

Is Dentistry a Profession?

Part 3. Future Challenges

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A b s t r a c t

In 2 earlier articles a definition of professionalism was developed, and several specific professional responsibilities were deduced. This third and final article in the series examines whether dentistry qualifies as a profession. On various levels, the professionalism of dentistry is found wanting. However, attaining the status of a profession is a work in progress, which means that each profession will always have some deficiencies. The author concludes that dentistry qualifies as a profession but that it is also exhibiting a trend toward once again becoming a business (as it was before the 19th century). For the sake of honesty with the public, dentistry must make a choice between these 2 models.

MeSH Key Words: dental care/standards; dentist-patient relations; ethics, dental; professional practice/trends

© J Can Dent Assoc 2004; 70(10):675-8
This article has been peer reviewed.

Without exception, dentists claim to be professionals, but their justification for this claim appears arbitrary. For example, both the American College of Dentists (ACD)¹ and the Canadian Dental Association (CDA)² consider dentists' distinctive expertise to be an important token of their professional status. Indeed, CDA considers expertise the primary foundation of dentistry's professional status.² However, in the first article of this series³ I showed that there is no necessary connection between expertise and professionalism. Educating 6-year-old children does not require a doctoral degree, yet elementary school teachers *are* professionals because they have committed themselves to the care of children. In turn, parents entrust their vulnerable children to these teachers, whose pedagogical competence fulfills a significant existential need.

CDA states that "dentistry is a profession, in part, because the decisions of its members involve moral choices."⁴ The ACD, on the other hand, claims no such relationship between the need to make moral choices and one's status as a professional.¹ Instead, it lists responsibility to the larger community as a decisive criterion, one that, conversely, is not listed by CDA.

Finally, both CDA and ACD agree that autonomy or self-regulation is a hallmark of dentistry's professional status, but both organizations seem to imply that professional

autonomy is a right — CDA uses the term "privilege"⁵ — rather than an obligation. Although no analogy is made with the patient's right to autonomy, use of the term "autonomy" suggests that they are comparable. Patient autonomy is the patient's right to self-determination, the freedom to accept or reject medical treatment even if such a decision is, by objective assessment, harmful to the patient. However, professionals are not free to decide whether, how and whom they will treat. Rather, the profession's autonomy is akin to that of the steward of a financial trust. The steward is free to manage the funds as he or she sees fit, but only if he or she actually manages the money well. If the steward fails, his or her freedom will be restricted or completely withdrawn by the capital's owners. Likewise, the public has entrusted the professions with the management of specific public goods. To that end, the professions have also been granted the necessary freedom of practice. But this autonomy should be understood as a responsibility rather than as a right or privilege.

This article assesses dentistry's claim to professional status in a more systematic manner, using the criteria developed in the 2 earlier articles in the series.^{3,6} First, I will examine whether the relationship between dentistry and the public at large qualifies as the kind of social contract that characterizes professions. If it does, the question arises

whether dentistry acknowledges and abides by the various obligations that are implied by the status of a profession.

The Social Contract between Dentistry and the Public

The many codes of ethics that have been written and rewritten by dental associations since the mid 19th century do not themselves prove the professional status of dentistry. After all, there are many examples of statements in codes that are quite trivial (e.g., “The professional dentist ... must deal ethically in all aspects of professional life and adhere to rules of professional law”) or border on the self-serving (e.g., “The professional dentist ... should act in a manner which will enhance the prestige ... of the profession”).⁷

A toothache can be a serious source of suffering and disability, resulting in an existential need. More generally, dental needs are serious because they affect people’s health. Because effective relief requires a dentist’s expertise, from the public’s point of view there is every reason to enter into a social contract with dentists. In turn, organized dentistry has professed to assume responsibility for meeting oral health care needs in an altruistic manner, at least since the mid 19th century.

