A Study of Ethics in the Profession of Dentistry

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Abstract

This applied project, the study of ethics within dentistry, examines internal and external influences that affect decision-making in dental practices within the province of Ontario. The topic of ethics and dentistry is important because it examines the increasing challenges of ethical behaviour in a self-regulated profession, that is a contract of privilege between dental professionals and society. Dental professionals have entered into a professional and social agreement of understanding that the health and welfare of the community shall be the priority of the practice, and making a profit through the business, secondary. The responsibility of caring for patients, while ensuring the practice remains profitable poses infinite potential conflicts of interest as demonstrated by internal and external influences. If the practice fails, the public will be unable to secure important oral health care, putting society in jeopardy.

This project begins by examining the internal and external influences upon the practice of dentistry. Influences include internal challenges such as practice management, leadership style, finances, technology and external challenges such as competition, regulatory oversight and social demand. The project next explores the definition of ‘professional’ and the hallmarks of professionalism as it relates to self-regulated professions. Stakeholder theory is next introduced as being the pivotal concept in the successful operation of a community dental practice. A stakeholder analysis helps the reader to appreciate the numerous internal and external stakeholders involved in a dental practice, and the complexities of managing these relationships. Next, the paper discusses the discipline and complaints process of dentists, as per the Royal College of Dental Surgeons of Ontario, and takes a high level look at the types of discipline breaches by dentists over a
12-year period. The review of breaches is necessary to understand trends or patterns in behaviour by dentists and complaint types by the public. After reviewing all of these topics, the paper makes recommendations on ways to mitigate internal and external influences and find better methods to support dentists who play such an integral role in the health of their communities.
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Abbreviations

The following abbreviations are referred to in this study:

ADR: Alternate Dispute Resolution
CDA: Canadian Dental Association
CDRAF: Canadian Dental Regulatory Authorities Federation
COE: Complete Oral Exam
CO-Payment: The difference between the dental fee and the insurance payment. Patients are responsible for the co-payment
CSR: Corporate Social Responsibility
FHRCO: Federation of Health Colleges of Ontario
HPARB: Health Professions Appeal and Review Board
IM: Issues Management
ICR: Inquiries, Complaints and Reports
ICRC (Complaints): Five panels x (three members). A panel is comprised of two dentists and one public member.
ICRC (Reports): One panel x (five members). A panel is comprised of three dentists and two public members
ISO: International Organization for Standards
NDEB: National Dental Examining Board of Canada
ODA: Ontario Dental Association
RCDSO: Royal College of Dental Surgeons of Ontario
RHPA: Regulated Health Professions Act
SCERP: Specified Continuing Education and Remedial Programme
1.0 A Study of Ethics in the Profession of Dentistry

The purpose of this research project is to examine the plethora of internal and external influences creating challenges for dentists in private practice management. The project identifies approaches to ethics to support practitioners coping with moral challenges. Anecdotal evidence suggests that internal and external influences on dentistry have increased exponentially in variety and complexity and has lead us to consider what factors influence ethical behaviour by dentists.

Dentistry has become more challenging as a result of increasingly complex internal and external influences on the dental practitioner in the delivery of high standards of clinical expertise and ethical conduct, while pursuing a profitable business. A high level view of internal and external influences prevalent in today’s dentistry are summarized in Table 1.0.
### Table 1.0: Internal and External Influences on a Dental Practice.

#### 1.0 Internal Influences

<table>
<thead>
<tr>
<th>No.</th>
<th>Pressures</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.1</td>
<td>Financial</td>
<td>• Personal debt (mortgage, vehicle, line of credit).</td>
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<tr>
<td></td>
<td></td>
<td>• Practice debt (capital and operational).</td>
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<tr>
<td></td>
<td></td>
<td>• Continuing education.</td>
</tr>
<tr>
<td>1.2</td>
<td>Staff</td>
<td>• Staff (hiring, training, retention, diversity).</td>
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<tr>
<td></td>
<td></td>
<td>• Human resource laws/practices.</td>
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<tr>
<td>1.3</td>
<td>Patients</td>
<td>• Ethics.</td>
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<tr>
<td></td>
<td></td>
<td>• Relationship and management.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conflict of interest.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The capable and incapable of decision-making.</td>
</tr>
<tr>
<td>1.4</td>
<td>Business Acumen</td>
<td>• Practice management (accounting, finance, marketing, human resources,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• leadership, strategy, operations, technology, economics, legal).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Entrepreneurship.</td>
</tr>
<tr>
<td>1.5</td>
<td>Continuing Education</td>
<td>• Remaining current.</td>
</tr>
<tr>
<td>1.6</td>
<td>Lifestyle</td>
<td>• Lifestyle (balancing practice, family, friends, spouse).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stress and management.</td>
</tr>
<tr>
<td>1.7</td>
<td>Financial Planning</td>
<td>• Estate planning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Life insurance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Professional corporation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Investment strategies.</td>
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#### 2.0 External Influences

<table>
<thead>
<tr>
<th>No.</th>
<th>Pressures</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Regulatory Authorities and Provincial Associations</td>
<td>• Pressures of growing regulatory and oversight.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Compliance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Managing patient expectations and complaints.</td>
</tr>
<tr>
<td>2.2</td>
<td>Lifestyle</td>
<td>• Societal expectations (financial and social).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Addictions and stress.</td>
</tr>
<tr>
<td>2.3</td>
<td>Competition</td>
<td>• Hyper-competitive market.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provincial fee guide. Is the cost of dentistry a differentiator?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trends in dental practices.</td>
</tr>
<tr>
<td>2.4</td>
<td>Foreign-Trained Dentists</td>
<td>• International accreditation of dentists (hyper-competition).</td>
</tr>
<tr>
<td>2.5</td>
<td>Multiculturalism &amp; Diversity</td>
<td>• Diversity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communication and cultural barriers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Immigration trends (location, location, location).</td>
</tr>
</tbody>
</table>
Dentistry plays a critical role in the health and welfare of Canadians and the link between oral healthcare and overall general health is highlighted by Barker:

...gum disease and heart disease often go hand in hand. Up to 91% of patients with heart disease have periodontitis, compared to 66% of people with no heart disease. The two conditions have several risk factors in common, such as smoking, unhealthy diet, and excess weight. And some suspect that periodontitis has a direct role in raising the risk for heart disease, as well (Barker, 2013, p. 1).

The Canadian Dental Association (CDA) asserts that “dentistry is a rapidly changing and expanding profession” and the stressors of providing quality dental care to patients, while maintaining a profitable practice are daunting. Successful practice management requires competency of skills including, leadership, business acumen, financial responsibility, and superior communication skills. In order to construct a thriving practice, dentists must encircle themselves with talented staff and build a network of competent professionals to help guide them through the demanding challenges of operating a successful practice. Cash flow is the cornerstone of any successful business, and dentistry is no different. In a start-up practice there may be an overemphasis on managing costs that may result in hiring incompetent staff. Staffing challenges represent some of the greatest stressors of practice management (Canadian Dental Association, 2014).
The next decade will create even greater challenges for dentists as the average Canadian family continues to struggle with high unemployment, and an under-performing economy as employers continue to aggressively reduce or eliminate benefit and compensation packages for employees. The high demand by baby boomers for superior dental care will continue and shift to a higher demand for specialty cosmetic dentistry, requiring practitioners to perform greater finite work in surgical implants and other major dentistry. The eighty percent of middle to lower income families will continue to struggle with meeting their daily financial needs and the need for dentistry will shift from preventative care to emergency treatment. Dentists will be challenged more than ever to create long-lasting relationships with patients, and demonstrate to patients, the bona fide importance and value in regular, preventative care (House, p. 2).

This research proposal is important to the dental profession as “ethical behaviour is the foundation of the public's continuing trust in the effectiveness of self-regulation.” (Code of Ethics, RCDSO). This research paper will also benefit society that deserves affordable, quality, oral health care and dental professionals that desire to help their community and build successful practices.
2.0 Primary Research Question

The goal of this project is to identify the internal and external influences that affect ethical decision-making by dentists and explore opportunities of supporting dentists in their decision-making.

Also, the project will examine how ethical decision-making may be affected by internal and external influences including organization design and practices, economic trends, professional self-governance, personal values and the competing interests of providing health care while building personal wealth. This project will provide recommendations on how dentists may be supported to improve upon the quality and consistency of ethical decision-making.

The guiding question in this study is:

How do internal and external environmental influences prevalent in the dental profession influence and contribute to ethical behaviour and decision-making?

The sub research question are:

1. What types of ethical dilemmas are prevalent in dentistry?

2. Why do ethical issues continue to be prevalent in dentistry?
3.0 Methodology

This study involved qualitative research and secondary data. The two sources for this data were a literature review and an analysis of the discipline hearings data, spanning years 1999 to 2012, as collected and coded by the RCDSO. The data is publicly available on the RCDSO’s website.

The literature review compared and contrasted internal and external influences that result in dentists to falter and behave unethically. It examined whether ethical behaviour was innate in dentists as a result of their environmental influences growing up, or whether ethical behaviour was a skill set that could be effectively learned and adopted as a good habit of professionals. The literature review examined whether punishment was a deterrent for unethical behaviour.

Stakeholder theory and principles were applied in the strategic management of small and medium sized dental practices. Internal and external stakeholders were identified and addressed, with analogies drawn as to their strength and weaknesses upon the success or failure of a practice. The position of office manager was identified as a key role, and discussions were had for the pros and cons of this stakeholder.

The literature review included the following keyword searches: professional ethics, dentistry; ethical decision-making, dentistry; conflict of interest, dentistry; codes of ethics, dentistry; ethical leadership, dentistry; ethical dentistry; public trust, dentistry; dental trends and, self-regulation, dentistry. The following sources and professional journals were also reviewed: The Canadian Dental Association (CDA); The Ontario Dental Association (ODA); Dispatch (RCDSO) and, Profitable Practice. Universities Athabasca and Toronto
on-line libraries and catalogues were searched, as well as the following websites and databases: American Dental Association (JADA); Code of Professional Ethics (AIIC); Association of Practical and Professional Ethics, and Ethics and Professional Standards (RICS). The code of ethics, conduct and guidelines, as they relate to the profession of dentistry were also examined.

3.1 Gathering The Data

The sample data were gathered from the Inquiries, Complaints and Reports Committee (ICR) section of the RCDSO's annual reports. The ICR Committee reviews member-specific concerns, brought to the College's attention, such as formal complaints, mandatory reports and information brought to the attention of the Registrar. Concerns include allegations of professional misconduct, incompetence and incapacity.

The discipline findings between 1999 and 2012 were sorted and organized into Table 5.0, 'Profile of Discipline Findings'. The actual data was converted into percentages, to enable easier comparison of category to category, year over year.

The IRC committees met in panels of between three and five members, reviewed formal complaints and took action. Their activity highlights were documented in Table 4.0, 'Activity Highlights of Formal Complaints,' under the following categories:

- Formal Complaints;
- Decisions - Formal Complaints;
- Other Activity Regarding Formal Complaints, and
- Alternative Dispute Resolution (ADR) Statistics.
Sub-categories were used in the complaints table to further define the type of discipline action taken for the complaints. The data, spanning from 1999 to 2012, from each of these categories was collected and sorted into a table for analysis.

Excluded from this study were decisions from the Registrar’s reports, and appeals of formal complaints, by either party. The appeals data was excluded due to the complexity of following the complaints and outcomes over multiple years. The Registrar’s reports were excluded as they predominantly address acts of professional misconduct or incompetence.

3.2 Limitations of the Data

There are limitations of the data used in this study. This study uses the broader activity highlights to show trends and patterns of formal complaints between 1999 and 2012, but excludes the Registrar’s reports and appeals.

Between 1999 and 2012, the RCDSO eliminated and/or added additional sub-categories of the major activity highlights. For example, the category ‘written caution’ appeared as a category from 1999 through to 2009, and was eliminated from 2010 through 2012. The ‘frivolous and vexatious complaints’ category was added in 2007 and was absent in prior years.

The profile of discipline findings is a compilation of numerous categories spanning from 1999 to 2012. A number of the categories change from year to year, and others are ambiguous, making analysis difficult. Ambiguous categories include, ‘other; ‘contravening/failing to maintain standards of profession; failing to meet and/or maintain the standards of practice of the profession’ and ‘disgraceful, dishonourable, unprofessional or unethical conduct’. The RCDSO’s intent to code the discipline findings and activity highlights is justified, however the ambiguity of the categories, makes analysis difficult.
Between 1999 and 2008, complaints were reviewed by the complaint committee, as directed by the Regulated Health Professions Act, 1991. The complaints committee was made up of one appointed public member, and two dentists. Beginning in 2009, as a result of amendments made to the Regulated Health Professions Act, 1991, the RCDSO introduced the IRC committee. The IRC panels are comprised of no less than three and no more than five members. There were five panels that reviewed formal complaints.
4.0 Literature Review

Dental practitioners play an important role in the delivery of health services within our communities. Dental practices and its owners are now, more than ever, scrutinized by their own profession, regulatory bodies, patients and major stakeholders in the ethical delivery of oral healthcare. Dental practitioners are expected to adhere to high moral standards such as honesty, fairness and justice, while building a healthy, vibrant and successful practice. On face value, it would appear that these objectives are diametrically opposed to each other. There is mounting anecdotal concern from within the profession that unethical decision-making and professional misconduct may be on the rise, and that is of concern. The relationship between business and society is complex and Sexty describes ethics as it relates to business operations and its relationship with society as follows: “the ethics of business refers to the rules, standards, codes, values or principles that provide guidance for morally appropriate behaviour in managerial decision-making relating to the operation of businesses and business’s relationship with society” (Sexty, p. xi). With Sexty’s words in mind, we review the literature on ethical dilemmas as they pertain to dentistry.

