
Risk Management Five Phase Plan for Dental Practice
I
• Identify Areas of Risk
II
• Prevent/reduce patient injury/dissatisfaction
III
• Prevent/reduce patient formal complaints/claims
IV
• Defend defensible and settle non-defensible claims
V
• Protect professional and personal assets

8th District
Bulletin
Volume 43, No. 3 Fall 2007

Eighth District Dental Society of the State of New York
3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors
The Bulletin of the Eighth District Dental Society (USPS 909–900) is published four times a year, in Feb., April, Aug. and Nov. by the Eighth District Dental Society for its members at a $2.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.
Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

From the Editor

Ethics-Based Risk Management: Do the Right Thing

By Chester J. Gary, DDS, JD

"Keep accurate and complete records". "Obtain written informed consent". "Practice defensively". These risk management mantras constitute good legal advice. However, risk management techniques alone, without adherence to fundamental ethical values, will not successfully protect dental practices from exposure to legal action. Only an ethics-based practice supplemented with sound risk management strategies can ensure dentists will do the right thing and be able to defend it.

The American Dental Association Principles of Ethics form the aspirational goals of our profession. Along with the Code of Professional Conduct, they challenge dentists to treat others the way they want to be treated or, in effect, to do the right thing. The Code's principles form the basis of most of the laws which regulate clinical practice. For example: "Patient Autonomy" – Informed Consent; "Do No Harm" – Credentialing regulations, assault and battery, defamation; "Do Good" – Professional Negligence; "Be Fair" – Antidiscrimination, labor laws; and "Be True" – Contracts, confidentiality, fraud. These ethical values and bodies of law exist on a continuum, where the laws function as a minimum enforcement of the higher ethical values. Hence, ethical conduct stands far above the behavior mandated under law; an effective risk management guideline.

Risk management techniques alone, without adherence to fundamental ethical values, will not successfully protect dental practices from exposure to legal action.

An ethics-based practice requires dentists to strive for higher values. It makes it more likely they will surpass minimum legal standards than if they merely aim for legal compliance. In so doing, the ethical guidelines assure they correctly place their primary focus on the best interests of the patient, not on protecting their own legal position. Acting in the best interests of the patient and trying to do the right thing will nurture the dentist-patient relationship and increase mutual trust. This will, in turn, form the foundation for risk management activities.

Make no mistake, ethical practice alone is not enough to ensure protection from legal exposure. Risk management strategies are necessary to make good dentistry legally defensible. They function to establish, through good communication and documentation, admissible evidence of the existing ethical values. Hence, these strategies are most effective when applied in an ethics-based environment, not as an end in and of themselves.

At times, dentists may be tempted to compromise ethical values for what may seem, at the time, good business reasons. Increasing overhead costs, combined with third party managed fee controls, can erode dentists' resolve to invest the necessary time, effort and money in their practices and professional organizations. At some point, they lose sight of the ethical principles set forth by our profession and mistakenly believe that defensive dentistry alone will relieve them of the hard work required of an ethics-based practice.

A risk management program in the absence of ethical values allows and even encourages practitioners to "get by" with marginal compliance of standards. Under these circumstances, the program is being applied for the wrong reasons: to protect and defend the dentist rather than in the best interests of the patient. Most importantly, when dentists focus on their own defense, it alienates patients who are then treated as adversaries, not partners in treatment. It will have the reverse effect of decreasing doctor-patient trust which produces dissatisfied patients more likely to elect legal recourse.

Knowing the right thing to do in difficult situations will always present a chal-

see **Editor** *page 15*

Editor *from page 3*

lenge to the practitioner. It is hard work and time consuming to proactively strive for higher values. It involves constant self analysis and courage to "catch yourself" in any potential violation. It is much easier to merely react to legal threats with defensive conduct and try to "not get caught". Dentists need to refocus their efforts on the best interests of the patient and reunite risk management with underlying ethical values; not only to experience reduced exposure to legal claims, but also to enjoy the greater satisfaction of meeting the needs of those we serve. So, when faced with a clinical crisis or ethical dilemma, don't merely do the defensive thing, do the right thing!

Please address any questions or comments to Chester J. Gary, DDS, JD at garyddsjd@roadrunner.com.

