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

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

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

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

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

    There are three possible courses of action:

Unjustifiable criticism: A1 in combination with C1 while disregarding B
Professional development: A1 in combination with B and C3
Justifiable criticism: A2 or A3 with C2, adjusted for B

This chapter will focus on justifiable criticism.

The Profession's Obligation to the Public

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

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

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

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

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

The Code of Professional Conduct [Second-level heading]

The American Dental Association Code of Professional Conduct, in the section on Justice states: "C. Justifiable Criticism**.** Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services."

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

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

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

How Do Practitioners Use this Rule? [second-level heading]

This rule is not an ethical principle, but an element in the Code of Professional Conduct. An ADA member can be sanctioned for not reporting a colleague who engages in gross or continuous faulty treatment, although I am unaware that this has ever happened. Neither do I know of any case where a dentist has lost his or her licenses exclusively for failing to report a colleague.

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

Should and Will [second-level heading]

It does not make any sense to simultaneously endorse an ethical principle and fail to act on it. The most typical way this is done is to endorse the ethical principle in theory but add practical circumstances that excuse one from having to do anything. A dentist peer may demonstrate consistent evidence of substandard treatment, but "who knows the circumstances?" or "You cannot believe everything patients tell you," or "My colleague certainly would not want me poking my nose in his practice." That is an automatic pass while still wearing the moral mantle. Although it has not been studied in dentistry, there is ample evidence in business that questionable practices on the part of others are tolerated as a form of "protection" for our own minor deviations. Not quite so obvious, but nevertheless a reason for avoiding calling out bad actors, is the cover they provide. If Dr. A cuts corners and engages in questionable practices, it is in his or her best interest to hide behind the cover of others who are behaving more outrageously. Certainly, there is little to be gained by more transparency and an open discussion of where the line should be drawn. Why draw attention to the problem generally?

Whistle Blowing [second –level heading]

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

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

persons who report gang activates, drugs, and domestic violence and assist in the prosecution of bad actors. They are given a U-visa. The program has all but dried up recently.

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

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

A related explanation for not becoming involved in justifiable criticism is deeply psychological. We all have images of what the world is like. For example most dentists believe, and there is much reason to support this, that they are members of a noble profession where dentists place their patients' interest foremost. This becomes a lens through which the world is seen, and inconvenient counter examples have a diminished chance of being noticed. Further, modifying that generalization can be challenging to one's self-image. Even maintaining the generalization but carving out and explaining exceptions is an unwelcome cognitive burden.

It is plain that the normative principle of justifiable criticism is a blunt instrument for correcting problems with dentists being reluctant to take appropriate action to stop colleagues from damaging patients. If principles were enough, there would be no issue to discuss. Even among dentists who publically endorse principles in a code, they can duck out is practice by any of several means. It is easy enough to hold that one has an obligation to take action in the face of recognized patient abuse without being required to take action. Nonmaleficence is a handy counter principle: Do no harm to others, especially one's colleagues would trump the need to report. Principle underdetermination is another escape. "I must report gross or continuous faulty treatment." "Conceivably, the case in hand has some plausible explanation." Therefore "I both hold the principle and need not take action."

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

But this analysis fits poorly in the case of justifiable criticism. There is a personal cost in terms of time, reputation, collegial relations, and the possible embarrassment of being wrong. But there is little or no direct personal benefit. The benefit is to the patient and to the profession

generally. This is what is known as a "common good" situation rather than one involving a "personal good." The individual pays a personal cost, but the reward is a fractional share of what everyone is entitle to (Fehr & Gächter, 2000). Typically the perceived share of a better reputation of dentistry generally is small and diminishing. An individual may be willing to act in a case where he or she stands to receive all or a significant share of the good coming from the action, but will be reticent to get involved where the benefit is spread evenly across many, including those who bear no personal risk and even a few bad actors. If the individual considering justifiable criticism views the cost of involvement as high or the changes of corrective action following as low, he or she will likely duck the issue. The determination of personal cost versus collective benefit is likely to dominate the decision to act or not, and this will be independent of judging the ethical nature of the previous treating dentist' actions.

