



Would Someone Please Explain What It Means to Be Ethical?

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ABSTRACT Definitions are offered to distinguish among behavior that is legal, charitable, professional and moral. Moral acts are especially important because that is what people do to bring about the right and the good that is mutually sought by dentists, patients and the community. Ethics is an academic discipline that teaches about appropriate behavior in an indirect fashion — what we say to justify what we do.

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It is not obvious that dentistry faces more or fewer moral challenges today than in prior generations, but there is so much more chatter now. Among the efforts to convert discussions into decisions, 18 years ago the Commission on Dental Accreditation added Standards 2-20 and 2-21 mandating that all dental schools teach ethics and provide evidence that students have skills in the area of ethical reflection. This should make recent graduates the most ethical cohort of practitioners. But still we hear rumblings. There seems to be a felt need for practical ethics.

There are about 18 journals of ethics for the professions.¹ Most are in the general subject of biomedical ethics, but there are four in medicine. Nursing, law and business have multiple journals. There is even a journal of ethics for the uniformed military services. But there

is no journal of ethics in dentistry. The *Journal of the American College of Dentists* has a regular feature on ethics. Sometimes there are one or two, but there are usually no ethics C.E. courses at the large state and regional dental conventions. If one were serious about mastering all the dental ethics literature each year, it would not be especially difficult. Ethics editorials have now almost become a substitute for doing something to improve the way dentistry is practiced.

Confusions remain over the meaning of terms such as ethics and legality, charity, professionalism and morality. The purpose of this paper is to present a summary of what has been learned about the various parts of the dental ethics elephant that some of us get our hands on from time to time. That should help us decide where it is best to push and where we should be pulling.

Legal

Illegal behavior is usually unethical as well — but not always. Driving faster than the posted speed limit in perfectly safe conditions may not be troubling to one's conscience, especially if trying to get an injured person to the emergency room. But it is still subject to penalty. And it could go the other direction. Some law enforcement officers have difficulty with strict interpretations of immigration regulations, and priests and lawyers are protected from prosecution if they choose not to reveal information they receive about illegal activity if learned in confidence.

I define legal acts as those mandated by civil authority so that acting inappropriately is expected to result in sanctions. They are ways we must behave, regardless of our conscience, and we are not even rewarded for doing the right thing. Who ever heard of having one's name published in the paper for not cheating on his or her income taxes? "Legal" means others decide what should be done and the only outcome of interest is avoiding a penalty for transgressions.

A classic example of the tension between what is legal and what is ethical in health care involves insurance claims. A patient cannot afford needed treatment without some deception on the dentist's part regarding insurance eligibility, or the patient could receive better care if the reporting rules were bent just a little. Legally, this is usually insurance fraud. Ethically, it is a shame the patient does not receive the best care available. Most dentists say they come down on the side of honoring their contracts. It is otherwise for physicians. A 2000 *Journal of the American Medical Association* paper by Wynia and colleagues² is typical of the literature in reporting that about half of physicians alter records or insurance claims to benefit patients.

Such blurring of the lines between what is legal and what is ethical is called a Robin Hood case in honor of the fictitious hero of medieval England. He robbed from the rich and gave to the poor. Ethicists actually make a living debating these cases. The minority view is that it is questionably ethical to get social credit for advancing your own causes by using other people's resources. Working with insurance companies to get around the technicalities is a hassle, but it is sometimes effective. And there is always the pro bono option for those with strong ethical urges.

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Charity

Charity has some of the opposite characteristics from legal behavior. What we do out of the goodness of our hearts and for the benefit of mankind is of our own choosing and we are rewarded for our goodness and not penalized if we take a pass.