In October 2012, CBC’s Marketplace (Marketplace, 2012) devised a plan to test the ethical decision-making by dentists across Canada. A CBC reporter, working with the dental faculty at the University of Toronto, submitted herself to a complete oral examination. The University of Toronto dentistry professors participating in this report, conducted a complete oral examination (COE), and concluded that minor treatment only was necessary. This reporter travelled across Canada, undergoing similar COE’s in randomly selected dental offices across Canada. The results and findings of the examinations were
diverse and profound, with a variety of dentists recommending complex, cosmetic treatment plans, costing upwards of $25,000. The results of the Marketplace experiment raises important flags that dentists vary widely on diagnosis and treatment planning costs, bringing ethical behaviour into question.

The economic report by Professor R.K. House to the dental profession, discusses the trends and influences of the economy and its effect on dentistry over the next decade. Dr. House, a professor of economics, reports on yearly economic trends for dental professionals, based on extensive survey results. Dr. House raises concerns that Canadians “have been rather smug since 2007” (House, 2012, p. 2) about the Canadian economy in contrast to the Americans and Europeans. Dr. House believes that Canadians are standing on “the edge of the cliff” and that the average dentist may be “closer to the edge than the average Canadian” (House, 2012, p. 2). Dr. House underscores the importance of the economy on dental practices, and the internal and external influence on practices since the stock market crash in 2008-2009. Dr. House underscores challenges on demand for dental treatment:

The demand for dental care among the top 20% is probably close to saturation now, so it is unlikely there will be any significant increase in demand for care from this part of the population in the next decade. Among the less fortunate 80% of the population, some families find their real incomes are shrinking and their demand for dental care will contract. They will have to cut back on many things simply to make ends meet, and dentistry will be among their victims (House, 2012, p. 2).

Nadean Burkett, a career and business transition coach within the dental profession confirms the financial stressors on dental practices, and believes that “dentistry is no longer recession-proof” (Burkett, p. 58). Burkett raises the issue that “dental practices have the high cost of technology, equipment and infrastructure necessary for a dental practice to stay current.”
Given the severity of the economic challenges at play, it is conceivable that dentists are faced with greater challenges in running a successful practice, and as a result, may feel pressured into making unethical decisions, such as suggesting costly and unnecessary treatment plans, not in the best interests of their patients.

Dental practices are small businesses run by entrepreneurs, and who live with the daily threat of business failure as a result of limited financial resources, lack of cash flow, and aggressive competition in the marketplace. Professor Robinson points out that the challenges for small business owners, such as dentists, face greater challenges than larger corporations:

Whereas their corporate counterparts may be guided by a company code or an established corporate culture that safeguards them from having to make morally significant decisions alone, the small business owner-manager has no such backstop. At the very least, corporate managers have a person higher up the hierarchy that they can refer to, but the small business owner-manager must often face the stark reality of a dilemma all alone (Robinson, 2006).

The majority of dentists operate in small to medium-sized practices and lack the support of a larger, connected community to resolve ethical dilemmas. As a result, dentists must rely upon their own judgment to determine what is ‘right’ from ‘wrong’ as business owners are responsible for the decision-making. Banfe views entrepreneurs as “compulsive” (Banfe 1991, p. 23), which he considers to be an undesirable trait: “A fly in the entrepreneur make-up often appears to be compulsive behaviour. The staccato demand to be right and the (need for) instant reaction, frequently lead to making off-the-wall decisions.” Dentists are tasked with busy patient schedules, staffing demands, the rigors of running a business, with little time for reflection and rarely an opportunity to consult a colleague or mentor for advice.
Dentists are trained with their medical oath of ‘do no harm’, and yet they receive only modest, formal ethics training. Dr. Shelli Karp, a part-time clinical instructor and demonstrator at the Faculty of Dentistry of the University of Toronto teaches ethics to first year students and believes there is value in teaching ethics to dental students. Dr. Karp believes “role models help to influence professional values, attitudes and behaviours for dental students” (Karp, 2009). Dr. Karp points out that the high stressors of the profession may trigger dentists to behave unethically: “fear of failure, greed and envy may trigger one to act unethically. The stresses and pressures of dental school and private practice may affect just how strong the temptation is to act in an unethical way. For dentists, the influence of their peers and their own ability to justify their behaviour can affect their actions” (Karp, 2009). Dr. Charles Bertolami believes that while ethics courses succeed in instructing students what the expectations are of them, they do not address the real questions of why be good? why be ethical? Dr. Bertolami believes in that introspection of one’s own true feelings, beliefs and long term interests for ethical behaviour to thrive.

Ozar and Sokol also stress introspection as the means to achieving ethical behaviour and believe that people do not choose to become ethical or continue being ethical when a difficult situation presents itself. Ozar and Sokol believe that individuals are influenced in a more complex means and are influenced by:

The qualities of the persons in their lives who they have come in contact with and admire, the communities with which they want to be identified and the efficacy of various courses of action and patterns of life in relation to these matters (Ozar & Sokol, 1994).
Dr. Karp believes that the teaching of ethics, coupled with appropriate role modeling by faculty, will help drive home the message of “the importance of defining values and learning ethical habits that reflect integrity and good moral behaviour” (Karp, 2009).

Yet, despite the educating of dental students in good moral practice, there can be no doubt that year over year, there continues to be a growing number of complaints made by patients against dentists. The complaints are reviewed and vetted by a complaint board and those which are not resolved by an independent arbitrator, go forward to the discipline committee of the RCDSO. Pursuant to the legislation, the name of the member who is the subject of the hearing must be published if there is a finding of professional misconduct. During the course of this research project, the complaints registered against dentists, between 1999 and 2012 will be reviewed in an effort to identify patterns of the types of ethical or moral infractions most common as well as the type of factors that may influence this behaviour. It is the goal of the research paper to review the training and support dentists have, and what, if any support, could be implemented in this profession.

Dentists play an important role in the delivery of health services. Dentists are scrutinized by their own profession, regulatory bodies, patients and major stakeholders in the ethical delivery of oral healthcare. Dentists must adhere to higher than average moral standards including honesty, fairness and justice, while building a successful business. On face value, it would appear that the objectives of caring for patients while building wealth are diametrically opposed to each other. There is mounting anecdotal concern from within the profession that unethical decision-making and professional misconduct may be on the rise, and that is of concern.
The literature review is broken down into the following sections that cover the interrelated areas of internal and external influences prevalent in dentistry that contribute towards ethical behaviour and decision-making, professional ethics in dentistry, ethics (learned or innate?) and stakeholder theory.

4.1 Internal Influences

There are numerous internal influences that contribute towards ethical behaviour and this section discusses the most compelling.

4.1.1 Leadership Style

Leadership style is an important attribute contributing to ethical behaviour. In the absence of appropriate leadership style, a dental practice may be vulnerable to unethical practices and behaviour of staff creating risk for patients, other staff and the community.

Leadership is the ability to self-manage and is a required skill in managing others effectively. Maria Gonzalez describes mindful leaders as being coherent and consistent (Gonzalez, 2012, p. 5) and possess nine leadership attributes include being “present, aware, calm, focused, clear, positive, compassionate and impeccable” (Gonzalez, 2012, p. 6). There are two types of leadership styles, transactional and transformational. Transformational leaders make the best leaders in dental practices and transformational leaders are:

- Charismatic to their staff;
- Create and share a vision of the type of practice they seek to build;
- Cultivate positive relationships with all stakeholders and support their team by instilling a sense of pride and shared ownership in their business;
- Understand that the team they build is only as strong as the weakest link;
- Inspire others by communicating high expectations and expressing important purposes in simple way;
• Provide personal attention to staff and patients and treat each individually through coaching and mentorship and,

• Provide intellectual stimulation by promoting intelligence, rationality and careful problem-solving.

In contrast, transactional leaders employ an authoritarian style of leadership and believe that rules, policies and procedures are needed to supervise staff, who would not otherwise be motivated to work. Transactional leadership is outdated and ineffective in modern dental practices, with highly-functioning professional staff. Dentists who employ a transactional leadership style are doing themselves and their staff a disservice and may not realize the potential of an autonomous, high-functioning team. Since that dental students are not selected for their leadership style, it may be prudent for the faculties of dentistry to recognize that transformational leadership style may have an advantage over transactional and would be worthy of addressing as part of the business/ethics teaching component.

4.1.2 Staff

The most critical factor of success or failure in a dental practice is the staff. Staff are professionals on the front lines who have the greatest influence on patients, patient care and patient relationships. Patients tend to form bonds or relationships with staff. It is not unusual for patients to ask staff for advice, in absentia of the dentist. Therefore, it is critically important for the dentist to carefully select staff who possess a combination of professional know how as well as empathy.

Staff are influenced by the leader of the organization (the dentist), and staff attitude can either contribute to a thriving, successful dental practice, or result in unethical behaviour that places the dentist, the practice and patients at risk. Selecting the right staff is the first step towards building a high performance team. Once the right staff has been
selected, it is the responsibility of the dentist to build a healthy environment where staff feel safe, respected, and encouraged to be the best they can be. Treating staff fairly and equitably helps to keep them engaged, and excited about being part of a long-term team, important in the care of patients within their community. Fair pay, benefits, vacation contribute to staff who are motivated to be ethical and contributing members of the team and helps to minimize risk to the practice.

Staff in a dental office is tasked with operational duties that can put the dentist and other staff members at risk. Front desk staff are responsible for correct billing procedures to insurance carriers. Fraudulent insurance claims do happen in dental practices, where leaders are unaware of what their staff are doing. Similarly, staff are often the first experience by new patients. A positive first experience results in the addition of new patients, as opposed to a negative, resulting in patients seeking an alternative dentist.

Dentists work in isolated operatories, and may not be available or aware of the actions of their staff. This makes communication between staff and dentist a critical tool in negating unethical behaviour by staff.

There exists an ethical obligation upon the dentist to treat staff with respect, equity and fairness. This translates to remunerating staff with appropriate salaries and benefits, providing regularly scheduled staff reviews with the opportunity for two-way, open communication. The dentist is also obligated to ensure the appropriate bookkeeping principles are adhered to, including the remittance of taxes, contributions to the Canada Pension Plan (CPP) and other deductions on behalf of staff.
4.1.3 Patients

Patients are a great source of stress on dentists. Patients are more informed and knowledgeable than ever before, and place great demand on dentists. Patients expect exceptional care and are quick to leave a practice in search of another if they perceive that their demands are not being respected. Patients are demanding not only of basic dental services such as restorative and periodontal care, but they are interested in improving their smiles through the use of cosmetic dentistry. Implants, whitening, orthodontics, and veneers have become the new norm in dentistry and dentists are being challenged to stay current with cosmetic procedures or risk losing a patient to another practice.

Insurance benefits are a double edged sword. Dentists are encouraged to collect payment for services rendered on the day of treatment. Patients with insurance benefits leverage their power agreeing to become a patient, only if the dentist collects directly from the insurance carrier. Numerous patients refuse to pay the co-payment to the dentist, placing stress and pressure on the dentist and staff. Dentists are expected to make reasonable efforts to collect the co-payment and failure to do so may result in suspension of their license for three months or more. The dentist must carefully weigh the risk/benefit of treating patients who refuse to make the co-payment. The only other option for the dentist is to carefully communicate the value and benefits of the practice, and to build a respectful relationship with the patient over time. If a patient refuses to make the co-payment, the dentist has an ethical and moral obligation to release the patient. This decision is a difficult one.

Patients of all generations present unique and interesting challenges and exert influence on the dentist. Aging patients have unique physical and emotional needs. Dental
practices must now ensure that their facility is handicapped accessible and safe, placing greater financial hardship on the practice. Balancing the needs, wants, and desires of aging patients takes special attention. The aging patient can afford expensive treatment options and it is the moral and ethical obligation of the dentist to balance the desire of the patient, with the treatment plan that makes best sense for the patient, considering the age, health and mental acuity of the patient. Dentists find themselves caught between the wants of an aging patient, and their privacy from concerned family members. Family members can be genuinely concerned about their parent, or they may quash reasonable treatment plans due to financial greed (loss of inheritance). Aging patients are often under the care/guidance of a power of attorney, who are responsible for the patient. Scheduling appointments for seniors that need the support of a family member or Power of Attorney can add complexity to a busy practice. In larger cities such as Toronto, elderly and disabled patients rely on the public transportation for mobility challenged patients, wheel trans, for transportation to and from their residences. Wheel Trans is operated by the City of Toronto, and is under-funded, resulting in long delays between being delivered or picked up from appointments. It’s not uncommon for an elderly or disabled patient to wait upwards of one to two hours for wheel trans transportation and this adds pressure to dental staff, tasked with the responsibility of the patient’s well-being in the waiting room. Patients need assistance with the washroom, and often need to eat if diabetes is a health concern.