8TH DENTAL
Bulletin
Volume 40, No. 3 Summer 2005

Eighth District Dental Society of the State of New York

3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors

The Bulletin of the Eighth District Dental Society (USPS 909–900) is published five times a year, in Feb., April, June, Aug. and Nov. by the Eighth District Dental Society for its members at a $2.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.

Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

From the Editor

By Chester J. Gary, DDS, JD

Ignorance of The Law & Ethics Never a Defense

Clinical incompetence, discrimination in access to care, patient or dentist substance abuse, breach of confidentiality, illegal duty delegation, misrepresentation in advertising, failure to obtain informed consent and harassment. Dentists, by virtue of their credentials, must make correct decisions in these and all other legal and ethical situations on a daily basis. Patients, the profession and the state all assume dentists know the applicable rules, regulations and ethical principles. But do they? More importantly, how do we know if they do until it's too late?

These are legitimate concerns since, unlike clinical competence, there is no authority which requires dentists to demonstrate their knowledge of relevant laws and ethical principles as a condition to obtain and maintain a license to practice. Dental education, state licensing authorities and organized dentistry stand accountable to patients, dentists and the profession to ensure that dentists know and follow the laws and ethical principles governing their conduct. In the prosecution of illegal or unethical behavior, ignorance of the law or ethical code is no defense. Fairness dictates that regulators have no defense for failing to ensure dentists know the standards to which they will be held.

The United States Constitution empowers state legislatures with the authority to regulate dentists. In New York the legislature and its regulatory agencies have set forth the State Education Law, Public Health Law, Board of Regents Rules, Commissioner of Education Regulations and other relevant sections, all commonly referred to as the State "Dental Practice Act". This sets a mandatory minimal behavior standard for dentists. The Office of Professional Discipline and State Board for Dentistry investigate and enforce violations to protect both the public and the profession's integrity.

The profession, in return for its special position of trust within society and the privilege afforded licensees, has made a commitment that its members will practice to a high ethical standard. Organized dentistry has published the Principles of Ethics and Code of Professional Conduct. This is a group promise to aspire to a desirable or ideal behavior, always in the best interest of the patient. Members voluntarily agree to abide by the principles as a condition of membership. However, while non-members are not bound by these aspirations, the profession should expose non-members to the Code as part of its commitment to society.

Dental education, state licensing agencies and organized dentistry stand accountable to patients, dentists and the profession to ensure that dentists know and follow the laws and ethical principles governing their conduct.

Dental education, state licensing agencies and organized dentistry all have a duty to update and disseminate the law and ethical code to all licensees. First, dental schools must require successful completion of courses in these areas for graduation. Second, state licensing agencies should update and expand the law/ethics section on written licensing exams. In addition, candidates for licensure should undergo significant background checks. Finally, organized dentistry and dental schools, in conjunction with state legislatures, should require that at least 10-15% of the minimum continuing education credit hours (5-7 hours in NYS) in each registration period be in courses with certified law/ethics content. For example, any course awarding a certificate or which presents marketing techniques should be required to teach and allocate part of its credit hours toward the

see **Editor** *page 6*

Guest Column


Gary P. Andelora

Tort Reform Efforts Gaining Attention

By Gary P. Andelora

Enacting meaningful tort reform in New York State has been a frustrating and elusive goal. Despite the consistent efforts of organized medicine and its allies to enact reform legislation, the tort system remains flawed, and professional liability premiums for physicians and allied health professionals remain among the highest in the country. Although the situation in New York has not been encouraging, there is a national trend developing, which some see as promising.

New York State is not unique with regard to its professional liability crisis. In fact, the AMA includes 20 states on its list of states currently in a professional liability "crisis situation," and another 24 states (and the District of Columbia) as exhibiting "warning signs." It wasn't too long ago when rates in New York were the highest in the nation, and the Empire State was by far the most litigious. In recent years, several states have seen dramatic increases in claim severity with concomitant premium increases. Many are facing the same struggles New York has been enduring for the past 30 years, and, as a result, they have joined with New York in calling for tort reform. Some of these states have experienced varying degrees of success.

