gets something and the patient gets something in exchange and that is the end of the matter. It is a relationship that affects both into the future and others, at a minimum all dentists and the community. Both dentist and patients can add a little something to the exchange that carries over in a positive way or they can steal from the common good. Dentists who attempt to skirt the norms of practice are unethical. That is true regardless of whether they think they can define what an ethical practice is. It cannot be defined, but it can be practiced.

MacIntyre even goes so far as to invoke the prevailing norms common across the profession and the heritage and traditions of the profession. "To enter into practice is to enter into a relationship not only with its contemporary practitioners, also with those who have preceded us in the practice, particularly those whose achievements expanded the reach of the practice to its present point" (181).

There is a saying, "A professional practices on the basis of his or her skills and the reputation of his or her colleagues. If dentists seek to give credence only to the first, the inevitable result will be fragmentation of the profession.

Dentistry, like all professional practice, is custom work. Cases that fall in a certain diagnostic range may nevertheless require different interactions. Those that fall outside the range must be referred. But within the range of treatment options for any case, only some approaches would be ethical. These are the ones that are recognized by one's colleagues. [ref to JACD article]

In his classic study of the professions in engineering, architecture, management, psychotherapy, and town planning, Donald Schön discovered that all professionals experiment with approach, but only within a range what they believe their colleagues might use. Donald A. Schön, in *The reflective practitioners: How professionals think in action*, New York, Basic Books, 1983, and *Educating the reflective practitioner*, San Francisco, Jossey-Bass, 1987], lays out an extensive line of research showing that professionals learn continuously on the job, but always within parameters set by their colleagues. Accept in trivial matters, professionals start with an observed gap between what they encounter as the problem and the solution they believe their colleagues would most approve. Then they go back and forth between the emerging effect of intervention and the goal, making those changes deemed most appropriate. This is known as "reflection *in* practice." Professional practice is often continuous problem solving. "Reflection *on* practice" is another matter. After the work has been completed, professionals sometimes think back on what might have been a better approach.

Dentists confuse the notions of practice with that of scope of practice. Certainly scope of practice is not a legal issue. It is legal or regulatory one. A dentist may be allowed to perform surgery in the sinus area in one state but not in another, regardless of his or her qualifications and technical skill. State legislatures determine scope of practice through statute, and the dental profession and other professional and public interest groups assist the legislature in defining what dentists can legally do and what they are prohibited from doing. They also assist in the interpretation of practice that may or may not fall on one side or the others of the scope of practice line. When a dentist performs a procedure which he or she is entitled to perform by the practice and but does it in a gross or continuously faulty fashion, that is an ethical violation. This topic will be explored in much greater detail in the next chapter.

Standard of care is not determined by statute but by the accumulation of individual court cases under various circumstances of the situation. Whereas practice acts (scope of practice) are codified in writing, standard of care is found in scattered court documents. It is determined by case law, with lawyers and witnesses presenting alternative interpretations of what patients are entitled to legally expect based on how communities of dentists practice and what the literature suggests. Generally, the dental and other professions pool resources in the form of malpractice insurance to provide protection for borderline cases of care that is simply bad outcomes as opposed to wanton breaking of standards of care. This is a professional responsibility since large groups of dentists can take advantage of this protection for a rate that is the same for all.

In a certain sense, it is unethical to practice in opposition to either scope of practice or standard of case, knowingly or in circumstances where one should have known better. It is also stupid. Practice contrary to scope of practice exposes dentists to legal sanctions; practice contrary to standard of case exposes dentists to monetary sanctions. Violators may not always feel shame or guilt, the traditional accompaniments of violating ethical norms. But their colleagues can be affected, as in rising insurance premiums.