Although oral health care needs are existential and demand expert treatment by dentists, the reverse is not true. Not every treatment performed by dentists is aimed at relieving serious pain or threat to the patient’s health. Indeed, more and more of the treatments now performed by dentists are elective, most notably orthodontic and cosmetic interventions. However, ugliness is not a medical indication; it does not necessitate medical treatment in the same way that a toothache, gingivitis or oral cancer does.⁸ By definition, dentistry does not qualify as a profession when and to the extent that the interventions performed are purely elective instead of medically indicated. It therefore behooves dentists who focus their practices on esthetic interventions to clearly state that they are not professionals. Doing so does not mean they are incompetent, dishonest or otherwise immoral. It simply means that the ethical structure of their practices differs from that of professional dentists. This is not the place to examine that alternative ethical structure, but it is akin to that of an interior designer rather than an oncologist.

In summary, then, the dental profession can be defined as the collective of oral health care experts who have jointly and publicly committed to altruistically provide their expertise in the service of all patients with important oral health needs and are in turn trusted by the public to do so. The social contract that arises out of the profession’s profession and the public’s entrusting itself to the profession

shares with all other such social contracts the characteristic of there being no tangible evidence of its existence.

The remainder of this article examines whether and how this social contract between dentistry and the public has been operationalized, according to the 3 questions raised in the second article in this series⁶: Who serves? What kind of service is provided? and Who is served?

Who Serves?

Competence of Providers

There can be no question that dentists nowadays have high levels of knowledge, skill and experience. From a historical perspective, the scientific achievements of the past century, including advances in dentistry, are unprecedented. More important, the standardization of dental education ensures that each dental school graduate is competent to practise.

Still, dental educators ought not to become complacent. Even if organized dentistry can now vouch that all dentists are competent at graduation, the ever-greater pace with which scientific knowledge and techniques become outdated places graduates at risk of becoming incompetent sooner. Rather than teaching students to memorize scientific facts, dental schools must foster students’ ability to independently gain new knowledge.

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Peer Review

Because patients lack the appropriate knowledge, they are usually not in a position to review their dentists. Even if they acquire the necessary knowledge, they cannot always observe what the dentist does, and, once treatment is complete, mishaps may remain hidden for a long time. Hence, it is up to the profession to undertake such review. This is not a pleasant task, but then again, professional autonomy is not a right — it is an obligation.

Most dentists are sole proprietors, and as such they do not benefit from informal peer review such as that occurring in medical clinics, where physicians routinely treat one another’s patients, become consultants on each other’s cases or, as members of care teams, see the records of a colleague’s patients. Fortunately, dental peer review committees now exist in most locales. Unfortunately, most of these committees are only used retroactively for mediating between a disgruntled patient and his or her dentist. Few provide a forum for internal and constructive review by and among dentists. Yet there is much to learn from one’s own mistakes and those of one’s colleagues. To err is only human, but to not learn from errors is simply unprofessional, even more so given that iatrogenic harm is one of the leading causes of morbidity and mortality.⁹

Internal Discipline

Prospective and constructive peer review can significantly reduce the need for corrective and punitive action. Nevertheless, there will always be a few rotten apples in the basket, and it is the unpleasant duty of the profession to find those rotten apples. The CDA Code of Ethics clearly states that “a dentist has an obligation to report to the appropriate review body, unprofessional conduct or failure to provide treatment in accordance with currently accepted professional standards.”¹⁰

Unfortunately, not all codes of dental ethics are as direct. The Code of Ethics of the American Dental Association (ADA) stipulates that a dentist must report a fellow dentist who appears to be harming his or her patients,¹¹ but the threshold for doing so is much higher than in the CDA Code of Ethics. The ADA code states only that “gross or continual faulty treatment” should be reported. This suggests that moderately faulty treatment need not be reported as long as it does not happen all the time. Moreover, the remainder of section 4.C and the associated advisory opinion instruct dentists to abstain from unjustified criticism of colleagues and to not make disparaging comments to the patient about the dentist concerned. No advice is given as to when and how best to report.

Noncompetition

Members of a profession should not compete with one another, but the yellow pages, radio commercials and billboards reveal that many dentists engage in competition. The ADA Code of Ethics specifically states that dentists are allowed to advertise.¹² Granted, the advertisements may not be false and misleading, but this restriction is a matter of business ethics rather than professional ethics. American dentists can rightfully lay the blame for this incursion of competition into the practice of dentistry elsewhere. It was the U.S. Federal Trade Commission (FTC) and the Supreme Court which in the late 1970s began to interpret the existing ban on advertising by various professional organizations as unfairly restricting competition.¹³ The charge could not have been more ironic. Of course these organizations were trying to prevent competition, for noncompetition is a hallmark of professionalism. The issue therefore is not whether the FTC’s charge was correct — for it evidently was — but why the FTC decided to level it against these professional organizations.