The middle-aged generation exert influence on dentists in different ways. This generation is demanding, placing great importance on cosmetic dentistry, and communicate their wants/desires to the dentist. This generation believes that their insurance should cover all costs of their dental treatment, and are vocal about not wanting to paying the co-
payment. This generation also feel that the only treatment they want is the treatment covered by their insurance plan. If the dentist recommends four hygiene visits yearly, due to periodontal disease, this patient will decline the doctor’s advice and prefer to stay within the prescribed limitations of his or her dental plan. This influence places great stress on a dentist, who is trying to service patients through proper practices and feels dismissed if that advice does not fall within the perimeters of an insurance plan. Middle aged patients are generally busy, working parents and who wish to see the dentist either on weekends, or evening appointments. Dentists who try to juggle a practice and family life, find themselves working extended hours to meet the growing demands of their patients, while suffering themselves.

The younger generation (aged 21-30), are young people who have received proper dental care as children. This generation has taken dental care provided by their parents, and under insurance benefits for granted, and who now express surprise and dismay at the cost of paying for their own dental treatment. This age group have graduated from school, and may be working at two or three, part-time or junior positions within an organization that do not provide pensions or benefits to their new employees. This generation is often saddled with student debt and are just making ends meet. A cost of $200 for a hygiene appointment is often beyond a young person’s budget. This influence on dentists is stressful as dentists try to communicate the importance of budgeting for dental needs. This generation is also the fast food generation, and their teeth are now seeing evidence of the negative effects of sugar, processed foods, sugary pops and juices. Often patients in this age group avoid dental visits over a three to ten-year period and then surface with extensive dental problems at a great cost. Dentists feel pressured into reducing cost for these patients, which impact upon
practice profit. Patients in this age group are technically savvy and are using social media to search for dental caregivers. This new way of searching for dental providers adds pressure to the dentist who has relied upon standard and outdated methods of advertising such as direct mail, ad space, and referrals. Social media has stepped up the game, and dentists need to have staff who are technically savvy to handle emails, texts and manage a dentist’s social media and on-line presence.

Children (aged two to 18), are under the influence of their parents. If the parents of these patients have dental benefits, and understand the value of proper oral health care, these children tend to emulate the positive experience of their parents. In major cities such as Toronto, many immigrants cannot afford dental care, and their children’s oral health care often suffers. Children are challenging to treat because of their small mouths, their immaturity in handling stress, their fear and the fear of their parents. These factors can stress and influence the behaviour of dentists. Teenagers have unique needs in their care. Dentists often must weigh privacy issues of their patient, with disclosure of information to parents. Private information is revealed through a medical questionnaire and discussions between patient and caregiver. Such conversations include drug use, pregnancy, and other high risk behaviour by teenagers. Should a dentist disclose a teen’s pregnancy or drug use to parents? These are some of the sensitive issues that dentists are influenced by daily.

4.1.4 Lifestyle

Balancing a healthy lifestyle is an additional challenge of dentists. The role of a dentist is really two-fold, caregiving of patients, and operating a business. These two roles take up many hours in a day, and all the while the dentist must also juggle his own family obligations, and possibly caring for aged parents. Dentists in small to medium-sized
practices face pressures to stay healthy in order to maintain their practice. A practice that closes for periods of time due to ill health of the dentist risks losing its patient base very quickly. Dentists work long hours, and weigh the opportunity cost of going on vacation with the loss of revenue and the impact upon staff. Continuing education while juggling the needs of a busy practice adds to the number of hours a dentist works. There is evidence that dentists feel a greater than average need to demonstrate their successful lifestyle through the purchase of luxury items including luxury cars and houses, and exciting trips with children benefitting from private schools and participating in expensive curricular activities. Dentists feel that private memberships in golf and other exclusive clubs are expected of them.

4.2 External Influences

There are numerous external influences that challenge dentists in making ethical decisions within their practice. The following are some of the most influential, external influences:

4.2.1 The Economy

Dentistry is sensitive to the economic theories of supply and demand. R.K. House and Associates Ltd., publish a yearly economic report based on a survey of dentists from across Canada and the 2012 economic report paints a grim picture of how dentistry is rubbing shoulders with other nations, standing on the financial edge of the cliff.

Dentistry is sensitive to the fate of the average family (House, p. 2). In most practices, the majority of patients have some type of dental insurance or health spending account. There exists a misconception that most dentistry is funded by third party insurers and this is incorrect (House, p. 4). House goes on to say that, “Only fifty-five percent of
dentistry is funded through insurance and forty-five percent is an out-of-pocket cost to the family. The forty-five percent (out-of-pocket costs), are made up of two components, co-pay for those who have dental insurance and payment from those without insurance”. What is frightening is the statistic that House forecasts, which is that over the next decade, these percentages will reverse and fifty-five percent will be out-of-pocket and forty-five percent will be funded by insurance. The result is that patients will be more price sensitive.

### 4.2.2 Competition

Competition in Toronto has increased with dentists being on every street corner. This hyper-competitive market has placed greater influences on dentists to step up their game. Because the Ontario fee guide, price is not a differentiator between dental practices and therefore skill set, customer service, hours of operation and other attributes are the differentiators in dentistry. Foreign trained dentists have also exacerbated the number of dentists who practice in Toronto. Dentist are having to consider new ways of attracting new patients, and training staff on customer service to retain patients. Competition is also affecting re-sale value of dental practices. As more baby boomer dentists approach retirement age, there may be an excess of dental practices on the market, driving down the resale value. Competition extends beyond the traditional, practitioner. Corporate dental practices such as Altima Dental are purchasing practices and turning them into franchise operations. Altima’s purchasing power on a large scale helps to reduce their operating costs, and make them more profitable. Statistics tell us that there are greater numbers of women dentists graduating, and women prefer to work in a city owned dental practice or be an associate, rather than starting their own practice. In this way, women dentists can balance a
healthier lifestyle while rearing children, looking after aged parents, and have a better quality of life.

Since there are greater number of dentists graduating each year, in a diversified multicultural mix, there are few dentists who want to move into satellite communities to practice. Multicultural dentists prefer to remain in larger cities, closer to their families and friends. This uneven balance is another influence contributing to the hyper-competitive market.

**4.2.3 Technology**

Technology in a dental practice is an external influence that causes challenges for dentists and staff. There is no doubt that in order to remain competitive, dentists must continue to upgrade their skills and so must their staff. Dentists who fail to upgrade their technology and skill sets are setting themselves up for failure. Outdated practices will have a harder time selling, and patients, who value the most current technology will seek out more modern dentists. A practice with a modern dentist, must have staff who are equally committed to change, learning and higher education. Staff are often resistant to change, and are intimidated by adopting new practices that relate to learning and embracing new technology. Staff who are stressed and reluctant to embrace new technology are a source of stress for dentists. Staff who require greater support in learning new technology are costly to a dental practice and stressed out staff translate to stressed patients.

With new technology, comes a hefty price tag that can be onerous on a practice. Technology is expensive and so are the contracts for the maintenance of the technology. Digital radiographs, three dimensional panorex imaging and state of the art sterilization equipment add pressure to dentists to remain current, or even exceed provincial guidelines.
Technology changes so quickly and the life span of expensive equipment is not as long as dentists would like. These financial hardship can be onerous on practitioners.

Technology and social media is changing so quickly and dentists are stressed with keeping up to the new and innovative ways to communicate with their patients, especially their younger patients. Many younger patients no longer have home phones and with their multiple contractual positions, work phone numbers are quickly out-of-date. Patients are relying more and more on their mobile devices to search for, and maintain contact with their caregivers. This means that the dentist must have the right staff who are either of a younger generation, or older staff who are willing to embrace new ways of doing business.

Confirming patient appointments is mostly done by email and patients want to confirm by text messaging. Communication skill exceed beyond the normal voice to voice and staff must be properly trained in order to avoid misunderstandings or mixed messages via the written word.

As we can see from the literature review, the internal and external influences are numerous and demanding. Internal and external influences including finances, practice management, continuing education regulatory oversight, competition in addition to the delivery of high-quality dental care place rigorous demands on dental professionals, and may, in fact, be contributing to the rise in professional misconduct. Journalistic reporting by CBC’s Marketplace highlight the inconsistencies in treatment planning by various dental practices across Canada, and contributes to the public’s confusion and mistrust of dental professionals. Economic pressures of a recovering economy, the high cost of setting up a private practice, and the fickle needs and wants of patients create stressors for dental practices. The next section, professional ethics, examines the complexity of ethical
decision-making and the hallmarks of professional conduct and the importance of the relationship between the public and professionals.
5.0 Professional Ethics

Dentists have always faced ethical challenges within their practice, but more recently, the frequency and complexity of ethical challenges have increased more than ever before (Ozar, p. 104).

Professional ethics has received a greater audience than ever before, and particularly in the latter half of the 1980’s and into the 21st century. During these periods of time a number of professionals and professions demonstrated outrageous greed and deception resulting in a loss of trust and deep cynicism by society.

There exist numerous definitions of ethics however one researcher, Phillip Lewis, took the four most mentioned concepts in existing definitions and offers the following definition: “Business ethics are rules, standards, codes or principles which provide guidelines for morally right behaviour and truthfulness in specific situations” (Lewis, p. 381). Robert Sexty defines the “ethics of business” as the “rules, standards, codes, or principles that provide guidance for morally appropriate behaviour in managerial decision making relating to the operation of the corporation and business relationship with society” (Sexty, p. 93). As we can see, the definition of ethics is broad and important and ethics is involved in all aspects of human interaction including religion, government, policing, law, medicine, non-government organizations (NGO’s), education, private enterprise, and in all human interaction. With such a broad definition, it is easy to see why there exists such widespread misunderstanding and misconceptions about ethics and specifically, the ethics of business.
Before we examine professional ethics in dentistry, it is important to establish the definition of a profession and understand why dentists claim to be professional members of the dental profession.

5.1 “Professional” Defined

The Oxford Advanced, American Dictionary defines profession as, “a type of job that needs special training or skill, especially one that needs a high level of education” (Anomaly, 2014). Oxford's definition is rather broad and may be outdated. The problem is that there are many organizations that label themselves ‘professions’ and that do not require a high level of education. As an example, in Ontario, dental hygienists are classified as ‘professionals’ within a self-regulated organization. The profession of hygienists view themselves as having special training and skill, however their education consists of no more than two years of college level training. How then do we differentiate between dental hygienists and say mechanics or carpenters or other type of individual who possesses a special skill with college level education? Why are chair-side assistants not considered professionals, particularly since a level II chair-side assistant requires two years of college training?

At present, professionalism is deemed to have special social, moral and political status (Welie, Vol. 70, No. 8, p. 529). Professions suggest high levels of expertise, extensive higher education, skillfulness, virtuousness and trustworthiness. But what are the virtues that separate real professionals such as doctors, dentists, lawyers, accountants, and chiropractors from the mainstream professionals such as dental hygienists? Historically, the term, ‘profession’ means a “public avowal” which means a statement asserting the existence or the truth of something. It is a generally acceptable principle that professionals profess to
protect and foster the benefit of the public. In other words, the profession’s responsibility is a commitment to protect and foster the benefit of the public (Welie, Vol. 70, No. 8, p. 530). In other words status is granted to a profession by society. This translates to the fact that the profession promises altruism, rather than egotism to the public, and enters into a mutual agreement with the community, referred to as a social contract (Welie, Vol. 70, No. 8, p. 530). An occupation cannot arbitrarily claim professional status. Status is granted by the public only if the service is vitally important to the community. In other words, professions fulfill a void that arises from existential vulnerability of the community. Society tends to equate professionals with doctors, dentists, accountants, lawyers and chiropractors who fulfill a special role to individuals who are experiencing a vulnerability. It is also important to note that the profession voluntarily enters into an agreement to care for fellow human beings who are vulnerable and in need (Welie, Vol. 70, No. 8, p. 532). In the next section we explore the hallmarks of professionalism, as set out by Welie in his journal article “Is Dentistry a Profession?” part two, (Welie, Vol. 70, No. 9) and test whether those assumptions are valid for dental professionals in Ontario. Finally, we will scrutinize where the deficiencies lie, and which may be causing negative influences within this profession.

5.2 Hallmarks of Professionalism

Welie, in his journal article, Is dentistry a profession? part two, (Welie, Vol. 70, No. 9) explores a series of specific professional duties required in order that members of the profession may serve the public good. This paper is adopting Welie’s list of professional duties, and will address each one individually as it pertains to professional dentistry in Ontario.
As previously discussed, professionalism is defined as:

...a collection of expert service providers who have jointly and publicly committed to always give priority to the existential needs and interests of the public they serve above their own and who in turn are trusted by the public to do so (Welie, Vol. 70, No.9, p. 599).

A profession has both collective and joint responsibility to serving others and to the profession, as a whole. The public good is of paramount interest to a profession, because the social contract it makes with society is believed to be a privilege. Therefore it is the responsibility of professionals to address the needs of all people, and not just the clients or patients on an individual basis. As an example, teaching professionals are committed to all children, no matter what their abilities or disabilities or special needs may exist. Legal counsel are available to society to provide legal advice, no matter whether the client is a victim or defendant. It is this professional responsibility in serving others, in a trusting relationship, that separates professions from non-professions.