Professionalism

Dentistry, medicine, law, pharmacy, nursing, and others speak positively about professionalism. So do first responders, phlebotomists, occupational therapists, race car drivers, and diplomats. It is not so much the status these groups are seeking as the freedom to chart their own way. An excellent resource on dental professionalism is Jos Welies three-part series of articles in the *Journal of the Canadian Dental Association* [Welie, JV. Is dentistry a profession? Part 1. Professionalism define. *Journal of the Canadian Dental Association*, 2004, 70 (8), 529-532; Is dentistry a profession? Part 2. The hallmarks of professionalism. *Journal of the Canadian Dental Association*, 2004, 70 (9), 675-678; Is dentistry a profession? Part 3. Future challenges. *Journal of the Canadian Dental Association,* 2004, 70 (8), 529-532]. Several papers on the topic have also appeared in the Journal of the American College of Dentists [refs]

There is broad agreement that professions are occupations defined by three characteristics: "specialized training in a field of codified knowledge usually acquired by formal education and apprenticeship, public recognition of a certain autonomy on the part of the community of practitioners to regulate their own standards of practice, and a commitment to provide service to the public that goes beyond the economic welfare of the practitioner" (36)" [William M. Sullivan. *Work and Integrity: The Crisis and Promise of Professionalism in America*. 2nd ed. San Francisco, CA; Josei-Bass, 2005.]

William Sullivan of the Carnegie Foundation for the Advancement of Teaching, who was just quoted lead an effort in the late 2000s to replicate the earlier studies of Flexner, Gies, and others. Five book-length reports have come out describing medicine, nursing, engineering, the clergy, and law. [A request was made by the current author to have dentistry included, but it was decided that medicine and nursing would bracket the oral health field.] The newest Carnegie reports focus on education, not practice, but the conclusions were remarkably similar across the professions. All disciplines do an excellent job of technical education in professional training, the professions perform weakly in preparing professionals for the tasks of managing their practices; there were few efforts to prepare professionals for the ethical challenges of professional practice, either in school or after graduation.

The classic professions were the clergy, medicine, and law. They were open only to the elite of society, essentially to those who had no need for earning a living by practice. Cicero, the famous Roman lawyer, was prohibited, as were all lawyers, from accepting a fee for services. Medicine was, until a few hundred years ago, and avocation for gentlemen and dominated by second sons who lost out on primogenitor. The Hippocratic oath would not have recognized dentists as it very specifically forbids doctors from cutting tissue. That, until recently was the domain of an inferior class of tradesmen called "surgeons." The clergy, until recently, was also the sinecure of second or third sons, the relationship was with a community devoted to God and not primarily a set of interactions between individuals.

Specialized training and skill are marks of professionalism. Add to this set personal characteristic and connection, if one wants to be a professional athlete or actor or an influential lawyer or dentist to the stars. Normally, completion of formal, accredited training is accepted as demonstrating professional status. Typically, professional status is not judged by actual practice performance. As will be discussed in detail in Chapter 3, determination of continued competency is usually left to patients and regulatory agencies rather than colleagues in the dental profession. Paradoxically, completion of accredited training is not accepted as sufficient evidence of professionalism for dentists. An additional requirement of demonstrating the successful completion of a few isolated procedures on a one-off test is also

expected. There is an exception to this rule, however, in some states a license is granted by additional education without the requirement to demonstrate performance. Further, no external performance evaluation is required to demonstrate professional competence for specialty status, for continuing education, or to ensure that one's knowledge and skills are adequate for contemporary standards of care.

A strong case can be made that entry into a profession and maintenance of one's standing are at least shared between the public and the profession. There is a measure of self-governance in all professions. An example of controlling entrance into a profession is the Reed Report. In addition to the Flexner Report in medicine and the Gies Report in dentistry, the Carnegie Foundation for the Advancement of Teaching commissioned a report on education in law. Conducted in the 1920s, Reed recommended, among other things that law schools be open to more individuals, primarily by opening night and part-time programs. This recommendation was squashed because the prevailing social ethos in America at the time was against immigrants such as Jews and Asians, exactly the group that would benefit from greater access to law training. The 1926 Gies Report on dental education contains a chapter on boards of dental examiners. He is critical of the behavior of some boards in abusing access to the profession.

