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Ethical dilemmas confronting dentists in Queensland, Australia

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Abstract

Background: This paper details contemporary ethical dilemmas encountered by Queensland dentists.

Methods: An age-stratified sample of 499 dentists resident in Queensland was surveyed. The questionnaire contained scenarios of five common ethical dilemmas. In addition, open-ended questions sought the respondent's most frequent, difficult and recent ethical dilemmas, and where they would seek guidance in dealing with ethical problems.

Results: Respondents acknowledged the patient's rights in treatment decisions and the dentist's right to refuse demands for inappropriate treatment. However, responses varied in the extent to which dentists may influence treatment decisions. Few respondents would ignore evidence of poor dental treatment but they are evenly divided in choosing to inform the patient, the dentist or both. Poor quality treatment is the most frequent and difficult dilemma, and half have experienced this problem recently. Requests by patients for fraudulent receipts occur in a third of responses. Dentists develop ethical values from multiple sources but for help with dental ethical problems, 90 per cent of respondents would consult another dentist.

Conclusions: Of the ethical dilemmas discussed in this survey, those relating to poor quality treatment confronted most respondents. Also the actions of dentists in dealing with these dilemmas were most varied.

Key words: Dental ethics, business ethics, professional behaviour, codes of dental conduct.

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INTRODUCTION

Dentists have two roles – as health professionals and as individuals operating a small business. Each role presents the dentist with distinctive and sometimes conflicting ethical demands. This paper sketches some recent changes in professional dental practice and then goes on to outline the results of a 'Survey of Ethics in Dental Practice' undertaken in Queensland in 1999. The survey explores the ethical dilemmas encountered by dentists in that State and their sources of assistance in addressing ethical problems.

Ethical dilemmas in dental practice – the context

In the last few decades the balance of decision-making in determining what is the 'best' dental treatment has shifted from professional paternalism towards respecting the informed and autonomous decision of the patient. Dentists have come to experience problems when patients seek inappropriate treatment, and when they choose, or are constrained to accept, compromise treatment.[1,2]

Dentists are distressed by evidence of poor quality work provided by another dentist, yet they are also upset by dentists who openly criticize the work of others.[3,4] Until the 1970s dental codes of ethics precluded criticism of another dentist's treatment publicly or to the patient. From about that time the terms 'justifiable criticism' or notification of 'gross and continual faulty treatment' were introduced.[5] By the late 1980s it was unacceptable to withhold information from the patient about their oral condition, including that which may reflect poor quality treatment.

Contemporary codes of practice direct dentists to provide all necessary information but to refrain from disparaging other dentists publicly or to the patient. Professional associations believe that it is preferable to deal internally with substandard dental work.[4,5] The code outlining ethical conduct for Queensland dentists[6] states that "[p]atients should be properly informed of their present oral health status, however, gratuitous and unnecessary disparaging comments about prior services should be avoided at all times". Moreover, "a dentist is obliged to report … grossly unethical or unprofessional conduct . . . provided that [there is] a firm factual and legal basis for making such a report".

Whilst the codes of conduct are designed to offer guidance, dentists continue to have difficulty in dealing with the evidence of substandard treatment by other dentists.[3-5] Dentists also report doubts about the value of such codes and the effectiveness of dental associations in dealing with dentists who violate the

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codes.[3] In business activities, codes of conduct have a more positive influence on ethical behaviour.[7]

Ethical dilemmas – business

As well as patient-related problems dentists, and other professionals in private practice, face the special ethical problems associated with operating a business. Private dentists have always competed with each other for patients. However, this competition operated, especially in the sixties and seventies, in an environment of comparative financial security and stability, and until recently it was constrained by a rigid code of practice.[8-10] There is widespread concern that government polices towards anti-competitive practices and the active involvement of third party providers in dental care are distorting the balance between competition and co-operation with a consequent increase in questionable ethical practices being used when competing for patients.[10-12]

The 'commercialization' of dentistry is often criticized by dentists for fostering inappropriate, misleading and untruthful advertising, for creating an emphasis on fees (discounts, competition, treatment 'packages'), for encouraging 'dentist-shopping' and stimulating dentists to treat people as customers buying a service rather than patients in need of help.[8,10,11,13,14] Advertising *per se* is not seen as necessarily unethical but the wrong type of advertising causes concern.[13,15]

Dentists claim that the involvement of third parties and managed care in dentistry challenges autonomy in decision-making (both for dentists and patients), and risks a loss of confidentiality and equity. In addition, there is a temptation for both patients and dentists to manipulate or defraud health insurance funds. Insurance companies through their advertising may stimulate inappropriate competition between dentists, and in their contact with claimants may create uncertainty about dentists and their fees.[14]

Sources of variations in ethical views

Variations in ethical practices (both in dentistry and in business) have been identified which correlate with age, gender, religious practices and peer influences.