As Welie discusses in his second of three articles, there are three categories of professional responsibilities that can be distinguished and they are discussed, in relation to Ontario dental professionals next.

**5.2.1 Category One -- Who Serves?**

**Competence of Providers**

Professions must ensure that their members are competent to provide services for which they are competent to provide. This is important as the social contract requires that professionals be competent to benefit all in need, not just small sub-groups.

There is no question that a reasonably minded individual would concur that dentists in Ontario are highly educated, highly skilled and highly competent professionals, trained in
reputable Canadian universities. The majority of dental graduates have already completed at least one undergraduate degree, generally in the sciences, and by the time they graduate as dentists, many of them have been in university for a minimum of seven years. Enrollment into any professional programme is competitive, and rigorous with the number of successful candidates capped.

It is imperative for universities to remain vigilant both in the selection process of students, and in the delivery of a quality curriculum to ensure that students receive the most current dental education possible. Welie believes that dental graduates are at greater risk of becoming incompetent sooner with the ever-greater pace with which scientific knowledge and techniques become outdated (Welie, Vol.70, No. 10, p. 676). Welie’s concern is not indigenous to the dental profession and, in fact, the RCDSO has taken appropriate measures to ensure continuing education for its members.

**Peer Review**

Since clients or patients do not possess the knowledge necessary to assess the professional advice for which it seeks, it is necessary that a profession submit themselves willingly to peer review. The intention of peer review is to continually bring best practices to the profession through learning from the successes and failures of peers. On a less pleasant topic, peer review can also be used to eradicate ‘bad apple’ peers from the profession, and/or bring unacceptable behaviour to the attention of the regulatory board.

The majority of dentists in Ontario work autonomously in small to medium-sized practices. As a result, dentists are isolated within their work structure, unable to consult with other practitioners on case management or treatment plans. As a result, peer review
and stakeholder relationships between co-professionals and specialists is an important mechanism for both professionals and the profession at large.

**Internal Discipline**

Internal discipline is a proactive mechanism to protect society from being harmed, and to protect the profession, in order that it may continue the privilege of social contract that society has bestowed upon it. The intent of internal discipline is not to punish rogue professionals, but rather to create a transparent process whereby members of the public have readily access to the complaint process and outcomes.

The RCDSO is the Ontario oversight for dental professionals and works closely with members of the public to ensure that the complaints and discipline process is transparent between the profession and society.

**Non-Competition**

The spirit of non-competition is based on the credence that professionals are trained to with equal quality of skills and abilities, with the added adjunct of willfully being open to peer review. Thus, any differences or nuances that exist from one professional to the next ought not to be exploited by peers for self-serving interests, and endangering the public's trust in the profession.

Although non-competition is a hallmark of professionalism it is easy to see how the lines have become blurred in this regard. Dr. Riley points out that “competition is what landed me and my classmates into dental school, and we must now move beyond competition and help each other as much as possible” (Riley, p. 5). Toronto has become a hyper-competitive market for dentists over the last decade, with more foreign trained dentists preferring to operate a practice in a multi-cultural city rather than in a rural area.
This overcrowding has resulted in dental practices becoming more competitive with each other, although many tread a fine line. Social media has taken the competitive landscape to a higher and more sophisticated level. Dental practices lure new patients with campaigns of free whitening, seniors discounts and a promise of the ‘perfect smile’. One highly contentious campaign boasts of a lottery for a dental cosmetic makeover. There are dental practices that attempt to differentiate themselves by including cosmetic botox therapy, and creating a spa-type environment with warm fireplaces, luxurious leather furniture, exotic aquariums, and with the subliminal promise of delivering dentistry, ‘pain free’.

In Ontario dentists are guided by a provincial fee guide which outlines procedures and costs for services. The fee guide is updated annually, and dentists are encouraged to adhere to the fee guide as closely as possible, or else clearly communicate with patients that the fees being charged are higher than the guide. The fee guide is a safety mechanism to ensure that treatment costs do not become a competitive advantage. Having said that, consumers have become price sensitive and more patients are demanding competitive pricing discounts and payment plan options, and are willing to shop around for their wants.

5.2.2 Category Two -- What Kind of Service is Provided?

Services That Are Beneficial by Objective Standards

Professions establish standards of care or service which are accepted by society as being reasonable. The standards must be objective both by the professionals, and by society. Naturally there are nuances between each professional which may be attributable to the patient relationship and individual communication styles. Professionals who actively listen to the needs of their patients are in a much better position to offer professional advice that
is in the best interests of their patient. Every dentist should be competent in delivery advice on the prevention of caries and treatment of caries, in the same manner that every legal counsel should be competent in producing a last will and testament for a client, no matter what area of law the professional ultimately practices in.

Although there exists reasonable standards of practice within dentistry, there also exists a wide scope of artistic freedom. For instance, dentists are able to perform standard treatments including restorative, post and crowns, root canals, extractions and periodontal care. Additionally there are dentists who enjoy to practice a wider scope of procedures including orthodontics, surgeries, prosthetics and sedation. Some dentists enjoy working with children, and others prefer referring younger patients to colleagues who specialize in dental treatment of children. No matter what the standard of dental work taught within the dental academy, a dentist will find, through experience and practice, to have special talents working in some areas, and not so much in others. Some dentists develop a niche practice for cosmetic dentistry and Welie believes that this individual freedom is an Achilles heel for the profession. Welie believes that the public has come to believe it is being ‘ripped off’ by dentists” (Welie, Vol. 70, No. 10, p. 677).

**Standardization of Treatment**

Professionals who have attained the same level of knowledge, skill and experience may approach problems differently than their peers which is normal as dentistry is scientific and artistic. Some dentist may choose to treat the area of an extraction with a partial denture, a bridge, or with an implant. The cost of these treatments vary greatly and unfortunately it is this ambiguity of treatment plans that the public may view as violation of
the social contract. Thus, professions are obligated to self-assess on service modalities to ensure quality and continuity of their effectiveness and efficiency.

5.2.3 Category Three, Who Is Served?

Guarding Against Conflicts of Interest

Guarding against conflicts of interest is an important tenet which professionals undertake to uphold. That is to say, one cannot serve two masters (oneself and society).

There are numerous types of conflicts of interest, one of them being personal interests prioritized over professional. For instance, does a dentist close their practice for a week to go on vacation, leaving patients without care until the following week? The response is yes, dentists need to balance work and lifestyle, but it is incumbent upon practitioners to provide either a locum within their practice, or contact information for emergency care to ensure continuity of care for patients.

The fee-for-service model is a highly scrutinized, conflict of interest, predicament. How do professionals, engaged in a social contract with society, deliver on their promise of prioritizing service and care for patients over fees for service, and while being viewed by society as having received a fair service for a fair price? The critical issue here is that the vulnerable public must trust the professional to provide treatment at a fair and reasonable rate, and without taking advantage of the patient.

Preventing Discrimination

Professionals are not able to discriminate by refusing patients based upon sex, race, religion, health status, or any other platform. Professionals are forbidden from entering into
romantic relationships with clients/patients and should not accept gifts under any circumstances.

Fostering Access

Professions undertake to provide accessibility to services so as to ensure that society's vulnerable have equal access to said services. For instance, medical practitioners must be available and accessible to society, within a reasonable geographical distance, so as not to provide undue hardship to society. This may not always be possible within the most remote regions of Canada, although there is an expectation that air ambulance and other services may be involved to ensure that medical attention is accessible to those in need.

5.3 Professional Ethics in Dentistry

Most individuals inside and outside of professions believe that professions and professionals have special obligations, and consider this to be a central tenet of their being professions and professionals (Ozar, p. 283). It may be prudent to begin with a definition of the word, ‘obligation’ and its context in this paper. For the purposes of this paper, Ozar's definition of ‘obligation’ is adopted:

1. Someone ought to act or refrain from acting in some way;

2. There are defensible reasons to support the claim that he/she or they ought to act or refrain in that way;

3. These reasons make acting or refraining relatively important in comparison with other possible actions in the situation (Ozar, p.588). Dentistry has long prided itself on
being a profession and dentists self-identify as professionals. Some common characteristics of professions and professionals include:

- Dentists possess a distinctive expertise that consists of both theoretical knowledge and skills for applying it in practice;

- Dentists’ expertise is a source of important benefits for those who seek their assistance and,

- Because of their expertise, dentists are accorded, both individually and collectively, extensive autonomy in matters pertaining to it (Ozar, p. 283).

It may be useful to examine two diametrically opposed views of dentistry, that is, the normative view that dentists and dentistry do hold obligations to themselves and society because they are professions. The commercial view denies this and sees dentistry as no different in principle from any other activity in the marketplace between a producer of a product and/or service and a purchaser (Ozar, p.294).

The commercial view considers dentistry to be no different in principle than anyone who produces and sells goods and services for a fair market price. The seller and the purchaser enter into an agreement where the seller is trying to maximize his position and the buyer is trying to gain the greatest value or gain for the least price. In this situation, the seller and the purchaser are self-interested participants in the marketplace and their positions are as competitors. In this situation, the seller’s (dentist) criterion on what services to provide to the purchaser (patient), may not necessarily be in the best interests of the patient, or serve in his/her best well-being, but rather will base services based on what the patient is willing or able to pay. In this scenario, the relationship is a push/pull where each is bargaining for the position that provides them with the greatest benefit. In the commercial scenario, the patients’ needs are secondarily only to the dentists judgment on which services to offer a patient, based on finances and the long-term best interests of the
patient are considered secondarily. In the commercial view, the dental professions obligations are the “product of explicit contractual arrangements with individual patients or other parties e.g., insurance companies” (Ozar p. 313). It is easy to find examples of conduct conforming to the commercial scenario by dentists and other individuals and groups within society. For the purposes of this paper, the commercial view of dentistry and the profession of healthcare overall, is refuted, both by the profession, as well as society, at large. Instead, society accepts the normative view of dentistry and healthcare, where dentists and healthcare providers have joined a group of like-minded individuals who both individually and collectively made commitments to their community and society that include important obligations (Ozar, p. 338). The basis of these obligations to relationships is triangular in nature, between the professional, the professional association and the community at large (Ozar, p.343).

One of the most characteristic features of a profession is “expertise in a matter of great importance to the community at large” (Ozar, p. 343). The kind of expertise we associate with a profession is exclusive in two ways: exclusivity and knowledge and experience. Firstly, a profession is exclusive in the sense that within the division of labour that enables a society to function efficiently, only certain persons will perform sufficiently and efficiently to perform this set of activities. Secondly, dental care involves education, knowledge and experience sufficiently esoteric that extensive education is required prerequisite to providing such care (Ozar, p. 348). This knowledge and experience is only effectively gained under the direction and guidance of someone who is already an expert in the said field. Society at large relies on such experts, including lawyers, doctors, and accountants and places value and trust in these professionals. In doing so, society places
great power and trust into the hands of these professionals. In the case of dentistry, society has granted dentists a wide berth of decision-making power and entrusts onto them the task of supervising how the profession will use this power. In dentistry, there is little to no supervision and there exists a great deal of trust. Why does society trust dental professionals? What assurance does society have that dentists will not abuse the power invested in them? The answer is simple: professional institution as understood in the normative view (Ozar, p. 359). This means that each profession and each individual professional takes an oath to use that power according to norms mutually acceptable to society and the expert group. In this way, the professionals are assuring society to use their power in such a way to secure the well-being of the community they serve, over and above their own personal needs. It is widely accepted that dentists do have obligations to their patients, over and above the marketplace obligations of not coercing, cheating or defrauding. A dentist has the obligation of meeting the needs of a patient. The phrase, ‘caveat emptor’ is not considered appropriate between a patient and a dentist. The normative view emphasizes the importance of the relationship between dentist and patient and competition is not an appropriate position by either dentist or patient. The dentist has obligations to the patient to act for his or her well-being in relation to oral health and function rather than maximizing the dentist’s self-interests. It is the duty of the dentist to work collaboratively with the patient, rather than in competing self-interests. Professional organizations share some commonalities with trade organizations however an important role of a professional is to articulate, interpret and supervise dentists’ conduct in relation to the obligations they have undertaken (Ozar, p. 380). Finally, and importantly within dental schools, dental expertise is not handed over to students as if it were a simple commodity.
The relationship between dental faculty and students is determined by the relationship between the dental professional and the larger community.

Now that we have determined that dentistry is normative rather than commercial, there is another important thought to consider: dentists cannot be involved in the delivery of oral health care in the absence of running a business. If the business fails economically, the practice of dentistry and the good of patients fail (Ozar, p. 478).

To an unprecedented degree, dentists today are facing difficult ethical questions with pervasive consequences. In recent years, the complexity of ethical issues for dentists has increased and ethical decisions surface with greater frequency. Dental professionals need to increase the level of attention and reflection to these challenges. Many ethical questions have legal ramifications but questions of ethics are different than questions of law because ethical questions have a different basis and they approach matters in a different way. In addition, ethical questions often concern matters about which the law has no opinion. Ethics is more fundamental than law. A clear-thinking person will ask the ethical question first, and the legal question after. Peoples ethical views and convictions come from many sources. People learn various aspects of their ethical views from their family, important people within their upbringing, their environment, culture, religion and personal reflections (Ozar, p. 200).