Charity dental care is substantial. The ADA places the value of pro bono and reduced fee treatment at about 5 percent of the total dental expenditures. Perhaps there is some bad-debt write off in there; certainly some of the care was offshore. In one recent study, participation in charity dental care was found to be unevenly distributed, with about half of dentists saying they do none.³

Without wanting to diminish the good impact of charity, it is pretty

clear that it is different from ethics and cannot be substituted for it. Charity is defined by the giver and may, on occasion, degrade the recipient. We have recently heard reports of tension between American medical personnel who donate services in underserved portions of the world where they do wonderful and life-changing care for small segments of the population but cause disruptions to the local health care system and may leave served populations with unrealistic expectations and no access to follow-up care. Dental students sometimes practice without licenses on mission trips.⁴ There are exemplary organizations such as Thousand Smiles that work to mitigate these disruptions. But the best charity typically begins at home.

Professionalism

Professionalism is the private ethics of groups that are recognized, by virtue of their trust and advanced training, to provide exclusive services to the public. Professional codes focus on the relationships among colleagues and secondarily on how professionals have agreed among themselves to serve the public. Such understandings were known historically as codes of professional etiquette.

The ADA statement is actually two documents. One is the Principles of Ethics and the second is the Code of Professional Conduct. They are tied together by a set of five principles, but it is clear from inspection that the largest part of the Code is about how dentists are expected to relate to each other. As far as I know, no patients were involved in the development of the Principles or the Code.

Professional codes come in two flavors. Some are regulatory. The

professional codes in the United States House and Senate are of this type, and members can be sanctioned for violations. The more common type is the aspirational code. Members are urged to guide their behavior by ideal standards in exchange for the expectation that their colleagues are doing the same. Typically, aspirational codes do not have specific criteria for identifying lapses and there is no intention of enforcing the code.

There is a very real possibility that dentists could act in a manner that satisfies their patients but annoys their colleagues. Botox treatment by dentists comes to mind. But it could go the other way as well. My men's book club recently ganged up on some of our local dentists. There were stories about my buddies being brow beaten over declining radiographs and treatments where the high-end work was scheduled first. One friend said he was denied a prophylaxis because he did not want other care and, according to the "voice on the phone," his request for only an exam and prophylaxis was "illegal." My friends seemed to think there was a conspiracy among the dentists.

The very first sentence of the ADA Principles of Ethics certainly seeks to avoid such impressions: "The American Dental Association calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal." Of course, that is not meant in any literal sense. Otherwise dental care would be less expensive and hours more convenient. The medical community has attempted to thread this needle by interpreting "patient first" in the Hippocratic sense that no third parties should stand between the doctor and the patient. The risk, of course, is a slip into paternalism. The patients' interests come first, but the doctor is the interpreter of what is in the patients' best interests.⁵

Ethics

Ethics is the formal theory of right and wrong, the good and the bad. It is about reasoning our way to a justification for our behavior. If this seems a bit academic, that is because ethics is a discipline of philosophy. If it appears that there may sometimes be a disconnect between behavior and ethical reasoning, that is because they are two kinds of activity.

Recently health care ethics has tried to pull itself away from the philosophical tradition. In medicine, nursing and

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biomedical research, the accepted school of thought is called the principles approach. It is so particular to medicine that it does not even appear in standard anthologies of ethical theories among academics. The principles approach works like this: One considers a behavior that appears attractive to follow. If the act can be classified as an example of an accepted ethical principle, the action is justified. There are literally dozens of these principles, such as self-fulfillment, confidentiality, consistency and dignity. Medicine follows the classic book by Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (now in its sixth edition),⁵ in focusing on four principles: respect for autonomy (each decides what is in his or her best interests), nonmaleficence (avoiding harm), beneficence (helping others) and justice

(fair distribution of burdens and benefits). The ADA Code of Ethics is built around these principles, plus one other. Veracity means not letting others hold false beliefs to their disadvantage. The largest portion of the items in the ADA Code fall under this fifth category and have to do primarily with dentists representing themselves to the public and interacting with other dentists.