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

Studies of Justifiable Criticism [first-level heading]

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

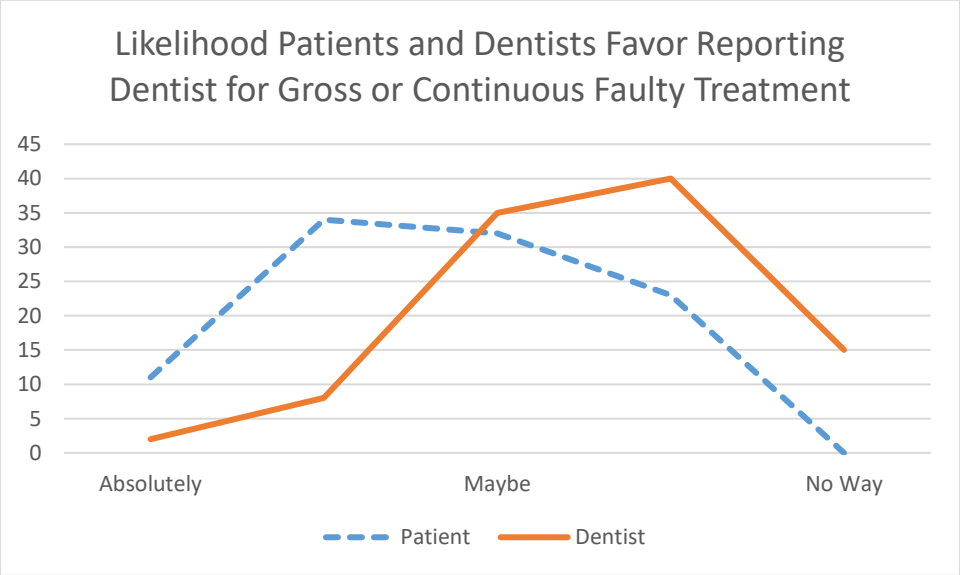
Five studies were conducted. They are summaries in this report, and each is discussed in more formal detail in a numbered appendix.

Study #1: Dentist and Patient Perceptions [second-level heading]

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

Dentists and patients alike strongly agreed that the patient should be informed of his or her oral health needs because current needs are paramount and all patients should be treated equally. Both dentists and patients were more mixed in the opinions regarding involving the treating dentist and the fact that dentists operate independent businesses and that patients personalities may be part of the consideration. Both dentists and patients were twice as likely to strongly favor giving a full explanation to the patient as they were to engage the treating dentist.

There were also significant differences between the views of dentists and patients. The most obvious discrepancy involved whether the matter should be private or more public. As shown below, patients were significantly more in favor of the consulting dentist lodging a formal complaint against his or her colleague. Patients were also significantly more prone to inform their friends informally of their dissatisfaction with the treating dentist than dentists were to mention anything to their colleagues. A supporting motive for dentists' reticence to become involved in such matters was their belief that there is a "code" that prohibits criticism of colleagues. The personal interpretations of their treatment carried more weight with patients than they did with dentists.



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

Study #2: Practical Exercise Involving Vignettes [second-level heading]

Subjects, 23 dentists, were tested individually. Following informed consent, participants were shown five sets of slips of paper and told that short descriptions were written on each. Participants were instructed to assume the role of an endodontist in a community. The scenarios in the Patient set were brief descriptions of the presenting condition of various patients, all from the same Dr. X, a general practitioners in the area. The messages on all scenarios are listed in Table 1 in Appendix 2. For patients these ranged from "Ms. 2 presents for RCT. There is extensive reconstruction work under way, which you find Dr. X started several months ago. The

approach is intriguing: it is not exactly what you would do with the case, but it might work." and "Mr. 9 presents for RCT. Two new posterior composites have been placed, and they both look well prepped and contoured." to Mr. 3 presents for RCT. There are preparations for veneers on the upper anteriors. Many of the teeth were previously unrestored. There is also clear evidence of extensive periodontal involvement in both the maxilla and mandible. The patient reports that this has not been brought to his attention" and "Ms. 14 is being seen on a referral from Dr. X for a confirming diagnosis on treating #18. The radiographs show poorly done root canals on #3, #4, and #5. There is also a clear image of an endo file in the sinus. The patient says the work has been "going on for many months," but is unaware of any complications."

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

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

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

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

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

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

Although 9 of 23 subjects in this study ended by referring the treating dentist for formal review, this was a conclusion that participants came to gradually rather than being based on a single instance of gross faulty treatment. Of the 139 initial visits, 42% of them resulted in no action being taken. Respondents were one and two-thirds times as likely to discuss the matter with the treating dentist as with the patient. Colleagues were almost never involved and referral for possible disciplinary action was rare, and only occurred based on an average of patient visits and repeated conversations with the treating dentist.

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

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

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

Study #3: How Dentists "See" Cases [second-level heading]

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

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

In the scenario exercise described as Study #2 respondents' reflections as they interpreted the case were recorded and transcribed into almost one hundred pages of text. This corpus was analyzed using the conventional techniques of qualitative research to extract major themes. Such themes were documented by verbatim quotations. This provided a picture of how subjects framed the issue of responding to a colleague's ambiguous treatment. The purpose of this research was not to count how many dentists responded in certain ways (as in Study #2) but to

show how they structured such problematic situations. How did they "see" the problem of possible gross or continuous faulty treatment?