Most of the actions we perform in life are not thoughtful and careful deliberations of what is right or wrong, but are more from habit. It is likely that ninety-five percent of actions are the product of habits about acting, perceiving, valuing and so forth.

Now let us turn our minds to ethics and dentistry or should we coin the phrase, the “ethics of dental business?”: isn’t that an oxymoron? How do we separate the seeds of moral
responsibility of treating patients, from the fiscal responsibilities of running a profitable business?

The business and moral responsibility of healthcare has not gone unscathed in recent years and it may be argued that the most recent scandals involving health care providers has left society reeling from distrust as much, if not more, than the financial scams of capitalism.

Dr. Mazza, founder and chief executive officer (CEO), of Ontario’s provincial air ambulance service, (herein referred to as ORNGE, due to the orange colour of the helicopters), founded the emergency medical organization in 2005 until late in 2011 when he, and the oversight board, were removed from the organization on accusations of gross corruption, fraud and deceit. It is alleged that Mazza received $4.6M in two years and that emergency services were withheld from needy accident victims. Health Minister, Deb Matthews, says the “former ORNGE regime avoided transparency, and demonstrated a true lack of regard for both patients and taxpayers” (Donovan). Unfortunately, cases such as this are neither unique, nor rare.

Earlier in 2013 a rogue dentist, Dr. Wayne Harrington, an oral surgeon with a practice in Tulsa, Oklahoma was investigated by the state dental board, and the state bureau of narcotics and the federal drug enforcement agency as one of his patients tested for Hepatitis C and the human immunodeficiency virus (HIV) without known risk factors other than receiving dental treatment. It is alleged that unlicensed dental assistants were administering medication in the absence of policies and procedures for logging controlled substance drugs. When interviewed during the inspection, Dr. Harrington shirked his responsibilities for sterilization and drug procedures in his practice, saying that staff were
“responsible for that” (Lupkin). While seven thousand patients may have been exposed, Dr. Joseph Perz, an epidemiologist with the U.S. centers for disease control and prevention said, it’s ‘extremely rare’ to see dental transmission of HIV and hepatitis B or C. Eight thousand patients were contacted and tested, and fortunately none were contaminated.

In both these extreme examples of gross negligence, and immoral behaviour, the loss of public trust cannot be understated. The behaviour of staff under the control of both Drs. Mazza and Harrington are also worthy of examination.

5.4 RCDSO’s Code of Ethics Analysis

An effective ethical code is an important tool to be communicated in organizations and assimilated into the culture. Ethical codes are designed for internal and external audiences and which state the major philosophical values embraced by an organization (Stevens, p. 43). Effective codes define the responsibilities of the organization to stakeholders and outline expected conduct for employees and set the ethical parameters of the organization by articulating what is acceptable or unacceptable (Stevens, p. 43).

Given society’s concern with the ethics of business, it is understandable that organizations have taken steps to “institutionalize ethics” (Sexty, p. 116). In other words, organizations are cognizant of the importance of ethics and have begun to implement policies and programmes to increase the awareness and importance of ethics within the organization. These programmes may include a statement of values, codes of conduct and ethics, and core values. The statement of values is a description of the beliefs, principles and basic assumptions about what is desirable or worth striving for in the organization (Sexty, p. 116). Codes of conduct explicitly states what appropriate behaviour is by identifying what is acceptable and unacceptable.
The code of ethics is a statement of principles or values that guide behaviour by describing the general value system within which a corporation attempts to operate in a given environment. Some codes of ethics are created as artefacts to simply make the organization appear more ethical to stakeholders (Stevens, p. 43): however, codes that are thoughtfully written, communicated and shared, have the ability to transform organizational cultures. In recent times, codes have emerged as one of the major corporate social responsibility instruments by which organizations align their actions and values with those of their customers, enacting a concept known as ethical consumerism (Stevens, p. 43).

This next section is an evaluation of the code of ethics, principles and core values governing dentists, and as set out by the RCDSO. The society for human resource management states that, “a code of ethics raises ethical expectations, legitimizes ethical positions, encourages ethical decision-making and prevents misconduct while providing for enforcement” (Sharrief, p. 1). The code of ethics by the RCDSO will be analyzed using the following six metrics: tone, clarity and organization, vision statement, personalization by the organization, accountability and reporting protocols, intended audience. A competing values framework will be used to identify its strengths, weaknesses, and competing interests.

5.4.1 Tone

The tone of the dental code of ethics is professional and thoughtful without being self-righteous. Simple phrases are used to convey the importance of trust within society in exchange for the extended ‘privilege’ and ‘opportunities’ afforded to the profession-led self-regulation. The additional phrase, ‘commitment of individual dentists to high standards of ethical conduct’ imply a win/win scenario for both the profession and society.
Following a short introduction of the code, this paper will examine a list of 15 principles which emphasize the paramount responsibility of dental professionals to patients and discuss core values. The short description of each value emphasizes the professional relationship between the dental professional and the patient.

Overall, the tone of the code is professional conduct towards patients, staff and other dental professionals, written in an easy-to-understand style using basic language.

5.4.2 Clarity and Organization

The code of ethics is concisely written in simple language, making it easily understood by most. The flow of the document is broken down in three main sections, and varying shades of gray are used to separate and highlight the different sections. Bold headings and numerical bullet points provides readers with an aesthetically pleasing document. Simple phrases such as ‘maintain a safe and healthy office environment’ and ‘protect the confidentiality of the personal and health information of patients’ provide readers with important information in an easy-to-read format. Phrases such as ‘practice management, volitional decision-making’ and ‘misconduct’ are absent making this document easy to navigate and read.

5.4.3 Personalization

A code of ethics document should be memorable and not simply a cookie cutter document that could justifiably be parachuted into any number of professional organizations. A memorable introduction should provide direction about how the organization should use the code of ethics and a commitment that the professional leadership intends to apply to the ethics rules (Sharrief, p. 2). The RCDSO’s code of ethics does not have an interesting nor memorable title, and lacks a meaningful letter from the
RCDSO to its professional membership. The absence of these two important markers results in a less than memorable document.
### 5.4.4 Accountability and Reporting Protocols

A code of ethics document should have clear guidance within the sections regarding its necessity, to whom the code will apply, how the organization will measure behaviour the code governs as well as accountability and reporting protocols for infractions against the codes (Sharrieff, p. 2). The RCDSO code of ethics defines who the code will apply to but remains silent on how the college will measure behaviour the code governs. There is also an absence of reporting and accountability protocols for infractions against the code.

### 5.4.5 Intended Audience

A code of ethics document should concisely articulate who the code of ethics it is intended for, and the RCDSO document accomplishes this. This code of conduct guides its members into make decisions that are ethically correct for its patients and staff. This code of conduct does not speak to other professionals who may work within a dental office, such as administrative staff, hygienists or chair-side assistants. Principle number two speaks to a dentist accepting responsibility for the care provided by authorized dental personnel.

### 5.4.6 Competing Values Framework

A competing values framework is used to highlight the rhetorical strengths and weaknesses of the RCDSO. There are four quadrants, each with competing values with the notion that the code has strengths and/or weaknesses in multiple areas. The four quadrants (transformational, instructional, informational, and relational), represent the rhetorical dimensions of managerial communication which are opposite or competing values (Stevens, p 48).
The competing values framework below, is the same one used by Stevens and Buechler in their analysis of the Lehman Brothers code of ethics. Stevens and Buechler used two different methodologies—the competing values framework (Quinn, Hildebrandt, Rogers, & Thompson, 1991), and Erwin’s eight-point benchmark analysis. The RCDSO’s competing values framework is not as sophisticated as Stevens and Buechler’s analysis, however it provides useful information for the purpose of this analysis.

For the purposes of our analysis, the writer of this paper and an independent, senior dentist assigned a grade to each category ranging from one to six (one being the lowest or weakest, and six being the highest or strongest). The code was rated independently and the results are as follows:

**Table 2.0 -- Competing Values Framework**

<table>
<thead>
<tr>
<th>No.</th>
<th>Values</th>
<th>Rater A</th>
<th>Rater B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aware, Discerning, Perceptive</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Emphatic, Forceful, Powerful</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Insightful, Mind Stretching, Visionary</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Innovative, Creative, Original</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Interesting, Stimulating, Engaging</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Conclusive, Decisive, Action Oriented</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Practical, Realistic, Informative</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Focused, Logical, Organized</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Rigorous, Precise, Controlled</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>Technically Correct, Accurate</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Credible, Believable, Plausible</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12</td>
<td>Open, Candid, Honest</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

The ratings are mapped onto a radar chart, where competing interests are exposed. Both independent raters had similar views in each of the categories. Rater A (dark line) scored a higher ratings within the relational trust, informational facts, and the instructional action, mid ratings in the instructional and the lowest ratings in transformational change. Rater B scored similarly in all categories, albeit with a higher than average score than rater A.
The RCDSO’s code received higher ratings in the relational trust, informational facts and mid ratings in instructional. These results indicate that the RCDSO code is more technically accurate than innovative, weighs practicality over perceptiveness and emphasizes control over vision. These results are not surprising, for a self-regulated profession that would rather see their members adhere to organizational policy than allow for independent innovation in constructive ways. The RCDSO is emphasizing the importance of adhering to the policies and procedures or risk losing self-regulation.

Diagram 1.0 -- Code of Ethics Rating - RCDSO

The RCDSO’s code of conduct meets a high percentage of the values upon which it was analyzed and there are some glaring holes that should be addressed, given the complexity and hyper-competitive market of dentistry. The code is mute on important topics such as the environment, CSR, and stakeholder management, including important lab technicians, pharmaceutical suppliers and other medical practitioners. In addition, the
general language of the code is outdated. The core value ‘compassion’ is described as “acting with sympathy and kindness” and should be updated to, “acting with empathy and kindness”. Emotional intelligence is another important descriptor to be considered in its relationship with leadership, another key concept absent from the code. Other important elements absent from the code are environmental protection, technological advances and community participation. In general, the code lacks in unique or modern day features, representative of the fast-paced and changing world we live in. Most of the sentences are command phrases such as, “never overstate or embellish qualifications, recognize limitations,” and “accept responsibility.” In providing strong directives, the code sacrifices the transformational examples.

5.5 Professional Ethics -- Innate or Learned?

Ethical behaviour and conduct is important for professionals, but what drives ethical decision-making and moral behaviour? Is ethical behaviour innate? Can it be taught? Is ethical decision-making a choice, a habit, or is it happenstance? Is there value in including ethics in a professional curriculum or is it too late to influence students once admitted into a professional school? These are some of the challenging and controversial questions to be covered in this section.

Dr. Crystal Riley, DDS, authored a personal essay in 2008 while a student at the Schulich School of Medicine and Dentistry at the University of Western, Ontario, and was selected as the winner of the Ozar-Hasegawa prize awarded for student ethics essays by the American Society for Dental Ethics. Dr. Riley describes an experience she had, early on in her first year at the faculty of dentistry. While she was waiting to enter an exam room, one of her fellow colleagues asked her to share with him the type of anatomical structure at her
workstation. When Crystal refused, she describes this young student’s shock and further efforts to coerce Crystal into co-operating. Crystal describes her shock and disconcert that a student, ‘aspiring to receive the title of professional’ would have behaved in such an unethical manner (Riley, p. 3).

Each year in Canada, there are three national dental conventions: the Pacific Dental conference, the ODA annual spring meeting and the Journees Dentaires Internationales du Quebec, along with the Academy of Dentistry’s Winter Clinic. Each year, dental professions are surveyed to better understand what the dental professional feels its members need to know. More than four hundred presentations were delivered over the course of these four conferences and a review of the respective programmes reveals something of where dentistry may be heading. The following are membership survey results, of what is considered important and what is not, as reported by the ODA:

- Restorative dentistry, forty-two percent;
- Preventative dentistry, twenty percent;
- Communications and personal development, twelve percent;
- Caries, geriatrics, oral diagnosis and treatment planning, 1/2 percent and,
- Ethics, 1/2 percent.

Dr. Feldman, editor of Ontario Dentist, and a 1971 graduate of the Faculty of Dentistry, University of Toronto, expresses concern that the combined subjects of caries, geriatrics, oral diagnosis treatment planning and ethics occupies a dismal 1/2 percent of the entire curriculum. Feldman highlights the lack of interest in these subjects, given that they are the fundamentals of a dental practice. Feldman also expresses his concern for the
coming crisis in geriatric health care, and the importance of seniors’ oral health care. And notably, Dr. Feldman addresses his concern for the apparent lack of interest in ethics:

> Ethics, in my view, forms the entire basis of professional practice. I commend those organizations that added lectures on ethics to their programs. Continuing education boosts our technical skills to a high level and helps us to understand the way, when, where and how of professional dental treatment. Ethics is more important, because it helps us understand the why (Feldman, p.10).