The principles approach is a rational one. Ethics training in dental schools includes a large dose of reflecting or reasoning from individual concrete cases to general principles. Sometimes — perhaps almost always — more than one principle might be applicable. In this situation, we say that there is an ethical dilemma. Beauchamp and Childress advise that dilemmas should be resolved by balancing considerations. This means that one should resolve the conflict between principles by using some other higher principle or a personal preference.

For years, I have watched students and practitioners in small groups work through dilemmas. This is the preferred method of teaching ethics in the schools. It seems to be an easy enough task to find the right names for the principles. It is more difficult to get consensus on what should be done. Participants take positions and then defend them with one or another principle. This happens because most teaching cases in ethics are short narratives, open to multiple interpretations. This is probably realistic of the world of dental practice where some different ways of framing the matter are defensible. The disagreements are not the result of ethical disputes over principles. They are legitimate differences of opinion about what the facts on the ground really are. We all bring considerable background to our choices.

One case in particular seems to defeat theory every time. The ADA Code addresses justifiable criticism. Section 4C states, “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.” I have never witnessed any philosophical discussions about the phrasing of this principle. Neither have I heard any question whether this should be a matter of avoiding harm rather than one of justice as the ADA classifies it. The debate is always about whether the particulars of the case really constitute “gross or continual faulty treatment” and whether there might be extenuating circumstances, not mentioned in the case, but easily imagined.

Human nature is masterful at maintaining lofty principles and avoiding having to act upon them by supplying imagined additional circumstances. Technically, this is known as “situational ethics.” A general view is endorsed as a cover position and its application is tailored to particular circumstances. Situational ethics generally has a low reputation among professional ethicists.

Morality

The way dentists actually treat patients and each other, as opposed to what they say about it, is called morality. The distinction is often missed. Many people believe (or hope) that once others see what is right they will automatically do what is right. There is also a cherished notion that we can trust others to have our best interests at heart because they say they do. Research in business shows that the Sarbanes-Oxley laws have been a waste

of time and that there is no relationship between a company’s having a code of ethics or an ethics officer or ethics training programs and its reputation or the number of lawsuits it endures.⁶ The only two factors that matter are the personal behavior of the leadership groups and whether complaints from employees and customers are acted upon. I use the term morality to describe doing what is right and good. I use the term ethics to mean what we say about our actions.

The first year I taught ethics in dental school I had this distinction forced on me. I presented a traditional ethical program grounded in the understanding of principles that students could use to talk about what they did. The final paper was a written case supported by reading material that I placed on reserve in the library. There was grumbling in the class about this assignment being remote from real concerns such as clinical requirements. I was nervous when the student body president and several officers asked to meet with me about the course a few days before the assignment was due. They were upset that someone had stolen the reserved reading material from the library. I quickly replaced it. But to this day, I secretly wish I had just waited to see who turned in a paper rich in theory so I could have separated the ethical students from the moral ones.

Morality operates on practical rather than theoretical criteria. The basic rule is that we should choose those behaviors that bring about the kind of world we would prefer to live in given the circumstances we find ourselves in and given that others involved in the situation are equal moral agents. Gone is the theoretical justification. Gone, too, is the false altruism in putting the patients’ interests first. Finally, we must also give up the notion that we are the individual

final arbitrator of what is right and good. Morality is a joint decision about futures that satisfy common needs. It is what happens when the dentist takes off his or her white coat and works with the patient.

The classical expression of morality in dentistry is informed consent. *Patients*, by law, in full charity, based on the ethical principle of respect for autonomy and grounded in morality, should participate in decisions that affect their personal values, their financial condition and their self-image. In the natural condition, they are not capable of doing that very well. They lack the technical knowledge to understand the expected progression of their condition and to evaluate the most likely costs and benefits of available interventions. By law, and other right and good considerations, that understanding must be given to patients or their guardians in order that they can participate as full moral agents in the decisions that affect them.

