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AMERICAN ACADEMY OF THE HISTORY OF DENTISTRY

2008 ANNUAL MEETING
Pathways to Knowledge
BOSTON
May 1-3, 2008

Thursday, May 1st • Harvard School of Dental Medicine
Dental Education in America: Boston, the Hub of the Dental Universe
Registration: Noon to 1:30pm
Presentations: 2:00 – 5:00
Opening Reception: 5:30-8:30 (complimentary bar and hors d’œuvres)

Friday, May 2nd • Simmons School of Library and Information Science
Knowing Where to Find Knowledge is the Most Important Part of Scholarship
Presentations: 8:00am – 5:00pm
Luncheon - Dr. Frank and Phyllis Orland Lecture

Saturday, May 3rd • Center for the History of Medicine, Countway Library/Boston Medical Library
The Role of History in a Doctor’s Education
Presentations: 8:00am – 1:00pm

Saturday Night Banquet • St. Botolph Club
199 Commonwealth Avenue Boston, MA 02116

Accommodations • The Harvard Club of Boston
374 Commonwealth Avenue Boston, MA 02215
1-800-957-6667 or (617) 536-1260
Rooms available from April 30 – May 3, 2008
Room Rate: $199 per night
For more information, visit www.harvardclub.com
AMERICAN ACADEMY
OF THE
HISTORY OF DENTISTRY

2008 ANNUAL MEETING
Registration Form

NAME: ____________________________

ADDRESS: ____________________________

CITY: ____________________________

STATE: __________

ZIP: __________

COUNTRY: ____________________________

PHONE: ____________________________

EMAIL: ____________________________

Registration Fees (all inclusive)
Member: $425, Late Registration: $595
Non-Member: $595 (No late registration penalty.)
Spouse/Student: $275, Late Registration: $395

(for individual events only)
Opening Reception: $45
Orland Luncheon/Lecture: $45
Annual Banquet: $100

Late registration fees apply after April 15, 2008.

Total: $_____

Visa & Mastercard Accepted
Card Number: ____________________________
Expiration Date: ____________________________
Security Code (3 digits): __________

Signature: X ____________________________

Thursday, May 1st
General Meeting Admission
Mid-afternoon Refreshment Break
Opening Reception with Complimentary Bar

Friday, May 2nd
General Meeting Admission
Continental Breakfast
Midmorning Refreshment Break
Luncheon - Dr. Frank and Phyllis Orland Lecture

Saturday, May 3rd
General Meeting Admission
Continental Breakfast
Midmorning Refreshment Break
Luncheon
Annual Banquet and Reception
Complimentary Bar

for more information, visit our website
www.historyofdentistry.org

Please complete this registration form and mail or fax it with payment to:

Dr. Marc B. Ehrlich
1371 Beacon Street
Brookline, MA 02446 USA

Fax: (617) 278-6593

Checks (mailed applications only) should be made payable to the AAHD.
Message from the Editor

David A. Chernin, DMD, MLS

This winter issue of JHD is devoted to the proceedings of our October 2007 meeting in San Francisco, “Ethics in Dentistry: Its Evolution and Its Future.” Dr. Morton G. Rivo and his program committee delivered an outstanding colloquium. The impressive roster of speakers offered a sequence that guided attendees through this broad and complex subject from its genesis to present-day deliberations.

In its entirety, the colloquium constructed an overview and framework for understanding the evolution and development of the role of ethics as it relates to the profession of dentistry. The panel discussions and questions generated by each presentation provided lively and enlightening exchanges. If this issue is well received, as an added benefit to our membership, the JHD will provide the broad membership with transcriptions of our future meetings.

The AAHD’s primary interest in ethics is an appreciation of its impact as we study the history of our profession. As clearly stated in Article II of our constitution, we define our Academy’s primary role as our ability to discuss and learn from the past literature of this topic. Our synergetic scholarship attempts to understand and analyze the social context throughout history. In so doing, we illuminate the evolution and development of American dentistry and offer insight and guidance for dealing with present day dental issues.

We would be deficient in our research and negligent in our scholarship to ignore the influence of ethics in the development and evolution of American dentistry. The Academy’s strength to promote the study of ethics lies in the depth and broad intellectual accomplishment of our members whose demographics include informaticians, archivist/curators, academics, clinicians, historians and collectors representing the sciences and humanities.

In pursuit of our goal to sustain the study of ethics, we have expanded our standing Committee on Education responsibilities to include the teaching of ethics as an integral component in the study of dental history. Energized by our October colloquium, the Academy will provide additional resources to enable our Committee to advance this agenda.
Message from the Colloquium Chair

Morton G. Rivo, DDS


In preparation for the publication of these Proceedings, each of the speaker’s presentations as well as the panel discussion was recorded, subsequently transcribed, and then edited.

Developing this program was a new experience for most of us. Several of us had only fleeting memories of ethics classes that we took in dental school. Many reported that their dental schools had assigned only a cursory hour or two to ethical behavior during the course of a four-year dental curriculum. Others remembered no ethics classes at all.

To be sure, there are many Dental Codes of Ethics codified, reviewed and updated by organized dentistry. The American Dental Association published its first Code of Ethics shortly after its founding in the mid-19th century. Each of our State Dental Societies has an active Code of Ethics as do most of the component dental organizations. So do the various Academies that represent general dentists and the specialists. However, other than these Codes, there is precious little to be found about ethics in the dental literature.