Age is reported as having the greatest influence on ethical behaviour and the general pattern that emerges can be summarized as follows. Older professionals have an increased interest in ethics, place a higher importance on ethical behaviour, have stronger ethical attitudes (they are less likely to conceal errors or falsify reports), and are more conservative and more inflexible in their views.[16-21] Notwithstanding these results, or perhaps because of their uncompromising approach, older dentists report experiencing fewer ethical problems than do younger dentists.[3]

One reason offered for the age differences is that the security of an established career and financial stability of an older professional reduces the pressure to compromise principles. Additionally, with more to lose if caught in an unethical situation, they are unwilling to place themselves at risk. With age comes a greater familiarity with professional norms and a reluctance to disrupt the *status quo*.[19,20] Even though the results of ethical tests may differ with age, the general direction of the results are similar for both young and old.[20]

Ethical differences are rarely correlated with gender in studies of health professionals,[22,23] although males tend to express greater confidence in their ability to make sound ethical judgements.[16] Female dentists experience more ethical difficulties concerning staff and management, and male dentists report more third-party problems.[3] Males and females also react differently to ethical situations in their business activities. Males tend to view ethics in terms of justice and rights whereas females in terms of compassion and relationships. For example, men comment more honestly on another person's appearance and women more sensitively. Men tend to distribute limited resources equitably and women compassionately.[18,24] However, in non-relational ethical situations, e.g., in concealing errors or falsifying reports there are no significant gender differences.[18-24] Gender differences are observed within all age groups but differences narrow with increasing age and whilst findings are not uniform, females are generally reported as being more scrupulous in respecting ethical principles.[7,20,21]

Ethical behaviour does not vary significantly with religious affiliation. However, there is a positive relationship between the strength of belief, or the observance of religion by regular attendance, and moral reasoning and ethical behaviour.[7,16,23,25] Those who observe religious practices are more confident in their ability to make ethical decisions and have an increased interest in ethics.[16] As with gender, differences in ethical behaviour due to religion are less evident in health related decisions than in business situations.[16,23]

Peer influence (measured by frequency and intensity) positively influences ethical attitudes.[7] Conversely, competitiveness has a negative influence.[7] Whilst the size of a dental practice and the nature of that practice generally do not influence ethical decision making, suburban dentists report more ethical problems (especially relating to third parties) than do urban dentists. Specialists report more dentist-dentist problems and general practitioners report more dentist-patient problems.[3]

Sources of ethical advice

Professional attitudes are influenced initially by family and religion, and later by codes of ethics and the norms of the profession. In addition, professionals may undertake ethical training within their education. The teaching of ethics started as an informal part of a curriculum presented by well-respected members of the profession, and relying heavily of the role model of clinical teachers. Contemporary training in ethics occupies a formal place in the dental curriculum often conducted by lecturers qualified in bioethics. The influence of formal courses varies. Some studies report