I know of no profession that does not claim to serve the public. Most businesses that would never be mistaken for professions also make this claim. Some professions and trades claim to "put the patients' or customers' interests first." This is a ridiculous public relations line. Only the clergy might come close here. If lawyers, for example, put the clients' interests first, they would provide their services at a substantially lower fee since cost is a great concern of clients. Often the "patient first" slogan means that professionals reserve the right to decide what is really in the patient's best interest, a form of paternalism. The ADA estimates that donated dental services can be valued at approximately 5% of billed services [ref]. That is something to be proud of. But not all dentists contribute: it is estimated that only half do and that much of this pro bono work is performed outside the United States or for those who are not patients or record [ref]. These are contributions to the public and profession, not to patients. The "new" professions, such pro basketball players, commercial businesses, such as Amazon, and of course charity and community groups provide services on the level of the professions. What is required of true professions is to demonstrate a direct connection between the reason one is a professional is to serve others. To a certain extent this connection must be plausibly stronger than the commercial or public relations benefit.

Most professional codes of ethics began life as "codes of professional etiquette." They described the behavior of a professional, especially with respect to one's colleagues. For example, the original ADA code required that dentists engage in price fixing. This was phrased as consulting and conforming with the prevailing fees charged by other dentists in one's area. Of the 32 standards in the current ADA code, 19 speak primarily to the relationships among dentists, not those between dentists and patients. 1.A in the ADA code is an example of the ambiguity between whether a dentist would act as other dentists expect him or her to act or as society would expect. "The dentists would inform the patient of the proposed treatment, and any reasonable alternative, in a manner that allows the patient to become involved in treatment decisions." Patients in the United States have the right, not only to participate, but to make the final decision on all matters concerning the body. A superstructure was adder in the 1990s referencing the standards in the code to four ethical principles advocated by the bioethics community. A fifth category, veracity, was added to accommodate about xx% of the standards that did not fall into the standard ethical categories. I know of no professional code that was created with input from patients. Codes of ethics are aspirational: codes of professional conduct are enforceable. Professional codes can be interpreted as defining memberships when they contain provisions for

sanctioning or expelling members. This is a difficult matter because the United States government would only allow such a provision for voluntary organizations, such as trade groups. There is confusion over whether a dentist can be considered unprofessional because he or she does not honor the code of conduct of one or another of the groups representing the profession.

There is a strong case to be made for professionalism as an essential part of ethics. Professionalism moves the criteria for what is good and right for dentists to do away from the individual dentists to a collective responsibility or one's peers. That is right and useful (even if insufficient) because it clearly identifies a profession as a collective moral agent. An entire profession can be a force for ethical integrity. Most likely, a profession, like any other group is society, sometimes shines ethically and sometimes not so much. But is it useful to broaden our inquiry to include what individual dentists do for the public good and what they do as well when acting collectively. Organized dentistry has the collective responsibility, not for providing care to the public, but for creating a context in which individual dentists can do so ethically.

Professionalism and ethics have much in common for raising the level of oral health care, but they are not quite the same thing. Among the important differences are who participates in creating the norms, who they apply to, and how they are communicated. Professionalism refers to a set of standards expected of all members of a group; they lay out a minimum list of expected behavior for every group member. These are often codified and published and they help define who belongs to the group in distinction from others. Professional standards are determined formally and by a representative small group within the profession. Others the profession interacts with (benefits carriers, the government, and patients) in the example of dentistry, do not participate in the creation, interpretation, or modification of the standards. Professions do, however, go to lengths to tell others about their professionalism; it is a group asset that is advertised.

Professions increasingly advertise that they are ethical. Usually this means that they have standards for their members. It does not always mean that they are informing the public of the benefits of their services for those who were unaware of that need. Advertising that a group is especially ethical has a certain unpleasant pale or even a bit of competitiveness in implying that others are not ethical as the public assumes all professionals are.