Dr. Shelli Karp, an instructor at the faculty of dentistry, University of Toronto, voices the concern that teaching ethics and professionalism to first year dental students is challenging but believes that this is the best way to positively influence students in their ethical conduct as dentists (Karp). Karp believes that the transition from undergraduate into the faculty of dentistry can be the most influential timeframe to share the moral views of the students. Karp goes on to say that the ‘white coat ceremony’ is a valuable experience in the lives of the students, and that many have “framed their oath of commitment” (Dispatch, June 2008, p. 12-13) as a reminder of their responsibilities as dental students, and a symbol of what the profession expects of them. In 2005, the dental faculties in Ontario instituted a formal oath of commitment for first year dental students and is now an annual part of the official program. The oath is recited, in unison, with the RCDSO Registrar, Irwin Fefergrad and the ceremony symbolizing the transition from student to a trusted health-care professional. Fefergrad explains the important link between the oath of commitment (refer appendix A) and ethical commitment by the students:

> The entire ceremony emphasizes the importance of professionalism and ethics. At the very outset of their careers, we’re saying to these students that they will be equipped with the best dental education in the world, and with that comes a responsibility for delivering excellent oral health care and using the new skill set in an ethical way (Dispatch, June 2008, p. 12-13).
The white coat ceremony is symbolically important as it represents a pact between the students to uphold professional conduct between each other as well as in their commitment to society. While the ceremony may not be effective in and of itself, it certainly lends itself to being an important adjunct in the teachings of professional conduct to first year students. The fact that some of the graduate students print and frame the code is a positive indicator that the ceremony is meaningful as a student, as well as a practitioner.

At this point in our discussion, we may conclude that dentistry is a profession that falls under the bailiwick of the normative view, rather than the commercial view. We may also conclude that factors influencing ethical behaviour include, selecting the right candidates for the Faculty of Dentistry programme; continuing education of ethics to first year students; adhering to an effective code of ethics and employing symbols and ceremonies to reiterate the importance of ethical behaviour. Despite adopting these important protocols, it is important to note that there will always be bad apples in any organization, and who's unethical behaviour harm the sacred relationship between society and the profession. Next, we discuss stakeholder theory and examine how the organizational management of small to medium-sized dental practices impacts the ethics and values in its management.
6.0 Stakeholder Theory

Stakeholder theory is a theory of organizational management and business ethics that addresses morals and values in the management of the organization. Community dental practices are small organizations, sensitive to and highly affected by the relationship quality of its internal and external stakeholders. With due diligence to the strategic management of these stakeholders, dental practices can create a competitive advantage in the marketplace, reduce environmental influences contributing to unethical behaviour and decision-making, and create a sustainable organization where stakeholders feel valued and supported through a strategic business model.

Professors Freeman and Friedman hold contrasting views on the goals and responsibilities of an organization. Freeman supports the stakeholder theory that anyone who has a stake/claim in an organization has the right to be treated as a participating determining factor in the direction of that organization. In other words, Freeman argues that stakeholders are critical to an organization, and should not be viewed as just a means to an end. In contrast, Friedman argues that businesses have no responsibility to anyone, over and above those who have ownership in the company. Friedman believes that the purpose of an organization is clear: “There is one and only one social responsibility of business -- to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game which is to say, engages in open and free competition without deception or fraud” (Hood, 1998).

A stakeholder is an individual, or group, who can “influence and/or is influenced by the achievement of an organization’s purpose” (Sexty, p. 47). Sexty argues that stakeholder
identification by managers is important to obtain resources, and understand the threat of groups controlling scarce resources and the support of other groups that contribute to the legitimacy of business as an institution in society.
Freeman emphasizes the importance of the use of the word ‘stakeholder’ and the stakeholder concept for this reason:

By using ‘stakeholder,’ managers and theorists alike will come to see these groups as having a “stake.” “Stakeholder” connotes “legitimacy,” and while managers may not think that certain groups are “legitimate” in the sense that their demands on the firm are inappropriate, they had better give “legitimacy” to these groups in terms of their ability to affect the direction of the firm. Hence, “legitimacy” can be understood in a managerial sense implying that it is “legitimate to spend time and resources” on stakeholders, regardless of the appropriateness of their demand (Freeman, p. 45).

Proponents of stakeholder theory believe that the appreciation for stakeholders is fundamental to good business, and making money (Sexty, p. 61). The argument can be made that this principle is even more prevalent in dentistry where patient care as well as the bottom line of the business must remain in careful balance. Arguments counter to the stakeholder, concept include (a) problems of categorization, (b) challenge in meeting expectations, (c) dilution of to management focus, and (d) impracticality of shared governance (Sexty, p. 60).

Although these four points may have merit and are worth of consideration in larger, more complex organizations, they do not have merit in the simple organizational structure of dentistry. This does not negate the fact that challenges do exist, particularly for the less-experienced dental practitioner who may not have the business skills and/or knowledge of stakeholders and other relevant business concepts.
6.1 Stakeholder Identification in Dentistry

Dentistry is a complex profession because it is a business that provides health care to the public. This complex business is often seen as a dichotomy of interests between making a profit, and providing health care to the public. Relationships within dentistry are two-way and dental practices must be mindful of how their decisions and activities influence stakeholders, and how stakeholders influence the activities (Sexty, p. 47). Therefore, the dental practice must consider the ethical implications of its actions towards stakeholders and vice versa.

In order to understand the complexity of stakeholder relationships in dentistry, a stakeholder typology map of a typical dental practice has been created below. This typology map does not take into consideration the myriad of organizational compilations that exist, including organizations with more than one dentist, partners, associates and larger practices. However, this map does include the main categories of internal and external stakeholders typical to the majority of practices.

Internal stakeholders are categorized as owner and employees. “Employees” are a combination of working agreements comprised of full-time, part-time, contractual and casual. Mintzberg considers owners to be external stakeholders, however for our purposes, we consider owners to be internal to the organization because the owner is always a dentist, and most dentists work operationally within the organization on a day-to-day basis. According to Phillips, the two types of stakeholders are normative and derivative. Phillips describes normative (or legitimate) stakeholders are “owed an obligation by the organization and its leaders, while derivative stakeholders hold power over the organization and may
exert either a beneficial or harmful influence on it” (Phillips, p. 2). In dentistry normative stakeholders include co-professionals, financiers, legal advisors, employees, community partners, suppliers, and community groups as normative stakeholders, and the RCDSO, government, and competitors as derivative stakeholders. Patients are a special hybrid of both normative and derivative stakeholders. Patients wield a great deal of power as informed consumers who pay a fee for services. Patients have become a great deal more savvy in recent years, and their expectations of care, due process and a fair and reasonable price for services rendered make them very special stakeholders.

6.2 The Manager -- A Special Stakeholder

The manager of a dental office is a special stakeholder. Many dental offices do not assume the financial responsibility of hiring a manager for mainly two reasons: (a) remuneration for a manager may be beyond the scope of a small dental practice and (b) most dentists are micro managers and have a reputation for wanting care and control of their business, and therefore are unable to remain ‘hands off’ with the day-to-day operations that a manager would assume.

The manager’s position in a small dental office may be an independently held position, or it may be held by the wife or husband of the owner dentist. If this is the situation, then the manager may well also be a shareholder in the organization. Regardless of whether the manager is related or unrelated to the dentist, the position holds an important responsibility in charge of the enterprise. The manager is responsible for identifying and analyzing the stakeholders that influence the organization, as well as the stakeholders influenced by the organization (Sexty, p. 59). One of the most important responsibilities of the manager is to identify stakeholders, and develop an action plan for
responding to stakeholders. Considerations of this important role include assessing opportunities, threats, understanding the influence of stakeholders on the organization, and preparing programs or policies detailing how to manage stakeholder relationships.

Dental practices that choose not to employ a professional manager encounter unique and challenging circumstances. A dentist who chooses to practice dentistry and assume the role as manager, places him/herself in a challenging predicament, and may be leaving the practice susceptible to unnecessary threats and risk.

6.3 Issues Management

Issues management (IM) is a related and important topic to the stakeholder concept. Issues management is an ongoing process of identifying stakeholder issues relevant to an organization, as well as developing strategies for appropriate responses (Sexty, p. 61). In the context of business and society, “an issue is a point in question or a matter that is in dispute where different views are held of what is or what ought to be corporate performance-based management or stakeholder expectations” (Sexty, p. 61). Issues management is a relevant concept within a dental practice, where patient values, expectations and financial resources, are often in conflict with those of the dentist.

Sethi argues that organizational issues can challenge the legitimacy and, in extreme cases, the survival of the organization. He goes on to say that, “...at any given time, there is likely to be a gap between business performance and societal expectations caused by certain business actions or changing expectations. A continuously widening gap will cause business to lose its legitimacy and will threaten its survival” (Sethi, p. 65). Wartick and Mahon expand the definition of an ‘issue’ and provides a more substantive answer to the question, what is a corporate issue?:
1. A controversial inconsistency based on one or more expectational gaps;
2. Involving management perceptions of changing legitimacy and other stakeholder perceptions of changing cost/benefit positions;
3. That occur within or between views of what is and/or what ought to be corporate performance or stakeholder perceptions of corporate performance and,
4. Imply an actual or anticipate resolution that creates significant, identifiable present or future impact on the organization (Wartick & Mahon, p. 306).

In understanding the definition of ‘issues,’ we can next identify the economic, ethical, social and environmental issues important in dentistry and its relationship to society. The following table outlines the main issues in dentistry and its relationship to society:

**Table 3.0 -- Main Issues in Dentistry**

<table>
<thead>
<tr>
<th>No.</th>
<th>Main Issues</th>
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<tbody>
<tr>
<td>1</td>
<td>Affordability</td>
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<tr>
<td>2</td>
<td>Accessibility to Dentistry</td>
</tr>
<tr>
<td>3</td>
<td>Dental Compensation and Benefits</td>
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<tr>
<td>4</td>
<td>Privacy of Information</td>
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<tr>
<td>5</td>
<td>Affordable and Flexible Payment Options</td>
</tr>
<tr>
<td>6</td>
<td>Pain and Anxiety Management</td>
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<tr>
<td>7</td>
<td>Health and Safety</td>
</tr>
<tr>
<td>8</td>
<td>Fair and Equitable Wages</td>
</tr>
<tr>
<td>9</td>
<td>Competition</td>
</tr>
<tr>
<td>10</td>
<td>Self-Regulation</td>
</tr>
<tr>
<td>11</td>
<td>Environmental Practices (Waste and Discharges)</td>
</tr>
<tr>
<td>12</td>
<td>Sterilization Techniques</td>
</tr>
</tbody>
</table>

Given the number of important issues that dentists face in the day-to-day operations of their dental practice, it makes good sense for a dentist to take a systematic approach in identifying, evaluating and responding to the myriad of economic, social and environmental issues that impact significantly upon the practice. The guideline for managing issues is
broken down into six steps: identification of issues, analysis, response formulation, implementation and monitoring.

6.4 Stakeholder Analysis

This section focuses on understanding the relationships between a dental office and its stakeholders. All dental offices should be engaged in stakeholder management, even at a basic level, in order to understand the stakeholders that influence and are influenced by the practice. The basic tenet for understanding stakeholders is addressed by answering the following questions:

• Who are our stakeholders?
• What are their stakes?
• What opportunities and challenges are presented to our firm?
• What responsibilities (economic, legal, ethical and philanthropic) does our firm have to all its stakeholders?
• What are their stakes?
• What strategies or actions should our firm take to best deal with stakeholder challenges and opportunities? (Sexty, p. 71).

In order to help us answer these important questions, the next step is to complete the stakeholder analysis. The next diagram is a stakeholder map for a typical dental practice. The lines with arrows denote the direction of influence and the thickness of lines indicate emphasis of the influence. In the dental typology diagram the stakeholders that wield the greatest influence are employees, patients, insurance carriers and the RCDSO.

The reciprocal relationships include employees, patients, co-professionals and educational institutions while most other stakeholders are uni-directional, meaning that their influence on the practice carries more weight than does from the practice to the
stakeholder. As an example, Canada Post has a greater influence on the practice than vice-versa. If Canada Post ceases to deliver mail daily to the practice, challenges of cash flow could follow as most of the insurance carriers mail the dental cheques via the post office to the practice.

The dental practice stakeholder influence map has a wide range of stakeholders that influence the practice. Due to the small size of a practice, many operations are outsourced, including web design, social media, printing, technical support, facilities et cetera. The sheer volume of stakeholders involved in a successful practice is challenging and yet each stakeholder is essential to the success of the business. Freeman defines stakeholder management capability as “the ability of managers to identify stakeholders and their influence, to develop the organizational practices to understand stakeholders, and to undertake direct contact with the stakeholders” (Freeman, 2010). The question every dentist should be asking is: who in the practice shall be responsible for stakeholder management? It is a reasonable expectation that the dentist should or could take on this role, given that the dentist spends the majority of his time treating patients? What if a practice does not have an office manager, or someone responsible enough to understand the important role of stakeholder management? Without a person duly assigned to the task, it is very easy for a practice to mishandle this important role, leaving the practice open to risk across many platforms.

The following diagram is a typical, dental stakeholder influence map. The thick black lines denote the greater stakeholder influence on the practice and the thinner black lines denote less influence. Accordingly, the arrows either have one arrow head, denoting
the direction of influence, or have a double arrow head, indicating that influence runs equally between the stakeholder and the practice.