We looked to address three audiences: the Academy, the dental profession, and the patient. We sought experts familiar with the teaching of skills that lead to competency, experts qualified to inform us about the way doctors’ behaviors lead to the establishment of professional standards, and experts who understand the relationships between dentists and patients. We wanted to learn from those who have studied doctors’ relationships among their colleagues as well as doctors’ relationships with others in the general commercial world.

Although dentistry has had an historic association with medicine, the fledgling dental graduate does not take the Hippocratic Oath. Some believe that this single factor—the absence of a formal acceptance of the tenants of the Hippocratic Oath—has led dentists to establish their own professional standards—separate from physicians—and more attuned to their own needs.

Why do dentists not take the Oath? It is for reasons of history. When the surgeons separated from the physicians several centuries ago, the physicians held on to the Oath. The dentists were counted among the barber-surgeons, and later, when the surgeons reunited with their physician brethren, the dentists were not included. By the 18th and early-19th centuries, dentists had developed their own educational and practice mores. The leaders of the newly-established dental “profession” recognized a need for their own set of ethical imperatives to separate themselves from the charlatans still functioning as dentists in the public arena.
In those early years, dental practice ethics were similar to those common to all other businesses. A reading of the early dental ethical codes shows that they spoke to matters of fees, of fairness, of access to the profession, of competition, and of self-policing. Recently, dental ethicists have turned their attention toward studying the influence of dental insurance on the practice of dentistry, and toward the increasing influence of corporations upon research and teaching in the profession through patterns of financial sponsorship.

Today’s ethicists are concerned about what they see as a dependency of the institutions of learning upon the largess of commercial enterprises. The list of ethical issues confronting dentistry today is long indeed—much longer and more complicated than ever.

To address these concerns, the Academy invited a diverse and distinguished faculty from academia, dentistry, and law. Our eight speakers included experts in philosophy and psychology, dental research and practice, social medicine and the humanities as well as authorities in the history of science, dentistry, and medicine. You will find their individual remarks and the contents of the panel discussions in the following pages.

The scholarship of our colloquium faculty has contributed mightily to our understanding of the place of ethics in dentistry today and in the future. It is our hope that this publication will become a catalyst, stimulating deeper study of dental ethics, which is, after all, most basic to the dental profession and to our individual professional lives.
The Sins of Specialists

Albert R. Jonsen, PhD, Professor Emeritus of Ethics in Medicine, School of Medicine, University of Washington

A lecture presented on September 30, 2007, at the 56th annual meeting of the American Academy of the History of Dentistry held in San Francisco, California.

Abstract

In medieval times, moralists compiled lists of sins that certain types of persons, such as clerics, lawyers, kings and physicians, were prone to commit. These persons were set aside from the ordinary crowd by their special duties, skills and knowledge. Today, we might call them “specialists” or “professionals.” These sins reflected failures to attain the ideals that the specialists were held to. Among the most common sins were actions that took advantage of those who depended upon the specialist’s ability to respond to calls for help. While the lists of sins did not include dentists, who did not exist as specialists at that time, this lecture will pursue the theme of the medieval moralists into the time when dentistry emerges as a specialty form of care. In essence, it asks how professional ethics protects patients or clients from exploitation.

I am honored to appear before you, since I am neither a dentist nor a historian. I am a medical ethicist with a patina of medical history. I would not presume to tell you anything about dental history. I will presume to link the history of dental ethics, the subject of this conference, to the history of medical ethics, and to the history of ethics itself.

Here is where I intend to go. I will stroll casually through the history of medical ethics with a stop at one particular point: the renaissance teaching about the sins of specialists. I will then dwell on a couple of concepts in ethics, particularly self-interest and altruism, and then finally draw these wanderings together with the little that I know about the history of dental ethics.

The term “medical ethics” dates only from 1804, when an English physician, Thomas Percival, published his book of that title. It was, for its time, and remains, a remarkable book. Intended to resolve a
major dispute between the medical and the surgical staff of Manchester Infirmary, it delved into the scholarly
moral philosophy of the time, and blended it with what
has been called “medical etiquette” (which we will hear
about later in this conference) as well as much sage
advice about practice. It was a book, said Percival, for
“the gentleman physician...who must unite tenderness
with steadiness, and condescension with authority, as to
inspire the minds of their patients with gratitude,
respect and confidence.”1 Percival’s Medical Ethics
achieved wide popularity among the nascent medical
profession. Indeed, it served as the model, in places
verbatim, for the first Code of Medical Ethics of the
American Medical Association, formulated at its first
national convention in 1847.

Although the term “medical ethics” is an invention
of the 19th century, the history of western medicine is
saturated with what we would describe today as ethical
concepts and imperatives. The earliest known example
is the phrase, “Bring Benefit and Do No Harm.” The
phrase appears in one of the Hippocratic writings,
dated from the 4th century BCE, entitled Epidemics. It
is inserted, with no warning or explanation, in a clinical
description of bodily fluxes. It appears in a nobler form
in the Oath, called Hippocratic but certainly not
authored by the great physician of Kos. Amidst a variety
of specific injunctions against giving poisons and
delecit to aid in abortion, as well as the odd prohi-
bition against “using the knife to cut for the gall
stone,” the Oath states, “I will use treatment to help
the sick according to my ability and judgment and
never do them harm or injustice.” A few lines later, we
find similar words, “Into whatever house I enter, I will
enter to help the sick, and I will abstain from all inten-
tional injustice and harm.”