I would add that dentists are moral agents as well, and they need full patient information to make the correct choice from their own perspectives. Patients who mislead dentists about their health history, ability to pay or intentions to cooperate in their therapy are immoral. Dentists and patients, as well as the entire dental office team, are moral agents. Dentists cannot be the dictators of ethics. Nor should patients be. There is probably no subdiscipline of ethics deserving of the name “dental” morality. There is only morality, generally.

Traditional approaches to ethics face three problems: First, theory does not automatically translate into action. Second, debates over whose theory to use are often intractable. Third, enforcement is messy. We cannot always count on the other guy’s conscience being in as fine a working order as ours. Legal and social sanctions are costly and may consume all

the benefit they promise. The advantage of morality, as opposed to ethics, is that it is self-enforcing. If a joint agreement has been reached such that neither party has any reason to prefer any other course of action based on their own dreams, the circumstances and other's intentions then we know we have found the right thing to do. We also know that neither agent has any reason to act otherwise. Legal action and ethical rationalization are often signs that original actions were based on morally inadequate grounds.

The logic of morality can be applied equally to the relationships among dentists in the profession. Finding the mutual best way forward based on input from all concerned is exactly what organized dentistry is about. Those who sit on the sidelines in order to preserve their private image of how things should be get exactly what they deserve. The conversation will move past them and they will be left with no option but to pass judgment on past opportunities. If dentistry as a profession prefers to address concerns that involve the profession, patients and the public at large based on only their own interests or standards, it will maintain a costly gap. ■■■■

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Additional Resources

The American College of Dentists has a tradition of engagement in ethics. Actually, this is better seen as a concern for morality in the profession, with primary emphasis on practicing dentists rather than students. For the past 15 years, the College has reached out to partner with other organizations in the profession, conduct workshops to train dentists in ethics and provide programs in dental schools and scholarships for dentists seeking formal, advanced training in ethics.

The College has also developed a range of resources online. These are free to any who are interested and can be found at www.dentaethics.org.

General Material: The aspirational *Code of Conduct of the College*, an ethics handbook and a set of cases exploring sound treatment decisions are found here. This set of material also contains descriptions of ethics programs sponsored by the College, including scholarships for dentists interested in training in ethics.

Courses Online in Dental Ethics (CODE): Set of 28 "courses" that can be attended on the Web. These are predominantly articles from the *Journal of the American College of Dentists*, covering practical topics. Because they come with computerized tests that are machine scored to produce a certificate of participation, CODE is accepted for ADA CERP credit. To date, there have been more than 28,000 courses taken.

Practice Ethics Assessment and Development (PEAD): This package is intended for practicing dentists and their entire office teams. It is a collection of self-tests, surveys, chart audit guidelines, patient satisfaction instruments and other "assessment" approaches, as well as "development" exercises, group discussions and suggestions for reworking office procedures and documentation to promote a moral practice. Offices, rather than dentists, participate for this program, which requires about 50 hours of work, with activities scored anonymously online. This program is also ADA CERP approved.

Interactive Dental Ethics Application (IDEA): This is a downloadable, interactive dental ethics textbook. It comes in searchable PDF format and resides on the user's computer, like a Kindle. There are eight sections. There are only two "chapters" in the traditional textbook sense: one on the basics of ethics and another on how to analyse a moral situation. General ethics resources such as codes are also available. There is a glossary of several dozen key concepts, each explained in about 500 words. Twelve cases are included, some in video format. Those using the cases are invited to indicate how likely they are to engage in any of several alternative behaviors and to give reasons for their actions. These can be compared with norms for how a sample of 75 dentists responded and also how 50 patients reacted to the same material. There are also some self-assessment instruments and exercises.

Predental Ethics Survey (PES): The College is experimenting with a set of open-ended ethics questions for dental students. An example would be to invite responses on questions such as whether it is worse to cheat on a written exam or to alter a patient's record. These questions will be available online to predental students, with their answers being sent electronically to become part of their admissions portfolio at participating schools.