In a typical practitioner’s practice, the greatest influence on the practice is from the staff, patients, and the RCDSO. These stakeholders must carefully be managed in order to minimize risk to the practice. Disgruntled patients and staff have recourse to lodge complaints against practices through the RCDSO. Priority must be given to manage these stakeholders. Insurance carriers are also critical stakeholders and they wield a great deal of influence on patients, and the practice. Insurance carriers have the authority to audit a dental practice for improper billing or non-collection of co-payments from patients. Insurance carriers have the authority to audit as far historically as they deem fit, and to register a complaint with the RCDSO, as well as demand re-payment from the dental practitioner.

Co-professional stakeholders play a vital role in support to a dental practice. Savvy dentists know and understand their scope of treatment, and feel comfortable referring their patients to specialists or other professionals to ensure patients receive proper care. Suppliers and consultants to the practice are also critical to the practice, and cultivating these relationships ensure that the practice realizes best cost savings for services and supplies. The government and media play lessor roles, however it’s important to monitor these stakeholders in the case of change of legislation or negative press. Dental franchises are vital to monitor as they threaten the future of the small to medium-sized practice and foreign-trained dentists are entering an already saturated market.
Diagram 2.0 -- Stakeholder Influence Map
Stakeholder management capability is an important task in the success of the practice. The question is: who is responsible and/or qualified to manage stakeholders? Many dental practices do not have a manager.

The next step in stakeholder analysis is to understand or interpret the influence (Sexty, 74) stakeholders have on the dental practice and for this we will employ the position/importance matrix, a technique of categorizing an organization's stakeholders by their influence according to two variables and usually involves plotting them on a two-by-two matrix. The two by two matrix below divides the stakeholders into four quadrants: problematic, antagonistic, low priority and supporter. The quadrants, problematic and supporter hold the greatest number of stakeholders, who wield the greatest amount of influence on the practice and antagonistic having a low number of stakeholders, but wielding importance on the practice. Finally, the low priority stakeholders having the least number of stakeholders but still need to be monitored, as they do not represent an immediate threat.
Diagram 3.0 -- Position Importance Matrix
These diagrams and matrixes illustrate that a dental practice has a significant number of stakeholders, approximately fifty percent of whom impose threat or concern for the practice, if they are ignored or mishandled. We come back to our earlier point on the importance of a dentist having a manager who understand the importance of stakeholder management in a dental practice. A competent manager adds an additional layer of ethical responsibility to a practice, and is a position to influence positive behaviour from practicing dentists as well as staff members. Layering of responsible and ethical decision-makers, protect the practice and the public.

Stakeholder theory and organizational management are integral to a healthy dental practice and help to guide appropriate moral and ethical decision-making. This section considered views of professors Freeman and Friedman who hold contrasting views on the goals and responsibilities of an organization. Given the fact that dental practices generally employ fewer than ten employees, it makes good sense that it is in the best interests of the practice owner and employees that the organization realize success in the long run. A successful practice generally employs a greater than average rate of female employees, and provides them with a means to support their families and communities. With this in mind, it makes sense in dentistry that Freeman’s position holds true in that anyone who has a stake or claim in an organization has the right to be treated as a participating and determining factor in the direction of that organization. Furthermore, a highly functioning team with a vested interest in the welfare of their patients, and the success of their organization will hold themselves and each other accountable to a higher standard in both operational performance and ethical decision-making.
The role of office manager as a special stakeholder is a critical position in working hand in hand with the owner/dentist of the organization. It is the dentist and office manager who build the vision for the practice, and then staff the practice with employees who are competent, caring and ethical. It is this layered approach in building a highly effective team that is the basis for an environment of trust, respect, and ultimately ethical decision making. A dentist alone cannot reasonably provide care to patients each day, and spend the required amount of time ensuring the welfare, happiness and functionality of a team. The manager is responsible for effective and ethical decision making in conjunction with the dentist. When all staff members begin from a place of accountability, it is easy to build upwards from there.

Patients and external stakeholders also play an important role in ethical decision-making by the dentist and staff. One of the greatest external threats to a dental office is a complaint by a patient, or an insurance carrier. Complaints that are filed with the RCDSO and result in an investigation cause great stress and hardship on a dental practice. Patient complaints are often associated with poor communication skills and misunderstandings, and with the appropriate attention to detail, could be avoided. The office manager is also responsible for setting up policies and procedures that meet or exceed the standards of good practice management. An effective manager is the key to reducing stress in a dental practice, and is a key role in providing support to the dental practitioner. This layered approach in stakeholder and issues management greatly reduce stress within the practice, and provides a transparent layer of accountability and professionalism of support to the dentist and staff. A practice that manages protocols and stress well can focus on providing above-average patient care and drive a business that is both successful and ethical.
Despite a rigorous pre-screening of dental students, educational emphasis on moral and ethical behaviour, and professional oversight, the RCDSO continues to receive, investigate and conduct discipline hearings from complaints, yearly. The next section, discipline and complaints, focuses on the process of complaints and discipline findings between 1999 and 2012. An analysis of this data is examined to identify trends and patterns of complaints that may highlight areas of concern within the profession.
7.0 Discipline and Complaints

On March 4th, 1868 the first dental act in the world received royal assent in the Ontario legislature. The RCDSO issues certificates of registration to dentists which allow them to practice dentistry, monitors and maintains standards of practice, investigates complaints against dentists who may be incompetent or have committed an act of professional misconduct. The mission of the RCDSO is to protect the public’s rights to quality dental services and their goal is a responsible and responsive system of self-regulation in partnership with the public. The RCDSO is committed to principles of transparency, accessibility, openness and fairness (Cayton, p. i).

The governing council of the college is comprised of twelve dentists, elected by dentists, nine to eleven members of the public, nominated by the provincial government and two additional dentists who are appointed from each university dental faculty in Ontario. The public members play a vital role in the college’s work to ensure inclusiveness, accountability and transparency (Cayton, p. i).

For the purposes of this project, we will include the number of formal complaints and complaint types received by the RCDSO between the years 1999 and 2012, and we will exclude activities of the alternative dispute resolutions (ADR), health professions appeal and review board (HPARB), discipline appeals, and incapacity referrals. The purpose for examining these formal complaints is to help identify insights into the trends and patterns of misconduct. The data source is gathered from the RCDSO’s annual reports, accessible on the RCDSO’s website.
7.1 The Complaints Process

The complaints process that the RCDSO must follow is set out in schedule two of the Regulated Health Professions Act, (RHPA), and the Health Professions Procedural Code (Cayton, p. 5). The inquiries, complaints and reports (ICRC) committees are pivotal in the complaints process, and meet in panels to consider complaints. In total, there are six panels responsible for 9,000 registrants (dental professionals), in a province with a population of 13.5 million (Cayton, p. 7). The panels are comprised in the following ways:

- ICRC (complaints) = 5 panels x (three members), comprised of two dentists and one public member.

- ICRC (reports) = one panel x (five members), comprised of three dentists and two public members.

For the purposes of this project, we will include the number of formal complaints and complaint types. The following flow chart sets out the complaints and reports process, as developed by Cayton in the performance review of the RCSSO’s Report, dated June, 2013:
The RCDSO is mandated to investigate every complaint that it receives, and is legislated to conclude a case within 150 days. This time frame is onerous, as Cayton’s report points out, using complaint statistics from 2011:

Of the 362 decisions issued in 2011 on complaints, we note that in only three cases was a referral to the Discipline Committee necessary. In six cases a Specified Continuing Education or Remediation Programme (SCERP) was ordered; in 41 cases an oral caution was delivered; a further 41 cases were ratification of the outcome of an ADR process; and in 56 cases the decision was agreement to no further action following satisfactory completion of at least two years of monitoring following a remedial course. The remaining 220 decisions, or 61 percent, were complaints which resulted in no further action (Cayton, p. 6).
Based on these statistics from 2011, Cayton expresses his concern that the legislative requirement is “inherently inefficient and time-consuming” (Cayton, p. 6). The legislation has set an unrealistic target of 150 days for the conclusion of cases. Given the small number of cases that proceed to the discipline committee, the median time taken is 570.5 days. For the larger case load concluded by inquiries, the complaints and reports committee, the median time taken is 315 days (Cayton, p. 6).

7.2 Formal Complaints, (1999 - 2012)

The following table summarizes the activity highlights of formal complaints to the RCDSO between the years 1999 and 2012. Of most significance are the first three rows of statistics. Row one indicates the letters of complaint received by the college, row two indicates the total number of formal complaints, and row three indicates the number of times the ICR panels met to review the results of investigations of the formal complaints.

Between 1999 and 2012, the total number of letters of complaints has been steadily climbing from 367 in 1999 to 502 in 2012. Running parallel and steadily upwards is the number of times the ICR panels met to review results of investigations. In 1999 the panels met a total of thirty-four times and in 2012, fifty-one times.

The total number of decisions issued has increased almost fifty percent from 157 in 1999 to 367 in 2012 with a high proportionate of decisions issued being ‘no further action’. A smaller percentage of decisions result in oral or written cautions and a handful directed towards education or remediation programmes. The resulting small number are referred to as the discipline committee.
### Table 4.0 -- Activity Highlights of Formal Complaints

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<td>Letters of Complaint or inquiry received by College</td>
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<td>301</td>
<td>439</td>
<td>391</td>
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<td>332</td>
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<td>of which became formal complaints</td>
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<td>369</td>
<td>305</td>
<td>243</td>
<td>364</td>
<td>310</td>
<td>294</td>
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<td>Cases Eligible for AdR</td>
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<td>119</td>
<td>56</td>
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<td>197</td>
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<td>72</td>
<td>48</td>
<td>47</td>
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<td>Cases That proceeded to AdR Negotiations</td>
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<td>Successfully Resolved</td>
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<td>Not Resolved</td>
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<td>Return to Formal Complaints Process</td>
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<td>Pending Consents from Dentists/Complainants</td>
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**Some decisions contain more than one action, example SCERP and caution. Therefore, the total number of decisions will not always equal the total number of actions.**

Compiled by the RCDSO Annual Reports, Years 1999 - 2012.

The number of discipline hearings per year have varied between two and 16 between 1999 and 2012. It is also interesting to note that frivolous and vexatious complaints were absent between 1999, appearing in 2007 and forward. This may indicate that the RCDSO were not keeping statistics on this activity type prior to 2007, or that this type of complaint has become more of an issue since 2007 and worthy of noting. Also noteworthy is the specified continuing education and remedial programme (SCERP) category which only becomes active in 2009 and may be indicative of the RCDSO's emphasis on rehabilitation through education rather than punishment.
7.3 Profile of Discipline Findings (1999 - 2012)

The following table summarizes profile of discipline findings between 1999 and 2012. The statistics were gathered from the RCDSO’s annual reports and presented here. The RCDSO did not record the 1999 statistics in their annual report, nor again in 2009.

As a general observation, the reporting of these statistics appears haphazard. The discipline finding types are ambiguous and the statistics may be assigned to these categories in a less than formal process. There are numerous categories that have spotty reporting, such as ‘contravening a provision of the act’ and other categories, such as ‘charging excessive, unreasonable or inappropriate fees’ that have constant abuse. The disgraceful, dishonourable and unprofessional or unethical conduct has a high percentage of reporting, however this category could be a catch all for other categories.

The inconsistency of reporting, and the ambiguity of the categories suggest that the presentation of this data is a reliable metric for identifying patterns of misconduct.
### Table 5.0 -- Profile of Discipline Findings

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<tbody>
<tr>
<td>Charging Excessive, Unreasonable or Inappropriate Fee</td>
<td>4%</td>
<td>0%</td>
<td>3%</td>
<td>22%</td>
<td>23%</td>
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<td>10%</td>
<td>9%</td>
<td>4%</td>
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<td>Contravening a Term, Condition or Limitation on the Member’s Certificate of Registration</td>
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<td>5%</td>
<td>6%</td>
<td>14%</td>
<td>13%</td>
<td>11%</td>
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<td>8%</td>
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<tr>
<td>Dishonest, Dishonourable, Unprofessional or Unethical Conduct</td>
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<td>5%</td>
<td>7%</td>
<td>22%</td>
<td>27%</td>
<td>30%</td>
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<td>25%</td>
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<td>1%</td>
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<td>Failing to Keep Records as Required by the Legislation</td>
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<td>2%</td>
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<td>12%</td>
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<td>17%</td>
<td>17%</td>
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<tr>
<td>Failing to Meet and/or Maintain the Standards of Practice of the Profession</td>
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<td>Failure to Make Reasonable Attempts to Collect Co-Payment Balances</td>
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<td>Inappropriate delegation of dental procedures to unqualified persons</td>
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Compiled by the RCDSO Annual Reports, Years 1999 - 2012.
8.0 Analyses

The guiding question of this study is: how do internal and external influences prevalent in the dental profession influence and contribute to ethical behaviour and decision-making?

Dentistry, a self-regulated profession, is held to a higher moral standard by society, however the relationship between dental practitioners and society is complicated by the fact that dentistry is also a business. These two factors have the propensity for creating an environment of mistrust between dental professional and patient. The results of CBC's Marketplace experiment highlights the potential that exists for dental professions to propose unnecessary treatment plans and/or cosmetic enhancements.