The Oath, whatever its origins, is a quintessential
statement of moral or ethical commitment in Greek
culture. Oaths were uttered in solemn circumstances,
taken most seriously, and non-compliance was punished
by the gods with earthly misfortune. The framing of the
duties of Greek doctors within an oath was a sign that
some practitioners saw their work as of great ethical
moment. Many other duties are sprinkled through the
Hippocratic writings but nothing is so centrally or
cogently stated as the obligation to benefit the sick and
do them no harm.

The early Christian church as well as Talmudic
and Islamic scholars produced many reflections on
the duties of doctors, seen now as obligations
imposed by divine law. The parallels between these
reflections are remarkable. The duty of benefiting the
patient remains central but a new notion is added to
the Greek ethic: namely, the duty of care for the poor
without recompense.

During the Renaissance, a form of Catholic literature
appeared which catalogued the sins to which persons in
various stations of life are particularly tempted. The
duties of kings and princes, of soldiers and tax gatherers,
are specified in detail. One set of this literature deals
with what we would today describe as the professions:
physicians, lawyers and notaries. One such text, entitled
The Sinning Physician, lists 23 sins commonly committed
by physicians: practicing without sufficient learning,
failing to entrust themselves and their patients to divine
providence, charging the poor and overcharging the
rich, prolonging treatment only for personal gain, aban-
doning a patient, fleeing the city in time of plague, dam-
aging the reputation of a colleague, revealing the secrets
of patients and, finally, treating a patient and prescribing
medicine when the physician is drunk.

These compilations of sins are more than just an
historical curiosity. The notion of sin is central to the
ethical worlds of Christianity, Judaism, and Islam.
Although each of these has its own rich interpretation
of the concept, the common notion is offense against
the law of God. Now, it is obvious that the list above is
not a segment of the Ten Commandments or a direct
clipping from the New Testament, the Talmud, or the
Koran. However, it was, in the minds of the Catholic
thelogians at least, a direct implication of a clear
imperative of the divine law.

They discussed the duties of physicians under the
heading of the Fifth Commandment: Thou Shalt Not
Kill. Their rationale was not just the obvious fact that
doctors were dangerous and those who sought their
services were in peril of their life. Rather it was that the
fundamental idea behind that prohibition of killing
was injustice: it is forbidden to take, or put at risk, a life
over which one has no authority. Life is mine alone,
sayeth the Lord. The theologians weave their discus-
sion of medical duties around the principle of justice.
Thus, it is not just endangering your patient by your
ignorance or your inebriation. It is also extracting
money from those who are poor and cheating those
who are rich.2

This theological view has found something special
about the professions, which in the 15th century were
just coming into shape. The professions were titles with
power. But so was kingship and knighthood, were they
not? The professions differed from these roles because
they professed explicitly to help persons through partic-
ular crises and difficulties, whether physical or legal. It is
the profession of helpfulness that gives both power and
the potential for exploitation of those who seek help.
Anyone, then, who achieves the status of doctor is held
to a special virtue, the virtue of justice toward those who
seek their help. The sins of specialists are violations of
that trust or, as we now say, that fiduciary duty.
Let us turn from this sanctified world of religious ethics to the secular thought that succeeds it in the 18th century. During the Enlightenment, it became common for philosophers to assert that it was self-interest, and only self-interest, that drove human endeavor. It was, as those philosophers used to say, the spring of all action. The problem of ethics was, in this new conception, how to reconcile the inevitable drive of self-interest between the multiple actors who, without some accord, would simply destroy themselves in the words of one of the most famous of those philosophers, in a world “nasty, brutish and short.” The concept of “enlightened self-interest” appeared: the recognition that when each pursued his own interests, he must recognize that failure to appreciate and account for the interests of others, would lead to defeat and self-destruction. The great proponent of this view was Jeremy Bentham who propagated as the fundamental rule of ethics that each person must act so as to maximize the greater good for the greater number.

Medical ethics as we now know it matured in that intellectual climate. Percival wrote his Medical Ethics in the years when Bentham held sway as the premier intellectual of England. At the same time, many other British authors proposed penetrating analyses of the moral life that differed from Bentham. Percival knew these writers, some of them personally. It is impossible here to trace all the intellectual and social forces that combined to create the professional ethics that we now see in those odd documents, the Codes of the American Medical Association and the American Dental Association.

However, it can be shown that, at least in 19th century America, the desire of some physicians and surgeons to win the trust of the public was a major motivation. In those years, the local doctor was often a real example of the sinning physician: he was poorly educated, grubbing and gouging fees, and not uncommonly a drunk. The public had little confidence in their services. By the 1830s most states had revoked all licensure laws because it was obvious that none of the many medical sects had anything to offer. It was the hope of the organizers of the American Medical Association, most of whom were educated abroad, that it was essential to gain public trust, and the trust of patients, if they and any other doctor who hung out a shingle, could make a living. Thus, their first act was to write a Code of Ethics, drawing, as I said, largely on Percival.

The Code’s creators were not philosophers, nor did they write a philosophical document. Still, they wove the medieval ideas of moral obligation and the modern ideas of self-interest together in an intriguing way. One of the principal authors, Dr. John Bell, wrote a preface in which he stated that “all the physician’s skills and talents are held in trust for the public good.” The Code began with a strong moral affirmation: “a physician should be ever ready to obey the calls of the sick.” Competence, compassion and confidentiality are key duties. Interestingly, consultation in difficult cases is imposed as a duty, a clear attempt to dispel the public perception that a doctor would keep his grasp on a hard won patient at all costs. Physicians should be gentlemen with “purity of character and high moral standards.”