This is a most serious question. What made the public, through the FTC, decide to revisit the social contract with law, medicine and dentistry and to curb their professional standing? Was the public simply gambling that it could get a better deal out of dentists by adopting a business rather

than a professional relationship? Or had dentistry in fact begun to look more like a business than a profession?

What Kind of Service Is Provided?

It was previously argued⁶ that professionals are expected to provide treatments that are, by objective assessment, in the interest of those served. If this tenet is accepted, how should we assess the many cosmetic treatments currently provided by dentists (though rarely medically indicated)? In this regard, it may be instructive to contrast these 2 types of therapy. In the case of procedures with medical indications, such as a root canal, the dentist may tell the patient that he or she really does not need the procedure; if the patient insists that the procedure is required, the dentist can simply refuse to perform it. In the case of a cosmetic procedure, a refusal to perform the procedure makes less sense; few dentists would argue with a patient who is concerned about the appearance of his or her smile and requests veneers, for example. After all, there are no scientific standards by which to judge oral beauty; it is foremost a matter of personal taste or social fashion.

However, even in the area of standard, medically indicated treatments, dentistry still has a long way to go to ensure that all patients receive objectively beneficial treatment. The much-cherished freedom of individual dentists has led to so much variation in treatment that the public has come to believe it is being “ripped off” by dentists.¹⁴ Unlike oncologists, for example, many dentists have continued to resist standardization of treatment even if the available clinical guidelines are based on the best scientific evidence.

Who Is Being Served?

The various codes of dental ethics leave little doubt that dentists are not to discriminate against certain patients, even if a patient is HIV-seropositive or has some other highly communicable disease. Many dentists provide charitable care to indigent patients, and similar initiatives are occurring at the level of organized dentistry. However, here too there is room for improvement. Many dentists claim the right to choose their patients and to dismiss noncompliant patients. Both the ADA and the CDA codes of ethics emphasize the dentist’s right to choose who will be served, but such choices raise questions about the profession’s commitment to the social contract.

Clearly a dentist should not treat a patient whose needs require some specialized competence that the dentist has not achieved; in that situation, the dentist should refer to another dental practitioner. But a serious problem arises if there are no specialists to whom the patient can be referred because the profession has neglected to develop expertise and train specialists in that area. For example, if it is discovered that patients with Alzheimer’s disease — an ever-increasing segment of the population — lack basic oral health care because dentists are not trained to meet their

specific needs, the professional collective must respond. Either the undergraduate dental curriculum must be adjusted, or a geriatric specialty must be created.

Likewise, if oral health care services are beyond the financial means of many people in need, the social contract is violated. Why should the public abide by a contract with a group of service providers who have collectively promised to be altruistic but who charge so much that few members of the public can afford the services? If large numbers of dentists, in an attempt to acquire more wealth, refuse to participate in dental insurance programs, leaving fewer dentists to care for patients of modest financial means, it is up to the profession to redress the situation.

Conclusions

Is dentistry a profession? Notwithstanding the various challenges in the foregoing paragraphs, this question can be answered in the affirmative. After all, attaining the status of a profession is a work in progress, which means that there will always be deficiencies as well.

Will dentistry remain a profession in the years and decades to come? There are signs that the public no longer believes that it will, and there are also many dentists who no longer want dentistry to retain this status — one needs only to count the number of dentists attending “continuing education” sessions about building a million-dollar practice or to calculate the staggering amounts earned on cosmetic dental interventions. Dentistry became a genuine profession only recently. Before the mid 19th century, it was largely a business, and it could certainly revert to that status once again. Although that would be a serious loss for the public, in and of itself, there is nothing immoral about being a business. However, it would be immoral for dentists to continue professing engagement in the social contract when in fact they are operating as business people. The time has come to make a choice and be honest about it. ♦

Acknowledgement: The research towards this article was supported in part by a grant from the NIDCR (1 R21 DE014969-01).



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The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

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