There is a difference between an organization of professionals and an organization for professionals. Membership does not define professionalism, and it is awkward for an organization to represent itself as speaking on behalf of an entire profession as opposed to speaking for its members. Some of the signs that the balance is tipping in favor of the latter are concerns with membership numbers, non-dues revenue, and the size of the lobbying budget.

There are reasonable concerns that the professions have retained the forms of specialized knowledge and skill, self-regulation, and service, but are gradually altering the balance between self-regulation and service. This will be a central theme in this report. We see, across all professions, greater effort being devoted at the organizational level to seeking partnerships with commercial and regulatory interests for protection of markets and less attention being placed on ethics. The professional group is becoming a corporate entity, working with other corporate interests on behalf of its members. Quoting Sullivan again: "The problem is that the whole notion of the conscientious discharge of one's function, traditionally described as an ethic of vocation, seems to be breaking down. At the same time, the ever more Byzantine elaboration of rules fails to satisfactorily replace it." (259). [William M. Sullivan. *Work and Integrity: The Crisis and Promise of Professionalism in America*. 2nd ed. San Francisco, CA; Josei-Bass, 2005.]

Oral Health

Although practice and professionalism are characteristics that partially define how dentists interact with the public, they do not present a complete picture. It has yet to be explained what the fundamental interaction is between dentists and patients. Why do we need dentists in the first place? How, for example, does a dentist add value to a patient's life? How do we know when an individual is better off for having gone to a dentist or dental hygienist, or used fluoridated drinking water or exercised effective personal oral hygiene?

The current definitions of oral health sponsored by organized dentistry favor the approach of defining ideal states.

> World Health Organization definition: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
> American Dental Association definition: Oral health is a functional, structural, aesthetic, physiologic and psychosocial state of well-being and is essential to an individual's general health and quality of life.
> World Dental Federation definition: Oral health is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex.

This opens the prospect that dentistry can define its role as anything that closes the currently existing gap between oral status and ideal. This is a very broad remit. Almost certainly, some of the features of psychological and psychosocial rehabilitation are beyond the training of dentists. Speaking and some other functions may be entirely in the domain of other disciplines or only incidentally dental. Certainly, it is assumed that this board field is shared with other professionals and to a very large extent with patients and even society at large.

These definitions also fail to account for maintainability. Two patients may be objectively in optimal oral condition after treatment but face very different futures. One may be capable of maintaining the condition achieved and the other incapable of doing so, even to the point of accelerating decline. The reasons are many and include financial condition, access to care, age, natural development, motivation, and understanding of their own role. Some would hold that this is all assumed in the standard definitions of optimal oral health. It would be more secure to explicitly state this and to quantify the relative contributions of various factors in maintaining oral health.

Perhaps a more robust definition would be oral health as resilience: the capacity to resist and recover from both current and future environmental insults. The patient whose oral health five years from now is better than another patient who starts from the same point is healthier than the comparison patient.

This definition is explicit in identifying overtreatment, unnecessary treatment, or treatment than cannot be maintained as unethical (in the sense of not doing for the patient what could be done). This definition calls out undertreatment, missed diagnosis, and failure to work with the patient's life situation as being equally unethical. Finally, the definition shows that oral health cannot be defined outside the context of the conditions and most likely future progression of the patient. Optimal oral health cannot be defined as a dentist restoring function and esthetics in the best way possible at the moment. The definition is robust even in the face of objective criteria about the technical quality of particular procedures.