The ideal of the gentleman physician or the gentleman dentist is clearly a social construct, dependant on cultural ideals and values of the era. In Georgian England, “gentleman” was clearly a person from a certain rather elevated socioeconomic status, not necessarily of the peerage but close to it. There was, at that time, a slow emergence of persons from “underclass” to a newly appearing “middle class,” from peasant to gentility. Accompanying this social emergence was a definite panoply of manners, forms of behavior to others from one’s own class, from superior classes and to lower classes. Jane Austin is filled with rich descriptions of these manners. George Eliot’s Middlemarch, in which the emerging gentle profession of medicine plays so large a role, is a veritable encyclopedia. These manners, exemplified in ways of speaking, demeanor, dress, was properly designated by the newly coined French word, “etiquette.”

However, at the same time, a literature was appearing in moral philosophy which attempted to define the ethical qualities of the morally upright person. Significant writers such as David Hume, Francis Hutcheson, Adam Smith, and the lesser known Thomas Gisborne, who was a personal friend of Dr. Percival, were attempting to define the moral virtues and sentiments whereby character could be judged as morally good or bad, and actions morally right or wrong. The distinguished Edinburgh physician, John Gregory, who lectured on medical ethics in the decade before Percival, was deeply engaged in these moral philosophy debates. Coincidently, many characteristics of manners or etiquette, and many of the moral virtues and sentiments carried similar names: gentleness, compassion, dignity, humility, fortitude, patience. For the moral philosophers, these qualities were not simply external behaviors; they were, or should be, reflections of an inner rectitude, a manifestation of moral principle. They understood that manners, as personal presentation, could make a moral reprobate acceptable. They realized that hypocrisy demands external etiquette to be an effective ruse. Thus, they strove to analyze the moral duties of humans in ways that required external behaviors be matched with internal intentions and formed moral character.
This British scene of social rank and its decorum is the original setting of modern medical ethics. In egalitarian America, another scene was unfolding. As I mentioned above, American doctors of the early 19th century had, in general, a dismal reputation. Most were apprentice trained, at best; very few had a collegiate education. Not only ignorant, they were often itinerant, unknown to those they treated or, if settled, practitioners of many trades in addition to medicine. Their medicines were poorly compounded and their fees extortionate. The small coterie of educated elite wished to raise the profession from this ignominy. Education and ethics were their levers. The gentleman image was an American one: a competent, self-disciplined, responsible, and religious man. However, the creators of the first Code knew as well as Dr. Perceval did, that men could easily fake these characteristics. The framers of the AMA Code subtly modified Percival’s exhortations into an American framework of rights and duties, of a tacit contract between doctors and their patients, and an envisioned goal of public welfare.

One of those framers, Dr. Austin Flint, explicitly distinguished between “the principles of duty applied to medicine [that are] a distinct branch of ethical science...with distinct moral weight.” He recognized that these moral principles were distinguished from the formalities of professional intercourse properly called etiquette, without the binding force of moral duty. Then he states that a Code made up of both ethics and etiquette “contributes to the purity and dignity of the medical profession...and are far more important to the public than to the physicians.” It was important, he thought, that doctors clearly know when their behavior was bound by moral principle and when it was a matter of convention, open to change in different circumstances. In short, the American doctor, as viewed by those who wished to elevate the profession and make its practice more dignified and, of course, more profitable, was a man both of rigorous moral character, with a sense of duties, rules and responsibilities, and a man of prudent discretion, able to adjust practices to meet the needs of patients and the public.

While some elements of all codes are quite clearly moral in tone—the first Dental Code, for example, states, “as patients are unable to correctly estimate the character of his (the dentists) operations, his own sense of right must guarantee faithfulness in their performance.” Many other provisions mix ethics and etiquette—Article 2 of the first Code states, “the dentist should avoid everything in language and conduct calculated to discredit or dishonor his profession... The young should show special respect to their seniors.” Is this ethics or etiquette? Given this coincidence of etiquette and ethics in the culture and in the philosophy of the time, it is not easy to place certain of the demands of medical ethics into the category of etiquette and others into ethics. Percival dedicated his book, Medical Ethics, to his son, a medical student at Edinburgh. The preface reveals how thoroughly Percival linked ethics to manners. “My dear son, it is the characteristic of a wise man to act on determinate principles; and of a good man to be assured that they are conformable to rectitude and virtue. The relations in which a physician stands to his patients, to his brethren, and to the public are complicated and multifarious, involving much knowledge of human nature and extensive moral duties. The study of professional ethics, therefore, cannot fail to invigorate and enlarge your understanding; while the observance of the duties they enjoin will soften your manners, expand your affections, and form you to that propriety and dignity of conduct which are essential to the character of a gentleman.”

In Percival’s own book, there are many examples of what we would call “etiquette.” For example, “in consultations on mixed cases (physicians and surgeons), the junior surgeon should deliver his opinion first and his brethren afterwards in succession, according to progressive seniority. The junior physician should then deliver his opinion and afterward the other physicians in the order prescribed.” Modern codes of medical and dental ethics are filled with similar etiquettes. They detail the ways in which practitioners should respect each other, acknowledge others’ professional capacities, report each other’s derelictions, consult and transfer, but not steal, each others patients, and so forth. However, just as in Percival’s day, these etiquettes often have a properly moral root: the benefit of the patient, fairness among practitioners, and justice in the health care system. Even when these moral roots are not obvious, it is sometimes necessary to dig down to them. The question of conflict of interest, of which Dr. Newbrun will speak and the problems of commercialism which Dr. Baumrind will discuss, may appear to be etiquette on the surface but ethical in their roots. It is for this reason that the compilations called Codes of Medical or Dental Ethics are never the last word in professional morality. A sound and deep understanding of the moral responsibilities of those entrusted with the health of others is essential.