It is a common belief among reformers that, in order to achieve "meaningful" tort reform, some form of a cap on non-economic awards is necessary. Actuarial studies have indicated that a hard cap of $250,000 on non-economic awards would have a significant effect on lowering premiums. The Physician Insurers Association of America (PIAA) currently lists 27 states that have some form of cap in place. The amount of the caps and the language in the statutes in which they are included vary significantly. The effectiveness of these caps, in many cases, is currently being determined; however, in some states, such as California, which has had a "hard cap" of $250,000 on non-economic awards in place since 1976, caps have proven to be quite effective. In fact, on the previously mentioned AMA list, only six states (that is, California, Colorado, Indiana, Louisiana, New Mexico, and Wyoming) are designated as "stable." Not surprisingly, five of these (with the exception of Wyoming), have enacted a cap on awards.

While tort reform activity in other states is encouraging to some, proponents are looking toward current activities in Washington, D.C. President Bush has been a consistent supporter of tort reform, particularly in the area of medical liability. He made it a major campaign issue in the past election, and has specifically addressed the issue in his State of the Union address, as well as other speeches in Illinois and Ohio. He has publicly stated that problems associated with the current system cost the federal government approximately $28 billion each year. He described the medical liability system as "broken" and called for "real" medical liability reform this year. He specified the need for a number of reforms, including a "hard cap" of $250,000 on non-economic awards and called upon Congress to enact meaningful tort reform this session.

The House passed a tort reform measure, including the $250,000 cap, in its past two sessions; however, similar legislation was not passed in the Senate. Nonetheless, many advocates are cautiously optimistic that 2005 might be the year in which tort reform legislation is passed. Many see a federal bill, which includes a cap and other meaningful tort reforms, to be the most likely means for tort reform to come to New York State, where similar efforts have been unsuccessful.

For proponents of tort reform, 2005 has the potential of being the year their goal is achieved. Certainly, as events unfold among their ranks, there will be a captive audience.

This article was submitted by Gary Andelora, Director of Legislative Affairs for MLMIC. Guest comments and articles dealing with scientific, public health, practice management or public policy issues may be submitted to the Editor for inclusion in the Eighth District Bulletin. Final determination of articles submitted for consideration is the decision of the Editor.

Editor *from page 3*

related legal/ethical implications of the particular topic (e.g., 7.0 hours total, 5.5 CE, 1.5 law/ethics). As another option for practicioners, the state and organized dentistry could offer specific courses dedicated entirely to law or ethics. Attendance at such courses could be mandated one time for all licensees and repeated for those found in violation of state law.

Society expects dentists to, whenever possible, aspire to high ethical standards of conduct. At the same time, it demands practitioners know and obey the law. State licensing authorities, organized dentistry and dental educators must tighten the controls which ensure dentists actually know and comply with relevant standards. These institutions have a duty to educate dentists in these areas as much as in areas of clinical competence. Failure to ensure administrative compliance allows for legal and ethical violations out of sheer ignorance. Harm to patients as a result of such failure will only erode the public trust earned and enjoyed by the profession. In the eyes of the public, professional ignorance is never a defense.

Please direct any comments to GaryDDS JD@adelphia.net.

New Members

Please join us in welcoming the following to the growing ranks of organized dentistry

Todd E. Pillion
Graduate Resident at
Women's & Children's Hospital

Kelly Tsimidis
8805 Sheridan Drive,
Williamsville

Learn how you may sponsor a fellow dentist for membership in dentistry's tripartite organization by calling the Eighth District Dental Society at 716-995-6300.

8TH DENTAL
Bulletin

Volume 40, No. 1 Winter 2005

Eighth District Dental Society of the State of New York

3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors

The Bulletin of the Eighth District Dental Society (USPS 909–900) is published five times a year, in Feb., April, June, Aug. and Nov. by the Eighth District Dental Society for its members at a $2.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.

Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

From the Editor

By Chester J. Gary, DDS, JD

Know When to Say You're Sorry

Never admit fault. Do not offer to settle or return a fee. Above all, don't apologize when treatment fails or a patient sustains an injury. Such legal advice, if followed by dentists, will certainly help their attorneys defend malpractice allegations against them. Paradoxically, such tactics can make patients more likely to file suit against practicioners in the first place! When things go wrong, saying you're sorry and negotiating an informal resolution to the problem may be the best legal medicine.