Table 1. Details of respondents to Survey of Ethics in Dental Practice

	Respondents		Qld Dentists	
	N=	%	%	
Age				
<25 years	13	7	3	(i) From 1999 Dental Register includes all dentists not
25-34 years	42	21	24	just residents of Qld[28]
35-44 years	50	26	30	
45-54 years	53	27	22	
55-69 years	30	15	21	1912 dentist total
	(missing =8)		(i)	1682 Qld resident
Gender				
Female	40	20	20	
Male	152	78	(i)	
	(missing=4)			
University attended				
Queensland	154	79	78	(ii) From 1999 Dental Register includes only residents
			(ii)	of Qld[28]
Type of practice				
Specialist	27	14	11	
General Practitioner	164	85	89	
(Government)	(30)			
	(missing=3)			
Size of practice				
Solo practitioner	64	35	43	(iii) From 1994 Dental Register includes only
Small group (2-3)	87	48	(iii)	residents of Qld[29]
Large group (≥4)	32	17		
	(missing=13)			
Location of clinic				
Metropolitan CBD	41	21		
Metropolitan suburb	68	35	54	
Provincial city (>50,000)	51	26	(iii)	
Rural town	33	17		
	(missing=3)			
Ethnicity				
Anglo-Celtic	147	77		
Continental European	24	13		
Asian	15	8		
Other	4	2		
	(missing=6)			
Religious affiliation				
None	63	32		
Roman Catholic	43	22		
Anglican/Lutheran/Orthodox	38	19		
Uniting/Presby/Method	13	7		
Other	4	2		
	(missing=35)			
Currently practicing	74	39		
ADA membership				
Member	181	92	96	(iv) ADAQ membership December 1997[30]
Active member	106	54	(iv)	
Served on a committee	87	44		

that such courses produce a 'significantly greater sense of responsibility to others',[26] and an increased ability in moral reasoning which remains evident even 20 years later.[21] Other studies find that ethics education plays a more limited role resulting in an increased interest in ethics and a higher level of altruism but no difference in moral development or confidence in exercising ethical judgement.[16] Most studies conclude that the impact of ethical training on ethical behaviour justifies such courses.[16,21,26]

The Queensland survey

The profile of professional dental practice sketched above provides the context for the 'Survey of Ethics in Dental Practice' undertaken in Queensland in 1999. While there have been anecdotal reports about ethical problems in contemporary dental practice in Queensland there have been no systematic and detailed studies to find out the nature and extent of these problems. The survey was undertaken to find out what professionals perceive as the central problems they face in the contemporary dental workplace.

MATERIALS AND METHODS

The 1999 survey of Queensland dentists was carried out using a stratified sampling technique based on dates-of-birth to select dentists from the Queensland Dental Register who were resident in that state. The sample of 499 dentists represented 30 per cent of dentists resident in Queensland (n=1682). The questionnaire presented five scenarios selected from cases used in teaching dentistry students. In four of the five scenarios, a range of answers was provided (with the addition of 'other' for personal responses). One

Table 2. Responses to scenarios depicting ethical dilemmas in dentistry

	n	(%)
Scenario 1. A dentist who, having considered all alternatives, presents the patient with only one option for treatment. Respondents are asked their reactions.		
The options should be explained and the patient left to make their own choice.	61	31
The dentist should explain options and guide the patient to an appropriate choice.	117	60
A dentist gives an opinion only if the patient requests, otherwise remains silent.	13	7
Dentists are entitled to use their experience to act in the patient's best interest.	3	2
Scenario 2. The dentist provides an insurance report for a patient who had a very minor accident which was treated by re-contouring chipped incisal enamel.		
The report includes:	n	(%)
The re-contouring as accepted by the patient.	75	38
Restoration options (patient may change their mind).	19	10
Endodontics and crowns although they are unlikely options.	1	<1
All the above options with an explanation of the likelihood of each event.	100	51
Scenario 3. A regular patient who recently dropped health insurance cover asks for a $150 receipt to be back-dated by three weeks.		
(open responses coded as below)	n	(%)
Refuse to back-date receipt (no explanations given in the response.)	84	43
Refuse to back-date receipt. Legal reasons explained to patient.	90	46
Refuse to back-date receipt. Explanations other than legal given to patient.	14	7
Agree to the patient's request.	7	4
Scenario 4. Overhanging margins with chronic periodontal involvement are discovered in an emergency patient whose usual dentist is on vacation.		
The respondent would:	n	(%)
Tell no one.	25	13
Tell the patient but not the other dentist.	58	30
Tell the other dentist but not the patient.	43	22
Involve both the patient and the other dentist.	69	35
Scenario 5. A patient wants all teeth removed and the dentist wants to treat those which can be saved. When the patient says they will find another dentist for the extractions, the original dentist decides not to treat the patient.		
The respondent believes:	n	(%)
The dentist has a right to refuse treatment.	160	82
The dentist is indifferent to the preferences of the patient.	21	11
The dentist is being unreasonably stubborn.	10	5
The dentist is being financially unrealistic.	1	<1

scenario required a fully open response. In addition to these cases, the survey sought information on the most frequent, most difficult and most recent ethical dilemmas encountered in dental practice, and any assistance sought in relation to these issues. Details on age, gender, ethnicity, religious background, ethical training, professional membership, and information about the size, type and location of the dental practice were gathered. The analysis of the data was undertaken using SPSS statistical package for frequency distribution and, where appropriate, bivariate analysis using the chi-square correlation co-efficient was undertaken.