The dental profession, as you well know, had several origins, the rough world of the toothpullers, the world of the barber surgeons, and the world of physicians who might dabble in teeth. The specialty of dentistry emerges, as you also know, as the barber surgeons evolve into surgeons and as physicians recognize that special skills are needed to deal with dental disease. This is taking place, in the United States, at the
same time that the medical profession is forming, and some of the same social problems that faced medicine in general also face the emerging dental profession.

I know little about the origins of the Code of Dental Ethics. (Interestingly, Dr. Milton Asbell’s *Dentistry: A Historical Perspective*, says almost nothing about it). Certainly, the early associations of dental practitioners came together in the same social circumstances as the American Medical Association: they were concerned to educate practitioners and to encourage the trust of the public. When the ADA issued the first Code of Dental Ethics in 1866, it echoed many of the same concerns. Indeed, its first words are an echo of the opening of the AMA Code, “The dentist should be ever ready to respond to the wants of his patients and should fully recognize the obligations involved in the discharge of his duties toward them.” Article II reflects the Percivillian ideal: “The person and office arrangements of the dentist should indicate that he is a gentleman; and he should sustain a high-toned moral character.”

Since we meet in San Francisco, we might recall Frank Norris’s 1899 novel, *McTeague: A Story of San Francisco*. McTeague was just the sort of dentist that the ADA was hoping to drive out of practice. Frank Norris describes him as learning his dental skills, more or less, from a charlatan itinerant Gold Country dentist. McTeague, says his creator, “had read some of the necessary books but was too hopelessly stupid to get much benefit from them…. His mind was as his body, heavy, slow to act, sluggish…. He suggested a draught horse, immensely strong, stupid, docile, obedient.” In the end, a drunk and a murderer, moved by greed. Hardly a gentleman of high-toned moral character.

Both the AMA Code and the ADA Code have gone through many revisions. While both have been cleansed of “high-toned” moral exhortations, they insist on behaviors and attitudes that, in the opening words of the current ADA Code, “protect the patient from harm…by keeping knowledge and skills current (and) knowing one’s own limitations.”

A detailed examination of the evolution of the ADA Code and a comparison with its AMA analogue would be interesting. However, I wish to leave you with one observation about ethics and codes. As I mentioned above, the early formulations of ethical and moral obligations of healers were pervaded with a sense of the link between human choices and divine law. The healer offends God when he brings to his patients, as the Hippocratic Oath says, “any harm or injustice.” The sin of exploitation, using special power and skills to benefit oneself at the expense of the one who has sought the benefits of your power and skills, is a violation of divine law and a disgrace to human dignity. This antique view of professional ethics calls on the practitioner to have a high degree of personal moral integrity, to have a conscience attuned to the needs and vulnerability of the other, one’s patient, to be willing to undertake risks and even losses to provide the needed help. These moral qualities are, indeed, the very shape of the person, the practitioner.

A more modern interpretation of morality, as a pursuit of the greater good of the greater number of persons, is much more a strategy of life than a shape of the person. It derives primarily from the motions of self-interest toward self-satisfaction and then modifies those motions in the light of an assessment that, in fact, a certain action may backfire and damage one’s self-interest. Thus, it is useful (hence the name ‘utilitarianism’) to take account of the interests of others. This enlightened self-interest, although far from the virtue of compassion, is at least a tenuous moral basis for principles of professional practice.

When it comes to professional ethics, a code or an oath or a contract may be written in terms that mimic the virtues of the first sort of ethics but that disguise the self-interest of the second. Indeed, no code of ethics that I know asserts self-interest as its basis. However, a code can serve as a sort of elegant ethical advertising, promising the benefits that may not be in the hearts of the purveyors of those goods. The actual history of professional ethics reveal a constant tendency to find ways to reduce the costs of being a proper utilitarian, that is, the personal costs incurred by modifying one’s behavior to benefit the greater good of the greater number. It is always possible to define that good in ways that make its practice less onerous, and to define the greater number as the group to which one belongs. Forms of practice are being constantly devised that can profit their creators and deceive the public that they are not being harmed thereby.

When we reflect on modern professional ethics, with its indistinct mixture of moral principles and etiquette, it might be helpful to recall from the vague past, the sins of specialists. Our professional ethic can so easily be transformed into a disguise or an excuse for self-interest. Our ethics can be but a public relations term for professional dominance over patients and policy. Our ethics can be little more than a polite demeanor toward clients. Professional ethics must hold a more serious place in professional life: it must have some of the seriousness that the idea of sin had to the practitioners of antiquity, namely, principles and values that, when violated or ignored, mark a person as unworthy and deserving of disdain.

In other words, professional ethics has a high pressure conflict built into it: it pulls ethical practitioners toward an altruism that is noble and demanding, and it pulls them toward a self-serving definition of their
duties. We have no intellectual solution to this dilemma. We do have consciences.