Lawyers and risk managers often send mixed signals to health care practicioners when it comes to managing the inherent risks associated with the delivery of clinical services. On one hand, take the Fifth Amendment and call your lawyer when you commit a diagnostic or treatment error. On the other hand, empathize with your patients; keep them informed of the risks involved and the progress of their therapy. In practice, dentists should employ both strategies depending on the status of the doctor-patient relationship. Importantly, dentists must know how to say they're sorry when they elect to do so.

The University of Michigan Health System has advised doctors since 2002 to apologize for mistakes. In many cases, practicioners will combine the apology with an upfront settlement offer. This approach has led to a decrease in attorney fees from $3,000,000.00 to $1,000,000.00, and a fifty percent (50%) decrease in the number of malpractice suits. Supporters of the strategy want the Illinois legislature to adopt a program entitled "Sorry Works" in two hospitals to limit health care spending.

Apologies, however, only work to avoid litigation when offered in a collaborative doctor-patient relationship with some level of mutual trust. The underlying reasons patients sue their doctors include patient anger, emotional breakdown between doctor and patient, and unmet treatment expectations. When a negative event or injury occurs, an apology with informed resolution can serve to diffuse patient anger, strengthen the emotional bond in the relationship, and satisfy any expectations that the doctor will do the right thing. The key is to nurture trust in all patient relations. If problems arise, then there is a greater likelihood that "sorry" will work to avoid legal intervention.

Saying you are sorry, regretfully, can backfire. If you over-estimate the patient's level of trust or your ability to resolve the matter, your apologies could be used as evidence of your own liability in a court of law. Once the patient retains a lawyer to investigate a potential claim, the relationship is over. At this point, the patient no longer trusts the dentist to fairly resolve their complaint. These cases often involve defensible dentistry with relatively minor injuries that should not have risen to the level of a lawsuit. Yet, the underlying circumstances have created an angry, vindictive patient, intent on re-establishing their self-importance in the eyes of the dentist and the community. At this point, dentists should terminate treatment and not discuss the case with anyone except their insurance representative and attorney.

Once you choose to say you're sorry, know what you are trying to say. Say you are sorry for what happened, for the patient's dissatisfaction, or for any inconvenience, discomfort or pain involved. You will refund a fee or re-treat the case because you stand behind your work. You are absolutely not implying and, hopefully, never stating you committed legally negligent acts; departed from the standard of care; proximately caused a verifiable injury and the patient is absolved from any and all culpable conduct. Only a judge or jury can make these determinations. Do no admit to what you cannot know.

In the final analysis, dentists must honestly appraise the quality of their relationships with patients. In the presence of mutual trust, an apology that recognizes an inequity and indicates you stand behind your treatment can avoid legal action. Know when and how to say "I'm sorry".

Juris Doctor

Peer Review Review

By Chester J. Gary, DDS, JD

You know you are right or, at least, believe your treatment rendered entitles you to your reasonable fee. An unreasonable patient or insurance carrier disagrees. Avoid unnecessary stress and/or litigation. Utilize the peer review process.

As one of the many benefits of membership in organized dentistry, the Dental Society of the State of New York has established a Peer Review Mechanism to definitively resolve dentist-patient disputes regarding the quality and appropriateness of dental care and disputes involving the implementation of third-party contracts. While non-members cannot participate, the DSSNY Code of Ethics obligates member dentists to engage in the peer review process and abide by its decisions. Under the Society's By-laws, failure to comply with peer review constitutes grounds for suspension or revocation of membership.