There were three schools of medicine in ancient Greece [Chambers, D. W. A brief history of conflicting ideals in health care. *Journal of the American College of Dentists*, 2001, *68* (3), 48-52]. The Hippocratic School believed that the role of the healer was to restore balance in the normal human functioning. The Cnidians, who flourished on what is now the mainland of Turkey across from the Hippocratic base on the island of Cos, intended to create health by direct intervention, even enhancement. (The C in Cnidian is silent.) The Asclepiad schools were based at oracle sites throughout mainland Greece. They favored palliative measures such as dream interpretation and healthy stays at resorts. The palliative view of

medicine dominated Western practice for centuries because cure and prevention were poorly understood. The latter were the province of women (herbalists) and mechanics (surgeons). Today, the Asclepiad approach is seen in spa dentistry or other approaches to managing symptoms and enriching the care experience. The rise of science in the Arab world in the eighth century and the eighteenth in Europe tipped the scales in favor of the Cnidian view. Disease was caused by germs, funguses, or trauma, so medicine was the elimination of the causes and repair of the damage they had resulted. The Hippocratic approach gained some respect in the nineteenth century with public health initiatives and a view of health as involving the entire individual in context. Since the 1960s there has been some rebound under the flag of holistic medicine [Nuland, SB. Doctors: the biography of medicine. New York, NY: Vintage, 1988].

Contemporary dentistry inclines very strongly in the Cnidian direction, with individual overtones of the Hippocratic and Asclepiad approaches. Dentists find it natural to hold an image of optimal oral health and see their responsibility as moving patients toward that ideal by direct intervention of the dentist. Environmental and personal factors, such as the availability of sugared soft drinks or homecare habits are given some consideration by dentists, but usually as they affect the direct treatment interaction between the dentist and the patient. The definition of ideal oral health may even be framed so as to support favored dental treatment patterns, as in defining market. One could only hope that the voice of organized dentistry on issues such as public water fluoridation or sugared drinks would be as strong as the positions on reimbursement or scope of practice.

Efforts have been made to define health as a capacity rather than a state. Norman Daniels [Just health care. Cambridge, UK: Cambridge University Press, 1985] is a well-known example. Martha Nussbaum and Amartya Sen edited a volume sponsored by the World Institute for Development Economic Research of the United Nations University [The quality of life. Oxford, UK: Clarendon Press, 1993]. The issue was discussed directly in the oral health area in Marita Inglehart and Robert Bagramian's work [Oral health-related quality of life. Chicago: Quintessence Publishing, 2002]. There is a rich empirical literature in this field. Regrettably, it has been dominated by quarrels over measurement methodology. It is both a characteristic of human nature and a fact of logic that "optimal states" are fuzzy, cannot be consistently rank ordered, tend to be resisted when imposed by others, rapidly become contradictory as the number of descriptive adjectives is increased, and are more likely to be decided on political or commercial grounds than scientific ones.

Professional Service Firms

Most dentists serve the public under a business model know as a professional service firm. (This is something entirely different from a dental service organization or DSO that will be discussed in Chapter 8.) This section draws heavily from the work of David Maister [Managing the professional service firm. New York: The Free Press, 1993; and David H. Maister, Charles H. Green, and Robert M. Galford. The trusted advisor. New York: Touchstone Books, 2000]

In extraction economies, such as oil drilling or farming, value accurs naturally or with certain help and it is economically feasible to harvest this value, provided that externalities such as environmental degradation can be passed on to the public. In manufacturing, the value of assembled parts exceeds the cost of the individual parts plus the labor and distribution costs. In sales, value is added by making products or services availed to consumers at a price less than what they would otherwise pay. Employees are reimbursed for time in a job grade. Innovative technology discovers new combinations of things and behavior that can be sold, one time, to others who manufacture or sell them.

A professional service firm provides customized, specialized, services to customers on an as-needed basis. Dental care is provided one patient at a time, usually only when a patient needs it. The work is highly individualized, and although there are similarities across all Class II amalgam restorations, every patient expects to have a personalized treatment plan. There is no inventory: neither patients nor dentists can stockpile procedures; they are only useful when they are needed. The delivery of services in almost always face-to-face. There are minimal economies of scale. PSFs are usually reimbursed on a fee-for-service-when-rendered bases, but sometimes on a retainer basis – in which case the provider of services could be considered an employee. For the most part, performing four quadrants of root planning on different patients requires four times as much chair time as performing one.