I conclude with words of the man called the founder of modern dentistry: Pierre Fauchard, the eighteenth century French surgeon-dentist. Dr. Asbell says of him, “No individual has exerted a stronger influence on the development of the profession than he did; in fact he is referred to as the ‘founder of modern dentistry.’ He created order out of chaos, developed a profession out of a craft, and gave to this new branch of medicine a scientific and sound basis for the future.” He also states clearly and strongly, the essence of a professional ethic for a healer.

“I SHALL NOT UNDERTAKE ANYTHING WHICH MIGHT PREJUDICE THE HEALTH OF THE PATIENT OR THE REPUTE OF THE ART.”

References
1. Percival, T. Medical Ethics, ed. Leake, C. 1803; Williams and Wilkins, 1927, I, i, p.71.
5. Percival, p. 63.
Professional Ethics and Professional Etiquette in Dentistry: Are They Compatible?

Ernest Newbrun, DMD, PhD, Professor Emeritus, University of California-San Francisco, School of Dentistry

Abstract

In keeping with the theme of this colloquium, two aspects of ethics in dentistry are addressed: its evolution and its future. With respect to its evolution, two examples of changes in the design of clinical trials in dentistry are discussed. These concern the current requirement of informed consent from the subjects in the trial, now taken for granted, but not necessarily observed before 1964. The Vipeholm dental caries study is one example of pre-Helsinki Declaration experimentation. The second example, also drawn from caries research design, concerns the stricture on the use of placebo-controlled trials in the face of a proven drug. For example, the design of clinical trials of fluoride dentifrices has evolved since the mid 1970s. The use of a placebo-inactive control group is no longer acceptable as it would deprive its subjects of a proven caries-preventive agent and would expose its subjects to increased caries risk.

While definitions of professional ethics in dentistry may vary, the ADA Code of Ethics includes five principles: patient autonomy (“self-governance”), non-maleficence (“do no harm”), beneficence (“do good”), justice (“fairness”) and veracity (“truthfulness”). Professional etiquette refers to the way dentists relate to one another and is governed by the ADA Code of Professional Conduct which expresses specific types of conduct that are either required or prohibited. Sometimes, ethics and etiquette may conflict. The problem of financial issues that conflict with ethical ones is discussed along with the problem of commercialism in the practice of dentistry. Debts from
Introduction

Let me start by thanking Dr. Morton Rivo for inviting me to participate in this colloquium with so many distinguished colleagues. My only regret is that a previous commitment to lecture in Japan prevents me from attending tomorrow’s lectures. I am honored to address the American Academy of the History of Dentistry though I am neither a historian nor an ethicist of dentistry, but throughout my academic career I have always had a strong interest in both these fields. I have been a member of the dental profession for more than fifty years, 53 to be exact, which I suppose entitles me to some historical perspective at least in my own area of dental research of oral biology, namely cariology and periodontology. I have come to realize that ethical standards and behavior in dentistry have changed during my time in the profession, as would be expected. Nothing is immutable. In my paper, I will make two points, namely 1.) that ethical standards in dentistry are evolving and will continue to do so, and 2.) that a potential conflict exists between professional ethics and professional etiquette that needs to be resolved.

Evolution of Ethical Standards

Two significant examples of this change in attitude regarding ethical conduct of dental research using human subjects come to mind immediately. The first is the Vipeholm study conducted at a mental institution in southern Sweden (Fig. 1), the results of which were published in 1954,1 the same year that I graduated from dental school. The Swedish Government had agreed to an investigation of the measures that should be taken to decrease the frequency of the most common dental diseases in Sweden. The purpose of the study, extending over five years, was to determine the effects of various modifications of carbohydrate intake on the development of caries. Since the subjects were in different wards it was possible to test not only different foods and beverages but also to control the frequency of ingestion. Sucrose was included in the diet in toffee, chocolate, caramel, bread, or liquid form. Caries increased significantly when sucrose-containing foods were ingested between meals. In addition, not only the frequency but also the form in which sucrose was ingested was important. Sticky or adhesive forms of sucrose-containing foods were more cariogenic than forms that were rapidly cleared. This study was a landmark in caries research, in that it showed under controlled conditions what had been observed empirically but not proven, concerning the role of diet in the caries process. Of course this study has since come under criticism from an ethical viewpoint,2,3 in that no informed consent (inform before you perform, this assumes the subject is of sound mind) was obtained from the subjects. Few if any of the subjects objected to receiving candies or chocolate between meals. In no way should the Vipeholm study be compared with the notorious Tuskegee Syphilis Study, none of the subjects’ lives at Vipeholm were at risk. Furthermore, because subjects were under careful dental observation, fewer teeth needed to be extracted than in the general population,
who at that time were experiencing very high decay rates. Remember that this was before widespread use of fluoride-containing dentifrices, fluoride mouth-rinses, or office applications of topical fluorides. So when contemporary ethicists condemn this study, through the benefit of that wonderful instrument, the “retrospectroscope,” applying current standards of the Helsinki Declaration of 1964 and subsequent amendments concerning use of human subjects, they fail to bring a historical perspective to the issue. Krasse, one of the original investigators in this study, wrote that at that time none of the dentists saw any ethical problems with the study as many of the cavities that developed were limited to early enamel lesions and concludes that the end justified the means.⁴ Fiske, in an editorial in the *British Dental Journal,* qualifies that idea by stating: “the end only justifies the means provided individuals’ well-being is not put at risk.” She cites the Vipeholm study as an example of evolving ethics: “Ethical practice poses an interesting concept as ethics change over time with increased knowledge and shifting cultural values.”⁵