The survey guaranteed anonymity to respondents and ethical approval was obtained from the University of Queensland Behavioural and Social Science Ethical Review Committee.

RESULTS

The response rate for the survey was 194 (39 per cent) and was consistent across age groups but is lower than the 55 per cent average response rate for mailed dental questionnaires.[27] A reduced response rate may be due to the fact that many of the questions were sensitive in nature and called for open responses. Over 98 per cent of respondents answered all of the case-study questions and 90 per cent answered the open section on ethical problems, a high proportion of which contained extensive and very detailed answers. A representative demographic cross section of dentists responded (Table 1) but it was impossible to gauge attitudinal differences between those who completed the survey and those who did not. That the respondents displayed an interest in ethics was highlighted by their detailed discussion, but non-respondents may not share this interest. Due to the additional expense of collating such detailed responses, a follow-up questionnaire was not sent. The sample size limited the ability to apply the results of this survey to dentists in general.

Of the respondents, 40 (20 per cent) were female. In comparison with males, these respondents were younger. They were more likely to be in government clinics and from provincial cities, and less likely to be specialists or in solo-practices.

Five scenarios were presented to the respondents for their comments. The results are summarized in Table 2. There were very few differences in responses based on gender, age, location, practice size, ADA membership or religious background with the exception of those mentioned below.

In Scenario 1, patient autonomy and paternalism in treatment decisions were examined and 98 per cent of respondents believe the patient should be provided with detail of all options and be involved in the choice of treatment. Opinions were more divided on the role of the dentist in selecting treatment. Respondents in the suburbs or in provincial cities were more likely to state that dentists should not interfere or influence decisions than were metropolitan or rural respondents.

Table 3. Ethical dilemmas encountered by Queensland dentists: most frequent, most difficult and recent dilemmas

	Ethical dilemmas in dentistry					
	Frequent		Difficult		Recent	
	n	%	n	%	n	%
Treatment related issues						
Substandard care by other dentists	66	36	53	35	22	21
Correcting poor work of other dentists	35	20	30	20	21	20
Conflict with other dentists on treatment decisions	14	8	13	7	8	8
Explaining personal treatment failures	5	3	6	4	2	2
Professional behaviour						
Unprofessional behaviour	12	7	7	5	15	14
Criticism of other dentists	8	6	2	1	2	2
Over-servicing	16	9	3	2	2	2
Patient related issues						
Requests for amalgam-free dentistry	25	14	9	6	2	2
Requests for inappropriate treatment	15	9	96	12	11	
Unrealistic expectations	4	2	–	–	–	–
Health Insurance related issues						
Defrauding health funds	54	31	13	9	8	8
Criticisms of dentists by health funds	6	3	3	2	2	2
Other						
Advertising	18	10	8	5	1	1
Fees	22	13	9	6	4	4
Compromise treatment due to fees etc	19	11	10	7	3	3
Human resource management issues	15	9	10	7	5	5
No ethical problem	3	2	5	3	17	16
Number of respondents						
(multiple responses permitted)	176		150		106	
(Missing)	(20)		(46)		(90)	

Scenario 2 sought opinions on the content of a report for an accident compensation claim. The respondents were divided between providing only that treatment which was done or defining the probability of future need.