The value of one service compared to another in a PSF is almost entirely a function of the skill level of the person providing it. This fact is dangerously underappreciated in dentistry. One could easily form an impression by reading the commercial as well as the research literature tha better dentistry is a function of better materials, methods, or equipment. There is an implication in EBD that better dentistry is a matter of proving that one independent variable is superior to another and that of the factors that "cause" good dentistry, the operator is somehow controlled out of the process. There are not journals that compare one dentist against another. In fact, the code of conduct of the profession discourages comparisons. In all professional service organizations, the skill and judgment of the person providing the service is a critical component and cannot be assumed to be uniform.

The classical professions, excepting some in the ministry, are all PSFs. So are real estate agents, building contractors, electricians and engineers, hygienists, pharmacists and optometrists, appraisers, financial advisors, social workers, therapists of all types, and plumbers. There is almost an exact correspondence between PSF agents and those who are licensed. Because the interaction between those in a PSF and the public is direct and of consequence that the consumer is incapable of fully evaluating each state has an elaborate system for qualifying individuals in a PSF. The state retains the prerogative of establishing qualifications, regulations, and disciplinary oversight of PSFs independent of the profession or trade group representing its members.

Because of the kind of value added by PSFs, they tend strongly toward being reparative in orientation and to charge based on fee-for-service. Almost always, PSFs are in the "fix a problem" business. Sometimes a lawyer or financial planner is consulted for business or estate planning in a preventive fashion. Optometrists occasionally; plumbers never. This means that the value relationship between PSFs and consumers is different from the relationship with a hotel in Hawaii, a Broadway musical, or a restaurant. Usually, the best thing that can be said about a visit to a PSF is that nothing happened. We seldom introduce our visits to the proctologist in social conversations. By contract, the value added by buying a new product or receiving a desired service is a net positive. And we do brag about our Rhine cruise but not our endo. PSFs add value in a different fashion than do other segments of the economy. Consumer's standards for judging value they receive differs as well. Many products and services are sought as positive enhancements; PSF work tends to be a "necessary evil."

There is an ethical implication to the difference in how value is determined for PSFs and other kinds of business. In the eyes of the public, patients, and regulators, the issue is to ensure safety rather than to promote the public good. States concern themselves with protecting the public from common abuses and harms and not with elevating the level of care or increasing the availability of services. Because consumers of PSF services are generally unable to accurately evaluate the quality of care, and certainly not the serviceability of this care into the future, there is a tendency to fall back on proxies such as friendliness, convenience, or cost. This means that the ethical standards in dentistry are different in

nature than those in other markets. Of course the comments in this paragraph must be qualified when considering elective dentistry.

There are ways profitability can be increased in PSFs. Economies of scale, inventory control, distribution channel managements, advertising, and innovation make small differences and can be easily copied.

Delegation is an effective strategy for PSFs. Lawyers use legal aids, contractors use subcontractors, pharmacists use technicians. Much of what highly trained professionals do, such as paper work, can be handled by properly trained and supervised auxiliaries with no loss of quality. The savings achieved by good work design and delegation can be passed on to customers or retained as profits, as the owner's ethical orientation suggests. ADA figures report that 70% of the difference in net income across dentists is a function of the number of auxiliaries they employ [Beazoglou TJ, Chen L, Lazar VF, Brown LJ, Ray SC, Heilley DR, Berg R, Baillit HL Expanded function allied dental personal and dental practice productivity and efficiency. Journal of Dental Education, 2012. 46 (8), 1054-1060; Guay AH Lazar V. Increasing productivity in dental practice: the role of ancillary personal. Journal of the American College of Dentists 2012, 79 (1), 11-17].