A watershed in attitude about the use of human subjects for research occurred between pre-World War II and post-World War II with the Nuremberg Code of 1946 following the prosecution of Nazi physicians for war crimes.⁶ A consensus developed that human experimentation was permissible only if it benefited the patient. But the problem remained, should anyone incapable of consent (children or mentally disabled) ever be a research subject, even if the harm is minimal and there is a prospective benefit?⁷

Mention of fluoride-containing dentifrices brings me to the second example of how standards for the conduct of clinical trials have changed during my professional career. For historians in the audience, I found online a 1952 photograph of very young Joe Muhler handing out samples of fluoride toothpaste before they were ever available over-the-counter. Muhler, working together with the Proctor and Gamble Company, developed the earliest stannous fluoride-formulated dentifrice, Crest, from which came the famous slogan: “Look Ma, no cavities!” (Fig. 2). Throughout the late 1950s and 1960s, when a trial of fluoride-containing dentifrices was being conducted, the accepted protocol was to compare caries increments in schoolchildren using the test product with another group using a similarly formulated dentifrice without fluoride.⁸ (Fig. 3) Of course such studies required parental consent and allowed for non-participation; no force, deceit, duress, or other form of constraint or coercion could be exerted on study subjects. Obtaining informed consent for studies of children, the mentally infirm, and persons with restricted civil freedom presents special problems. Some studies involved supervised use of the product; most did not. This was the *modus operandi* whether testing Crest, Colgate or any other brand product, whether the study was industrially-sponsored or conducted by NIH-funded investigators.

However, by the 1970s, it had become evident that fluoride-containing dentifrices reduced decay rates. In the USA in 1967 fluoride-containing dentifrices had captured about 50% of the market and by 1975 almost

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**Early Clinical Trials to Study Fluoride-Containing Dentifrices**

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**Fig. 3**—Experimental design of early clinical trials of fluoride-containing dentifrices
80% of the dentifrice-sales were of fluoride-containing products. (Fig. 5) Accordingly, to use a placebo or untreated group for study would deprive its subjects of a proven caries-preventive agent that was by then being used by most consumers, and would expose its subjects to increased caries risk. Such experimental design became unethical and would no longer pass muster with human experimentation committees.9 Instead, now a test fluoride-containing dentifrice is compared to a previously proven caries preventive product, a so-called “active” control (Fig. 4). The Helsinki Declaration now strictly forbids placebo-controlled trials in the face of a proven drug; but the NIH and FDA require placebos; ethicists are, as usual, divided.

FDA requirements may differ entirely from what actually occurs in clinical trials. The FDA audits fewer than one percent of testing sites and most of its inspections focus on the accuracy of study information rather than the protection of human subjects, according to a recent report of the inspector general of the Department of Health and Human Services.10 It is interesting, in view of this colloquium’s topic, that the report cites a
Ethics and Etiquette in Dentistry: Are They Compatible?

In my initial search of ethics, Google revealed more than 1,220,000 citations, but no clear definition. Perhaps it is like the definition of pornography by Supreme Court Justice Potter Stewart who said he could not define it, but he knows it when he sees it. For those who are more comfortable with a dictionary definition, ethics (from the Greek *ethikos*) is the science of morality, being able to distinguish right from wrong and to make decisions based on that knowledge. Ethics is the branch of philosophy that explores value-laden decision-making and conduct. There exists a long tradition of medical ethics, going back to Hippocrates and Maimonides, that focuses on the responsibility of the physician or healthcare provider to the patient. Bioethics, a neologism from the 1960s, refers to reflection on the social implications of medicine and science and has been defined as "the systematic study of moral dimensions—including moral vision, decisions, conduct and policies, of life sciences and healthcare, employing a variety of ethical methodologies in an interdisciplinary setting." Many dental organizations include ethics of dentistry in their mission statement. The definition of professional ethics in dentistry may vary but the ADA Code of Ethics includes five principles: patient autonomy ("self-governance"), nonmaleficence ("do no harm"), beneficence ("do good"), justice ("fairness") and veracity ("truthfulness"). Professional etiquette concerns how dentists relate to one another and is governed by the ADA Code of Professional Conduct, which is an expression of specific types of conduct that are either required or prohibited. In discussing the potential conflict between ethics and etiquette, some issues are unique to dentistry; others apply to all healthcare providers. Many years ago Chauncey Leake, an "elder statesman of medical ethics," noted that medical ethics was confused with medical etiquette based on Greek tradition of good taste and developed in the profession to regulate the professional contacts of its members with each other. Leake distinguished between ethics and etiquette, believing that ethics must be concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society.

Financial interests may conflict with ethical ones. The problem of debts from dental school and residency programs may adversely affect the professional behavior of young dentists, or simply the greed of older dentists, and promote commercialism. Specialists are providing all sorts of "goodies" for general dentists who refer patients to them including: continuing education courses, gifts, trips and kickbacks. Many manufacturers are providing services to the profession and individuals that range from free dinners to hear lectures to fully paid vacations at resorts to attend continuing education courses promoting their products. Such inducements create a clear conflict of interest.

Let us consider a couple of case examples that could create a conflict between ethics and etiquette.