Scenario 3 presented a request to alter the date on a dental insurance claim. This question called for an open response. Of the 96 per cent who refused to back-date the receipt, 43 per cent just said "refuse" or a similar comment in their open response. A further 53 per cent of respondents described how they would present the refusal to their patient. The majority of these would discuss the legality of such an act and the remainder cite practice policy, computer systems, random checks and professional reputation as alternative explanations. Whilst still rejecting the request, some dentists commented on the added dilemma when a friend makes such a request. The dentists who elaborated their answers were more likely to be active members of the ADA and to have read the ADA ethics guidelines. Only seven respondents would agree to the patient's request, most were males, mid-30s, and in small metropolitan group practices. Their comments included "only if the patient is under extreme financial hardship"; "considering the sum involved and size of monetary cost to the insurance company – if crowns would be different"; "a one-off and not normal practice"; "warn her not to tell anyone. Depends on patient. Generally do it". One respondent who declined the patient's request commented "[w]e have a sign in the waiting room and on the reception desk which states that to pre-date and/or add item numbers is fraudulent. We do not get this type of request any more".

In Scenario 4 the respondents were asked for their actions when confronted by poor quality treatment of another dentist and multiple responses were permitted. In addition to the four options listed in Table 2, 'write on the treatment card' and 'tell the ADA or the dentist's superior' were included. Only one respondent selected the latter option in addition to telling the dentist. Overall only 52 per cent of respondents indicated that they would write details on the treatment card. Eight per cent of respondents would do nothing other than this notation. Many respondents added comments on the need for diplomacy and to refrain from directing blame or from criticizing the other dentist. Dentists who were younger than 25 or older than 55 years were most likely to do nothing. However, if they acted, they were more likely to involve only the patient.

In Scenario 5, the case was presented of a dentist who refused to treat a patient who requested treatment with which the dentist disagreed. Eighty-three per cent of respondents believed that a dentist has the right to refuse such a request but 16 per cent believed that to refuse would be wrong, stubborn or indifferent to the preferences of the patient.

Contemporary ethical dilemmas

The respondents were asked to provide details of the most *frequent* and the most *difficult* problems encountered by them or their colleagues, and to give details of *recent* problems they have encountered personally. Some direct quotes from respondents are provided in Table 5. Table 3 has a summary of the responses. Although many respondents recorded several issues for each question, 2 per cent stated that

Table 4. Sources of ethical understanding and guidance for Queensland dentists

	Sources of ethical guidance					
	In gaining sense of professional ethics		Have used for past ethical problems		Would use for current ethical problem	
	n	%	n	%	n	%
Single source						
Family/friends	20	10	1	0.5	3	2
Religion/clergy	1	0.5	–	–	1	0.5
Dentists/ADA	6	3	86	47	101	55
Doctor/lawyer	–	–	2	1	3	2
Self/no one	2	1	2	1	6	3
Multiple sources						
2-3 sources	96	49	78	42	67	37
≥4 sources	69	36	15	8	1	0.5
Number of respondents						
(multiple responses permitted)	194		184		182	
(missing)	(2)		(12)		(14)	
Dentist included as source	151	78	176	96	168	92
Family included as source	171	88	53	29	27	15
Clergy included as source	73	38	5	3	2	1

there were no ethical problems in dentistry, 3 per cent that ethical problems in dentistry were not difficult and 16 per cent stated that they had not encountered any ethical problems in the last two years. "I don't have a problem. I just do the right, moral, legal and ethical thing"; "Ethical problems are not difficult once you have established a philosophy. Don't expect to win all the time. Feel comfortable with trying your best".

Ethical dilemmas relating to treatment, especially concerning poor quality, were the most frequent and most difficult issues that dentists encountered and more than half of the respondents had dealt with such issues recently. The comments indicated that this dilemma was more difficult if the patient requested an opinion on prior dental treatment than if the dentist observed the poor work. Amalgam-free dentistry caused concern in three ways – the time it takes to provide patients with explanations about amalgam, the difficulty in dealing with dentists who push amalgam-free dentistry, and the involvement of alternative health practitioners (both medical and non-medical). "Originally I took the ADA line and counselled patients to leave sound amalgams, however several patients returned 1-3 years later with all amalgams replaced elsewhere, so now I stress to the patient that sound amalgams should be left but if they feel strongly about wanting them replaced then I will do that for them."

Most incidents in the category of unprofessional behaviour related to 'poaching' patients who were referred for treatment or who attended as emergency patients. In addition, assistant dentists taking patient details with them when they change employers was a perceived problem. Patient requests to defraud health insurance funds occurred frequently but only two respondents mentioned dentists defrauding the system. Both respondents suspected that this unethical behaviour was connected to over-servicing or manipulating the item numbers to increase profits by dentists who advertise 'rebate-only' practices. Few dentists who mentioned advertising as a dilemma wanted advertising abolished but rather were concerned by "extravagant, misleading claims which place unfair pressure on maintaining the loyalty of patients" and "the National Competition Authority on advertising is a gross backward step as dental personnel will try and compete on grounds which are unprofessional".