Reviewable Disputes

Not every dispute qualifies for resolution by Peer Review. Where the dispute lies only between member-dentist and patient, it must meet the following criteria to qualify:

1. All parties must sign and submit an "Agreement to Submit to Peer Review" contract;
2. The dentist involved is a DSSNY member at the time the agreement is signed;
3. The matter pertains to quality or appropriateness of care;
4. It is less than two and one-half years since the treatment was completed;
5. The treatment in question must be complete, and not altered or removed (in practice, failure of this element precludes peer review in many cases);
6. The parties agree to appear at mediation or hearing without their attorneys;
7. The patient did not request a fee refund in writing;
8. The parties have not commenced litigation on any related matter;
9. There is no Office of Professional Discipline (OPD) investigation or State Education Department proceeding pending or completed related to the dispute; and
10. The dentist has neither hired a collection agency to pursue the patient's account nor has the account been previously resolved involving a "release from liability" or court order or settlement.

see **Juris** *page 16*

Juris *continued from page 11*

In disputes involving third party payors, the parties must exhaust the payor's internal procedures for resolution of claims. Finally, in all claims, the Peer Review committee must believe it can evaluate the claim before it and render a fair and impartial evaluation from the evidence.

"Agreement to Submit to Peer Review"

A patient, dentist or third party payor may initiate the process by completing an "Agreement to Submit to Peer Review" and forwarding it to the component society of the district where the treatment occurred. The complainant must state, in writing, the intent of the treatment, date started, date completed, fee charged, amount paid, the reasons for dissatisfaction, and vouch that the treatment has not been altered. This statement, along with the "Agreement to Submit to Peer Review" signed by all parties, is then submitted to the committee chair for acceptance.

This agreement represents a legally binding contract, in which each party describes their position in the dispute and agrees, in writing, to the following eleven conditions:

1. They have received and read information regarding the peer review process and a copy of the "Agreement to Submit to Peer Review";
2. No attorneys will be present at mediation or hearing, but the parties' respective attorneys may, and should, review this Agreement prior to signing;
3. To abide by and carry out any decision of the Peer Review Committee;
4. The maximum award is the fee charged or amount paid by the patient;
5. To release of confidential information from practitioners who examined or treated the patient and the patient agrees to submit to a clinical exam by the Peer Review Committee;
6. The Peer Review Committee members have immunity from claims by the parties for acts while performing their duties as committee members;
7. The proceedings are confidential and, consistent with the State Education Law 6527, patients cannot raise any aspect of the testimony, documents, findings, or awards in the peer review process in a subsequent action or proceeding based on the same facts;
8. Breach of the Committee decision by non-compliance entitles the non-breaching party to enforce their award in the courts without the confidentiality limitations;
9. Appeals to the DSSNY Sate Council on Peer Review must be filed within thirty days after the committee decision;
10. The DSSNY will retain only the "Agreement to Submit to Peer Review" and the decision letter after close of the case; and
11. Upon request of the patient, DSSNY members MUST participate in Peer Review.

Mediation and Hearings

Upon acceptance of the case for Peer Review, the chairperson of the local committee places any disputed fee in escrow and mediation can occur. The chair informally discusses the case with each party and, based solely upon documentary evidence, attempts to arrive at a definitive resolution. The parties cannot appeal decisions resulting from this informal process. When mediation fails, the chair schedules a final hearing.

DSSNY By-laws govern the hearing which is held locally, often at the district offices. The hearing panel must consist of at least three dentist who have not treated the patient and have no vested interest in the case outcome. The chairperson/mediator cannot serve as a voting member. In addition, parties can challenge the composition of the panel and request a change for cause. The committee will utilize specialist consultants in appropriate cases and special hearing committees comprised of specialists to review specialty cases.

The chairperson determines the order of presentation, how participants will make and rebut statements, the timing of questions by the committee, and the need for a clinical exam. After all parties have been heard, the chair adjourns the session and the committee retires into executive session in an attempt to reach a majority decision. All parties receive notification of the committee's decision by mail. Parties may appeal an adverse result within thirty days. The DSSNY Council on Peer Review will grant the appeal only in the event of a prejudicial procedural irregularity constituting reversible error or the discovery of new evidence not available at the time of the hearing.

Malpractice carrier and Data Bank reporting

Dentists should check their malpractice policies to determine whether to report peer review actions to their malpractice insurance carrier. While insurers can make refund payments on behalf of a dentist based on peer review decisions, carriers must report such payments to the Office of Professional Discipline and the National Practitioner Data Bank. Conversely, DSSNY members who personally refund fees solely through the component dental society escrow account, need not report the incident, where no written patient request for a refund exists.