The second way that PSOs can become profitable is to serve better clients. It is well understood in business that products migrate upstream over time. Additional features are added and the strategy of extending low margin services and products to a larger market is avoided. It is a common refrain among CE gurus that services to high end patients pay well. In study x in the appendix, the zip codes of 138 dentists in California selected at random were recorded. Software is available that reports the median household income of individuals by zip code. The average median household income in California was $61,888 in 2016. The median household income in the zip codes where dentists practice was $79,095. Dentists practice in communities that are about 25% more wealthy than average. There is one country in the state that has no dentists and several with fewer than ten. There is an ethical issue associated with providing more services to those patient who need them less. Aws will be discussed in Chapter 3, there is evidence that patients with lower incomes receive poorer quality care.

The third way that PSFs thrive is by obtaining monopoly status or securing regulations that are favorable to there for of practice. The ADA spends approximately [xxx, need data] each year to secure a playing field favorable to their PSFs, in addition to what is spent in various states. This is an effective strategy. Since the mid-1980s, dentists have worked on average fewer hours but their net, inflation adjusted incomes have increased by an average 56%, compared with the rise in average household income of 3%. The CPI for dental services has risen twice as fast of the general CPI, and dentists are now in the top 3% of income earners in the country [Chambers, D. W. Factors driving recent changes in dentists' incomes. *Journal of the California Dental Association,* 2014, *42* (5), 331-337.]

Is the Professional Services Firm Model Sustainable?

We accept that dental practices that conform to the prevailing PSF model are prima facie ethical. Or at the very least we hold up the lens of traditional dental practice as a standard for judging whether dentists are ethical. It would be very difficult to maintain that an individual dentist who practices according to the norms of the profession is unethical.

The professional service firm model has served dentistry well. Many regard any development that may curb it as a threat to be counterattacked. Certainly the past decades have placed dentists in a position, economically, socially, and politically, where necessities do not prevent considering giving back to

society or broadening one's definition of professional service and success. There are signs, however, that the remarks in this paragraph should be qualified. The PSF model may not be maintainable. There is nothing wrong with the model; it just may be that society will find alternatives more to their liking. That is an ethical matter of the first importance. The mettle of the profession will be tested by how it responds to a changing world.

Since 2006, shortly before the Great Recession, dentists' income went flat and have remained so since. There are multiple explanations, including an oversupply of dentists, more aggressive posture by benefits carriers, declining attendance by adults, conservative states reducing Medicaid benefits, and commercial ownership models that compete on price in an effort to secure a sustainable market share. Educational debt is not a factor in this equation since that has increased at a constant rate for decades and only shows up in a negative fashion because practitioners ability to service the debt from income has declined [Chambers, D. W. Factors driving recent changes in dentists' incomes. *Journal of the California Dental Association,* 2014, *42* (5), 331-337.].

The PSF model is subject to several vulnerabilities. It is unlikely that dentistry can prevent these changes, but options are possible regarding how the changes are negotiated. Certainly, the capacity to alter the course of changing practice models in future will not be in the hands of individual dentists. The profession as a whole must decide who, if anyone, it wants to work with.

Consumerism will drive patient behavior toward cost considerations. For some time now the dominant concern of patients has been cost of dental care. This shows up as more than twice the level of concern as the nearest other motive [ADA ref], and figured prominently in the focus groups studied for this report. Recall that in the PSF model, clients are not seeking a positive value in dental care; they are seeking to minimize a negative situation. That means there will be a limit on how much value can be added by dentists. The business model of "corporate" practices is not to augment the product, but to drive down cost by standardization, consolidation of back-office functions, volume purchasing, and aggressive marketing. This is a price-driven strategy, and traditional offices will be forced to compete unfavorably on price, seek high-end customers, or work at an economic disadvantage in rural and inner city areas where corporate practices do not choose to locate.