There were no differences in the ethical dilemmas encountered by male and female dentists. However, there were some age related differences. Those who were younger than 40 years mentioned poor quality dental care as a more frequent concern and a more recent concern than do older dentists. In addition, younger dentists commented on the frequency of patients having unrealistic expectations of dental treatment and on recent difficulties with issues relating to fees. Dentists older than 40 years commented more often than younger dentists on the difficulty they encountered in dealing with health funds.

Government dentists in small rural towns mention some ethical dilemmas that were not mentioned by other respondents - long waiting lists and restricted access to free treatment. They were disturbed by patients who tried to circumvent the system by giving the staff gifts or using their friendship with the dentist. Added pressure was caused in one case because the only private dentist in town was perceived to provide poor quality treatment and was disliked by the community. Dealing with limited resources and patients with extensive oral disease (especially children) caused tension for government dentists, and one dentist made the comment "[w]hen does gross caries become child abuse?"

Source of ethical guidance

The respondents were asked where they gained their sense of professional ethics, whether they had any formal training in ethics, where they sought ethical advice in the past and where they would seek advice

Table 5. Representative selection of suggestions for additions or changes to the Ethical Guidelines for the ADA

"Ethical guidelines are like the ten commandments – obey them if you wish. Totally unenforceable."
"We need an independent advisor/referee who has the power to enforce further action and to whom we can refer patients for an opinion, without being made to feel disloyal to the profession."
"Big stick-financial penalties."
"It is very difficult to enforce guidelines as found over the years. Even obvious negligent, fraudulent, unscrupulous dentistry will be strongly defended (even in a court of law) by the accused."
"Peer review by a panel as a preliminary in complaint mediation – with teeth!!"
"Current guidelines tend to focus on the dentist/patient, it may be useful to broaden the scope to dentist/population. We need to think about the 'have nots' as well as the 'haves'."

were it needed in the next few weeks. Table 4 contains a summary of the responses to these questions and there were no significant variations in the responses based on demographic variables. Dentists reported that they gained their sense of professional ethics from many sources (only 15 per cent cited a single source). Family and religious background were included frequently as initial sources but not when dealing directly with dental issues. With ethical problems in dentistry, past or future, over 90 per cent of respondents sought guidance from another dentist and discussed these problems with fewer people. Differences in responses in two of the five scenarios were observed between those dentists who sought ethical help from fellow dentists and those who did not. This latter group was more likely to believe that dentists should not interfere in the patient's choice of treatment. When confronted by poor quality dental work, they were more likely to do nothing and were less likely to make notes on the treatment card.

Queensland graduates younger than 25 years in this survey completed a dental ethics subject as undergraduates. With the exception of this age group, formal training in ethics (either as a stand-alone course or incorporated as part of another course) was undertaken by 22 per cent of respondents, three quarters of whom felt that the course was helpful in dealing with their ethical dilemmas.

The ADA (Queensland Branch) produces a code of conduct and ethics which 81 per cent of respondents believed has an influence on professional standards. Although only 54 per cent of respondents had read the current code, nearly 75 per cent of respondents believed that changes were needed to address contemporary ethic issues. Whilst more of those over 40 years of age had read the code (61/45 per cent) there was no age differences in the recommended changes. Changes relate to the powers of enforcement (13 per cent); advertising (11 per cent); how to handle poor quality work (6 per cent); training in ethics (5 per cent); and changes to peer review (3 per cent). Some comments that accompany these responses are included in Table 5.

CONCLUSION

This Queensland survey identified three broad categories of ethical concern within the dental profession: (i) problems arising from the quality of care provided by other members of the profession, including under- and over-servicing and apparently substandard treatment; (ii) problems relating to dental health insurance; and (iii) the commercialization of dental practice. These broad concerns were widely reported from dentists practising in Queensland irrespective of the type, size or location of the dental practice. A large number of other issues were also raised which will be the subject of further papers.

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