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

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

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

2. *Patients are informed tenuously:* Patients were often informed of the existence of a compromising condition, although that information may have been ambiguous, and consulting dentists resisted responding to patients other than regarding the technical nature of their clinical condition.

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

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

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

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

   "There's no line that separates competent from incompetent."

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

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

6. *There is no sense of general professional responsivity:* There was no "we" in these cases; treating dentist, consulting dentist, and patient had separate interest that were confined to individual treatment and they did not work together for a general resolution of difficulties or a general elevation of the profession.

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

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

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

Study #4: Questionnaire Regarding Who and What Should Be Reported and by Whom [second-level heading]

A survey study was used to explore the relative contribution of "severity" of gross or continuous faulty treatment and practice experience of Dr. X. Sixty-two clinical faculty members at the University of the Pacific Arthur A. Dugoni School of Dentistry reported the likelihood of reporting on each of the 12 cases in Study #2 where there was some ambiguity regarding quality of treatment. They offered these judgments with respect to the work having been performed by a colleague they had known in the community for many years, a new dentist in the community, and a candidate on an initial licensure examination.

There were differences in "reportability" of the 12 cases, and these paralleled the findings in Study #2. There were no differences in tendency to report ambiguous cases performed by new or veteran practitioners, but the same fault observed in a candidate on an initial licensure examination was slightly more likely to be actionable. The largest source of variance came from the consulting dentists themselves (respondents on the survey). The chance of reporting any incident in the set for any treating dentist ranged from 6% to 92%, depending on who observed the case. Respondents were more apt in this study to urge reporting in general than respondents were in Study #2 to say that they would be willing to make a report.

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

Study #5: Patients' Perspective on Dentists' Responsibility for Maintaining Quality of Care [second-level heading]

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

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

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

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

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

The perception of dentistry as a profession seems to differ slightly for dentists and patients. Patients in Study #5 gave the clear impression that the specialist was a member of the profession, fully responsible for the care of the patient. If there were problems that the consulting dentist could manage, he or she was expected to do so. That extended to brokering the proper relationship with the original treating dentist. Even though the specialist was not expected to render all aspects of care, and the general dentists had primary and more general responsibility in that regard, the specialist was seen as a member of the profession with the same overall responsibility for the oral health of the patient. Fully four of five patients expressed the opinion that their issues were the reasonability of the profession and they did not expect that the profession would be segmented in a manner that added to their burden.

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

The pattern of responses on Study #2 is consistent with the view that many dentists consider justifiable criticism to be a matter of the relationship among dentists and that should good faith efforts in that direction prove insufficient, at least one has done one's duty. It may be recalled from Study #1 that patients were significantly more likely to expect that dentists will police their colleagues and are more willing to take their concerns to the street informally. Dentists and patients appear to have a different interpretation of the definition of dentistry and the extent to which professional responsibility can be segmented. Although these conclusions pass muster by fine-grained statistical tests, they are orders of magnitude effects that should be noticeable to all.

Discussion [first-level heading]

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

Judging Clinical Situations Rather than the Process that May Be Responsible for It [second-level heading]

Of the three alternatives tested in the survey study, individual standards of the potentially reporting dentist account for significantly more of the variation that do either the objective nature of the mistreatment or the professional status of the treating dentist. Three quarters of the variance was associated with personal standards of the consulting dentist. About half of this is attributable to personal opinions regarding how faulty each type of problem is and half to personal willingness to see situations as needing intervention.

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

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

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

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

Involvement in a Thin Relationship [second-level heading]

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

First, the case is considered clinically as a single incident that the consulting dentist can either treat or not.

Second, if the patient is dissatisfied with the care provided by the treating dentist, that is largely the patient's problem.

Third, if the consulting dentist chooses to engage the treating dentist, simply alerting him or her is considered to be the appropriate response.

Fourth, if the treating dentist adopts a posture of resistance to feedback, the consulting dentist either reports the treating dentist or seeks to avoid future contact.

Passing over faulty work by Dr. X necessitates no defense of one's own standards. Attempting to bring about a reconciliation (or the assumption that this would happen) is undertaken with at least the possibility that Dr. X will see the better position of the judging dentist. When that fails, the judging dentist appeals the matter. This view is supported by the fact that colleagues are almost never consulted; the matter is kept confidential for as long as possible.

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

Changing the Code? [second-level heading]

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

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

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

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

Conclusions [first-level heading]

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

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[Photo]

Dr. Chambers is professor of dental education at the University of the Pacific, Arthur A Dugoni School of Dentistry and editor of the American College of Dentists; dchabmers@pacific.edu.

[potential pull quotes]

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

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

Most dentists believe, and there is much reason to support this, that they are members of a noble profession where dentists place their patients' interest foremost. This becomes a lens through which the world is seen, and inconvenient counter examples have a diminished chance of being noticed.

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

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