Although we are waiting to see what the next boom will be to replace esthetics from the early 2000s, there are voices urging that dentists concentrate on the upper end of the market. This may work for some, but costly or elective dentistry is too narrow a market to support more than a segment of the profession. There is also a cautionary view in the business community generally. Clayton Christensen has argued persuasively that the strategy of moving up-market by continually adding features that few customers understand or feel they need creates an opening for disruptive markets [Clayton M. Christensen. The innovators dilemma: When technologies cause great firms to fall. Boston, MA: Harvard Business Review Press, 1997; Clayton M. Christensen and Michael E. Raynor. The innovator's solution: Creating and sustaining successful growth. Boston, MA: Harvard Business Review Press, 2003]. These are entrants that come in with basic products and services at a price point where consumers say "I did not need those extras anyway; I am satisfied with a less expensive but basically adequate service." This progression has been observed predictably in many markets, and especially likely to be effective where there is unmet need, where potential customers are forced to choose between a service they cannot afford or none at all. Dentistry has long maintained that there is substantial unmet need, and at the same time that there are no alternatives to the highest level of care possible.

Price competition is not the only threat to the traditional model of dental care delivery. Technology is moving forward at a very rapid pace. This will be considered in detail in Chapter 8, but the preview is that imaging, diagnostic, treatment, and management technology is already having an impact. To the extent that patients will pay for the improvements in speed and quality that technology affords and that dentists can maintain a monopoly over the distribution channel, it will benefit those dentists who have the capital to invest in expensive and rapidly obsolete technology. To the extent that technology makes it possible for patients to move around the dentist, they will do so is the cost is reasonable. Dentists may argue that the quality of do-it-yourself dental care is inferior to dentist-provided care, but patients have always been poor judges of quality; they just had no alternatives previously.

Patient needs are also changing. There is a shift away from reparative dentistry toward prevention and maintenance. Already 85% of dental visits are asymptomatic [need ADA ref]. Because the procedures most in demand now require less training and skill involve stronger relationships and less technique, they will increasingly be passed to technology and to auxiliaries. Because dental benefits organizations supply a significant proportion of patients and they deal in groups rather than individuals, they will increasingly seek to work with group practices. This will reduce the traditional role of the dentist as the chief decider, one individual patient after another. If dentists turn to web designers, marketing services, incentives, and success merchants, this will further erode the dentist-to-patient relationship that is the foundation for traditional PSF models.

The final challenge to the traditional model for dental care is fragmentation in the profession. Dentists have long maintained an independence, preferring in many cases to assume that the standards of care they practice were superior or at least not open to inspection by others. Our focus groups identified this as the number one problem in the eyes of dentists, and patients are well aware of it. Membership in organized dentistry is falling off at a steady rate of decline. To the extent that the profession insists on this posture, individual practitioners and segments of the profession will be picked off by strong emerging forces in society at large.

Perhaps all of these forecasted changes will not take place, perhaps they will roll out in different ways, and it is even possible that a few major market disruptions will appear tha no one has seen yet. The smart money is betting that there will be big shifts that knock the traditional model off its course. The ethical issue is who the profession responds. Ignoring or denying these trends seems unwise. Resisting them is overly optimistic. Letting each dentist manager on his or her own is a betrayal of dentists by their profession. Looking around and getting into the conversation with the big players seems like the wisest way forward. The ethical challenge will be for dentistry to find a way of engaging with other that does not begin with the assumption that dentistry is the ultimate decider in these matters.

There is an ethics of engagement and leadership that starts with recognizing that others are moral agents. That is so vast a change in perspective regarding ethics in dentistry and so different from a few hours of seminar and a code that it may go unrecognized as the ethical perspective that will make the most difference to how current dental students practice and how patients are served in future. It matters little whether how many dentists can spell nonmaleficence or sound intelligent discussing a hypothetical dilemma. That is small ethics when bid ethics are needed. What is required is leadership to mobilize the entire profession to engage the growing forces that will certainly change dentistry so that the traditional values remain when the form is inevitably altered.