Risk Management

Organized dentistry did not intend peer review to eliminate malpractice suits. Certainly, few patients will submit to it without retaining an attorney to review the agreement, and no competent attorney will allow an injured patient to contract away his/her right to pursue a significant, legitimate claim. We can, however, keep those matters which lend themselves to a quick resolution and closure for all parties out of court. Under New York State law, a peer review decision stands as an enforceable binding contract. Properly pleaded as a defense, it should serve to have a patient's attempt to re-litigate a peer review matter, as a malpractice action, dismissed. Contact DSSNY immediately if a patient attempts to sue you regarding a matter previously decided by peer review.

A credible peer review process bolsters public confidence in the dental profession's intent and ability to control the quality of care and regulate itself. If we don't, someone else will.

Editor *continued from page 4*

of work. In a capitalist society, someone will always be looking for ways to make money. That is the nature of our economic system. It is something we just have to deal with as best we can.

I won't be losing any sleep over this article, however. I believe in providing an excellent service for my patients at a reasonable cost. All the dentists I know believe this, too. If my fees are too high, the patient always has the opportunity to seek care elsewhere. That is their right. This is, after all, a free country. At least, it was the last time I looked.

8TH DENTAL
Bulletin
Volume 40, No. 4 Fall 2005

Eighth District Dental Society of the State of New York

3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors

The Bulletin of the Eighth District Dental Society (USPS 909–900) is published five times a year, in Feb., April, June, Aug. and Nov. by the Eighth District Dental Society for its members at a $2.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.

Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

From the Editor

By Chester J. Gary, DDS, JD

The Patient is Not Always Right

"Step right up, ladies and gentlemen. Welcome to the world of quick, easy, and painless cosmetic dentistry." The elements of the dental profession who market products and services in this manner find, at some level, it works. It is successful because it exploits America's obsession with personal appearance and immediate gratification. It is certainly profitable for those who reap the short term financial benefits of the trend. However, marketing dentistry as an elective cosmetic commodity and allowing patients, to their detriment, to consume that commodity erodes our ethical commitment to provide competent and timely care. In the long run, it will threaten our very status as a profession.

> ***...dentists should ask not what the patient wants from dentistry but what dentistry can do for the patient's oral health.***

Dentists know the attainment of good oral health is not always quick, easy or pain free. Excellent esthetics, while an integral goal of all treatment, can only be competently achieved as part of a comprehensive treatment plan; a plan that could involve, believe it or not, a significant patient investment of time, discipline and money. Isolated and fragmented cosmetic fixes external to such a plan can be harmful to the patient. Dentists need to disclose these truths both in the media and in each dentist-patient relationship. Patients, unlike customers in business transactions are not always right. This is especially true when patients are confused by the misleading advertisements of commercial vendors and cosmetic "specialists." When the public hears a bleaching or bonding promotion in the media, they often demand that dentists give them their Hollywood smiles before they attain their healthy mouth. Dentists who succumb to this pressure violate the central tenet of professional ethics; they choose their own financial self-interest over the best interests of the patient.

Some patients will argue that their legal right to self-determination allows them, as adults, to do what they want with their bodies. However, a dentist's duty to recognize this right is not absolute. If the procedure could injure the patient, then the dentist must refuse to perform such treatment to avoid the risk of malpractice liability. More importantly, if the procedure is not in the best interests of the patient, the dentist should decline treatment, counter to the dentist's financial self-interest, to remain true to ethical standards.

The profession's continued irresponsible marketing and individual practitioners' abdication of ethical responsibility will reduce dentistry's credibility in the eyes of regulators, health insurers and patients. Dentistry will be viewed as an elective cosmetic service undeserving of professional status. It would lead to decreased insurance reimbursements, the loss of our privilege of self-regulation and the erosion of society's trust in our profession.

The dental profession must refocus its marketing from exploiting cosmetics to educating the public regarding the relationship of the oral cavity with general health. Individual practitioners must develop the skills to motivate patients to seek comprehensive care. Most importantly, dentists must have the courage to decide to treat only in the best interests of the patient. When presented with a misinformed patient, dentists should ask not what the patient wants from dentistry but what dentistry can do for the patient's oral health.

Please direct any comments to GaryDDS JD@adelphia.net.