Dentists are faced with surging capital and operational costs as they struggle to stay current with the high cost of technology, equipment and infrastructure in today's fast-pace world while they juggle patient needs with shrinking discretionary budgets. Given the mirage of conflicting influences on dental practitioners, the question we need to ask is: why be ethical? Because dentists are self-regulated, they must adhere to a higher than average moral standards, else lose the privilege of the social contract they have with society. Dr. Karp believes that teaching ethics, coupled with role modeling by the faculty of dentistry will provide the answer to the question, why be ethical?

Despite the compelling reasons for dentists to be ethical, the fact remains that there are numerous internal and external influences exerting pressures on dentists, challenging them to provide exceptional care to patients, with the competing interests of running a business. Leadership style affects and influences the way dentists operate their business,
and treat staff. Dentists who use a transformational leadership style over transactional are better able to lead their staff, and manage stakeholders.

Stakeholders have the greatest influence on dental professionals. There are numerous internal and external stakeholders that influence the way health care is delivered and how the business is run. When any of these stakeholders are out of synchronization and an imbalance occurs, both patient care and operations of the business suffer. The most influential stakeholders are patients, staff, insurance carriers and the RCDSO. A dental practice cannot operate successfully without professional, high functioning and trust worthy staff. Patients are critical to any practice. If a patient feels that their rights as patients are being infringed or if they feel that the dentist may be trying to ‘sell them’ on a treatment, the patient has the opportunity of filing a complaint against the dentist at the RCDSO. A complaint against a dentist is a serious and significant influence that not only affects the dentist, but also has the potential to affect the staff, other patients, and stakeholders.

A critical and often absent position in a dental practice is that of a manager. A manager is often not hired either because the expense is considered too great for a practice, or because the dental professional does not have the skills, time or resources to appropriately fill this key position. Without a manager, the important role of stakeholder relations is either haphazard or not fulfilled at all, leaving the practice open to unnecessary risk.

There is no doubt from the literature, reports and journals that dental professionals are under ever increasing internal and external influences that affect performance and decision-making. But how do we measure behaviour, performance and outcome in order to determine whether the moral compass of professional dentistry in Ontario is pointing due
north? One barometer, for measuring behaviour is the complaints, discipline hearings and outcomes, as monitored by the RCDSO -- the Ontario watchdog for dental professionals, if you will.

The most telling statistics are the number of complaints that the RCDSO receives on a yearly basis. The total number of complaints since 1999 through to 2012, except for a few years, has been steadily increasing. The RCDSO has ensured that the complaint process is easy for the public to access. In fact, technology and social media has made access to and the distribution of information easier than ever before. This easy access by the public may be one reason that complaints have increased year over year. The internet has also made sharing of information and complaints by the public against dentists easier than ever before. Social media sites such as ‘RateMyDentist.com’ are popular with the public, and with the click of a button, patients are able to voice their complaints and hide behind the anonymity of the process.

In each year, only about fifty percent of the total number of complaints received by the RCDSO become actual formal complaints, and a high percentage of those are resolved through a ratification or alternative dispute resolution process. This is an indicator that a high percentage of complaints are likely to be a result of miscommunication between a dental professional and a patient. This is good news for both the profession of dentistry and for the public.

The actual number of complaints that result in a discipline committee hearing is very small, given the number of practicing dental professionals in the province of Ontario. Between 1999 and 2012, there have been zero referrals to the incapacity proceedings, which again speaks well of the dental professionals in Ontario.
The RCDSO does a good job in meeting its standards of good regulation, and this claim is supported by the independent review conducted by Mr. Harry Cayton, OBE, the chief executive of the Professional Standards Authority for Health and Social Care. Mr. Cayton and his organization conducted the review and reported back to the RCDSO with a positive report in June 2013. The report made a number of recommendations, most of which were accepted by the RCDSO. The report highlighted the fact that the length of time to resolve cases was onerous (Cayton, p. 34), and should be improved upon.

The review of discipline findings between 1999 and 2012 was less than fruitful. The reporting of statistics was ambiguous with descriptor types being duplicated in generalities. There are a few categories which appear more reliable, such as the ‘charging excessive, unreasonable or inappropriate fees’ because the pattern of complaints year over year is more plausible. Categories such as ‘other’ and ‘providing an unnecessary dental service’ are general, ambiguous, and unreliable.
9.0 Conclusion

This chapter will highlight the research problem, summarize the dissertation research, identify the main methods used and discuss their implications in this study.

9.1 Problem Statement and Methodology

Dentistry, a self-regulated profession, provides an important service to the community. The problem is that dentistry has become increasingly challenging as a result of complex internal and external influences on dental practitioners in the delivery of high standards of clinical expertise and ethical decision-making. Dentists have entered into a professional and social agreement of understanding with the public that the health and welfare of the community shall be the priority of the practice, and making a profit through business, secondarily. The providing of ethical services, while running a profitable business presents a conundrum to both the public and the profession of dentistry.

The guiding question in this study considers how internal and external environmental influences prevalent in the dental profession influence and contribute to ethical behaviour and decision-making. The study also considers the types of ethical dilemmas prevalent in dentistry and explores reasons why ethical issues continue to be prevalent in dentistry.

The methodology involved qualitative research and secondary data. The two sources for this data were a literature review and an analysis of the discipline hearings data, spanning years 1999 to 2012, as collected and coded by the RCDSO, the profession’s oversight.

The literature review included keyword searches such as ‘dentistry, professional ethics, leadership, public trust’ and ‘ethical decision-making’. The review discussed a
number of recent professional misconduct scenarios and the negative impact that has on society as well as the profession. The literature review also discussed the internal and external influences that may result in dentists faltering and behaving unethically. These influences include economic uncertainty, financial pressures (personal and business), practice management (staff/manager), leadership style, technology, regulatory oversight, competition, and its impact upon the profession in its pursuit to serve the community ethically, while making a reasonable profit. Stakeholder theory and principles were applied to the strategic management of small to medium-sized dental practices, with an examination of the role of manager within the practice. Lastly, the literature discussed whether ethical behaviour in dentists was innate due to environmental influences growing up, or whether ethical behaviour was a skill set that could be learned and adopted. The code of conduct, and the white coat ceremony examined to identify their positive or neutral impact on ethical behaviour of the profession. Punishments, deterrents and their relevancy were also examined.

The secondary data examined was publicly available complaints and complaint types as investigated and reported by the RCDSO. The reporting of data commenced in 1999 and was analyzed through to and including 2012. The data was collected and sorted into tables for analysis. Excluded from this study were decisions from the Registrar’s reports and appeals of formal complaints due to the complexity of tracking complaints and outcomes over multiple years.

The reporting of data has shortcomings. Complaint types are ambiguous and there is overlap and redundancy of the category types. Ambiguous categories include ‘other’ and ‘unprofessional or unethical conduct’ and complaint types are arbitrarily assigned to a
category. In addition, complaint types are added and deleted throughout the years, making analysis of the data challenging.

9.2 Results of Summary

Activity highlights from formal complaints show a steady increase in complaints from 367 in 1999 to 502 in 2012. There is no breakdown of number of complaints in relation to number of practicing dentists, so it is unknown if actual complaints increased or whether complaints increased in relation to increasing number of practicing dentists. From 1999 through to 2012, a number of complaints categories were eliminated, which may have resulted in inflated numbers in remaining categories.

The profile of discipline findings hold the same ambiguity as activity highlights. The reporting of these statistics appears to be haphazard and the presentation of data is not a reliable metric for identifying patterns of misconduct.

Despite the ambiguous reporting of activity highlights of formal complaints, and the profile of discipline findings between 1999 and 2012, there exists increasing concern from within the profession that unethical behaviour is on the increase. The Faculty of Dentistry, University of Toronto introduced the white coat ceremony in an effort to increase the importance of ethical decision-making and behaviour of their graduates. Ethics continues to be part of the curriculum for first year dental students, and the RCDSO continues to improve their complaints process, in an effort to make reporting a seamless process in the eyes of the public and practitioners. The information that is absent from reporting is number of practicing dentists, and the type of business practice model that is associated with complaints. As an example, there is no information available on whether a complaint was made against a solo-practicing dentist, or a practitioner from a multi-practitioner
practice. Also absent is demographic information. For instance, are complaints made against dentists who practice in isolation in rural practices, or are more complaints made against dentists practicing in a hyper-competitive market such as Toronto proper? The collection of statistics is in isolation to these important factors which may provide an insight into if unethical behaviour is on the rise and what factors may be influencing it?

9.3 Discussion of Results

The results of this paper highlights the fact that the profession of dentistry believes that unethical behaviour is on the rise, and that should be of concern both to the public and to the profession of dentistry. The paper highlights a number of situations where doctors have quite clearly crossed the line of morality in such a way that criminal charges have been laid, but these types of crimes are not the norm.

The literature supports the fact that internal and external influences create stress on dental professionals and the Faculty of Dentistry believe that teaching ethics as part of the curriculum and implementing the white coat ceremony go a long way in reinforcing the importance of ethics within the practice of dentistry.

Internal and external influences have been discussed as areas of stress for dentists. The cost of a practice start up in Toronto is exorbitant and coupled with student debt and personal expenses can culminate in added pressure to conduct more treatment on patients that may not require it. Practices that do not have a manager may be subject to additional stress as a dentist struggles to practice dentistry and deal with the rigors of running a successful business. Patients create undue stress on dentists as patients want more dentistry for less money, and do not want to pay for services not covered by their insurance benefits. Patients without insurance expect to receive dentistry, while negotiating lower cost for
treatment. Patients have become more savvy consumers, demanding more services for less cost, and have the ease of making a complaint against a dentist with the help of technology and the RCDSO. Dentists struggle to stay current with expensive technology that continues to evolve and change with lifespans less than five years. Foreign trained dentists open new practices in major cities resulting in an unsustainable business model for dentists.

The RCDSO has an obligation to the public as well as to the profession of dentistry, and to ensure the continuity of self-regulation. As a result, the RCDSO continues to improve its data collection of formal complaints and discipline findings. Unfortunately, the collection of data between 1999 and 2012 is ambiguous and very little information can be gleaned from the presentation of data. For instance, the ratio of dentists to patients is unknown over the period of study, and therefore it is not known whether complaints increased or stayed the same. Complaint types changed throughout the study period, with new categories appearing, and others becoming obsolete. The remaining categories are undefined and open to interpretation.

Despite the ambiguity in the collection and reporting of complaints by the RCDSO, there exists the concern for the profession that unethical decision-making is on the increase, and this potential problem should be addressed, both in the interests of the public and the self-governance of dentistry. The next section discusses recommendations to the profession of dentistry and the public given the importance of dentistry to society.

### 9.4 Recommendations

The following recommendations are made to the profession of dentistry as a whole, given the importance of dentistry to society and to self-governance of the profession. Included in this grouping is the RCDSO, the professional oversight for dental professionals...
and the protection of society. It is certain from the literature review that there are dental professionals who appear to be ‘bad apples’ and they cast negative aspersions onto the profession as a whole. There also exists evidence that the profession, as a whole, feel that the importance of ethics is not being appropriately addressed and that unethical behaviour is on the rise. And lastly, the RCDSO, tasked with keeping the community safe, has implemented measures to make reporting of complaints easy for the public, and ensuring dental professionals are held accountable for their actions. The RCDSO has implemented a reporting system for both complaint types and findings which is ambiguous and does not show trends or patterns that may support or deny the claim that unethical behaviour is on the increase. Based on these remarks, the following recommendations are made:

1. The RCDSO to create a task force that includes members of the public, dental professionals, and academia to create a fair and non-ambiguous reporting system to capture formal complaints and discipline findings.

2. The RCDSO to report on additional and supporting data including number of practicing dentists to per capita of active patients.

3. The RCDSO to privately survey a sampling of practicing dentists yearly, to understand what internal and external influences have the greatest impact on stress for dental professionals.

4. The RCDSO to privately survey members of the public yearly to understand their greatest sources of stress.

5. The RCDSO to update their Code of Conduct to address the glaring holes in areas such as the environment, social responsibility, and additional transformational areas.
6. The ODA, RCDSO and Faculty of Dentistry to work collaboratively together to address the less than 1/2% of interest in ethics by dental professionals and students. Greater information-sharing about the internal and external influences that cause stress is needed, as well as coping mechanisms and support for professionals.

7. Implement additional symbolic and traditional ceremonies to professionals and students, to make ethics an area of professional pride.
10.0 Appendices

Appendix A

Oath of Commitment

As a new dental student, I recognize that the practice of dentistry is a privilege that comes with considerable responsibility.

I solemnly acknowledge that my paramount responsibility is to the health and well-being of my patients.

I pledge that I will practise my profession with conscience and dignity.

I will strive to always act with sympathy and kindness to all patients in alleviating their concerns and pain.

I will respect my patients’ rights to make informed decisions about their care, based on their personal values and beliefs.

I will endeavour to work with the faculty and my colleagues in a spirit of co-operation and respect.

I recognize the limits of my knowledge and will seek to maintain and increase my understanding and skills throughout my professional life.

I will always uphold the ethical standards of this honourable profession, and behave with honour and decency.

In the presence of this gathering, I make this oath of commitment solemnly, freely, and upon my honour.
11.0 References