Case #1: A patient who has been treated for many years by a general practitioner notices that some of his teeth are loose and decides to seek a periodontal consultation (self-referral). The periodontist after taking radiographs and recording probing depths, attachment levels, bleeding sites, tooth mobility and so on makes a diagnosis of advanced chronic periodontitis associated with extensive subgingival calculus and plaque deposits. From the patient’s history it is evident that, although he has been seen on a regular basis for dental check-ups, there was never any oral hygiene instruction, never any diagnosis of periodontal disease or mention of the need for referral. What is the periodontist’s ethical duty with respect to veracity? If he tells the patient honestly that he has had this condition for many years and it could have or should have been diagnosed sooner, when some of his teeth could have been saved from extraction, will he risk losing referrals from this and other general practitioners? Will the ADA condemn him for lack of professional etiquette?

Case #2: A periodontist, in performing a connective tissue graft, severs the palatal artery and for the time being stops the bleeding by soft tissue suturing. The patient has repeated episodes of bleeding, goes back to the periodontist who temporizes in stopping the bleeding, the patient again hemorrhages, cannot reach the periodontist, goes to a hospital emergency room where again he only obtains transient control of the bleeding. Finally in desperation he goes to an oral surgeon who performs a cut down and ties off the severed artery. What should the oral surgeon reveal to this patient? What is his ethical duty with respect to truthfulness versus his professional etiquette? Will the periodontist stop referring all those lucrative third molar extraction patients to him?

These two hypothetical cases are not just about differences of opinion about a treatment plan, rather I have raised the issue that the ADA seems to skirt around in its Code of Ethics. Under "Justifiable criticism" (see Item 4.C. 2005), it refers only to cases that have been reported to an "appropriate reviewing agency" but does not consider the problem of continually faulty treatment of which the patient is unaware. In fact it states that:
“Patients should be informed of their present oral health status without disparaging comments about prior services (emphasis added).” It goes on to define the meaning of “Justifiable criticism” (see 4. C. 1 2005) “…the dentist should exercise care that the comments made are truthful, informed and justifiable. This may involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment.”

The Code is more concerned about “the discretion of dentists” and advises against “unknowing or unjustifiable disparaging statements against another dentist,” rather than the need for full disclosure and veracity to the patient. In fact it goes on to warn that: “where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.” But what about situations when such criticism is justified? Should not the patient’s right to know take precedence over professional etiquette?

The answer in contemporary bioethics is unequivocally yes. I raise this issue of potential conflict/incompatibility between ethics and etiquette in dentistry not because I have any simple solution. We live in a capitalist society where financial motives can compromise professional behavior; however in order to resolve the problem, we must face some of these conflicts of interest. More than 20 years ago, Nash wrote: “The profession of dentistry is not as rigorous in regulation of itself as necessary, with resultant assumption of increasing degrees of government by society.” Considerable attention to conflicts of interest has been given in bioethical literature and a significant regulatory effort has been initiated in the regulations of NIH, FDA, and NSA.

Finally, from a historical perspective, this problem of conflict of interest among health professionals has been around for a very, very long time. Geoffrey Chaucer alluded to it in the prologue to his Canterbury Tales circa 1387, when he described a doctor/physician, and his apothecaries:

He was a really fine practitioner. Knowing the cause and having found its root, He’d soon give the sick man an antidote. Ever at hand he had apothecaries To send him syrups, drugs, and remedies, For each man put money in the other’s pocket— Theirs was no newly founded partnership. (emphasis added)

Unfortunately the situation has not changed much in the interim.

Summary

We have discussed two ethical issues in dentistry. First, using examples from the design of clinical trials in caries research, we have shown how standards have evolved with time and with advances in scientific knowledge. Formerly acceptable protocols are no longer ethically valid. Second, we have discussed the potential conflict that exists between professional ethics and professional etiquette, one which the ADA Code of Ethics appears to gloss over in favor of “professional conduct.” This does not resolve the issue that will continue to present a challenge for ethics in dentistry.

Acknowledgement

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References

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What Have Teeth Taught Us about Culture? Practice, Patiencethood and Ethics in the History of Dentistry and Public Health

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Abstract

Teeth cut across cultures. They transgress cultural boundaries but also define social boundaries. They provide information about what goes into the mouth, and what the mouth is appropriately used for. Scrutiny of teeth identified a new biomedical space to analyze pain, and created a new culture of medicine for such practices. This paper uses the evolution of dentistry since the 18th century to look at how our social and scientific understanding of teeth has shaped cultural attitudes about pain, politics, beauty and prophylaxis. It then raises questions about how these attitudes in turn create ethical contexts for the practice of dentistry around the world.

Introduction

This paper sketches the history of the creation of the professional identity of the dentist. It shows how, in the 18th century, the profession fashioned itself after the image of science in order to shed its associations with quackery and align itself with the prestige of natural philosophical inquiry. In the process, the mouth became recognized as a new site for specialized attention, and its medical management was linked to the health of populations. The move from a patient-centered philosophy of treatment to a population-based approach to oral hygiene—represented in 19th- and early-20th-century dental public health movements—formed a new ethical core to the profession’s identity. This paper concludes by suggesting that the practical shortcomings of such movements, hindered as they were by political and commercial interests, did not signal the disappearance of this ethical core, but rather a re-transformation of a professional ideology toward the promotion of global health.

The Birth of Modern Dentistry

A good place to start our historical reflections is the moment often identified as the birth of modern dentistry. This takes us to 18th century Paris, where the surgeon Pierre Fauchard published a three volume treatise that introduced the very term “dentist”: Le Chirurgien-dentiste, ou Traité des dents (1728). It was a timely moment. French medical academies were pioneering a scientific approach to the study of medicine and pathophysiology. And with regard to oral health—at this time more than ever—people’s mouths were begging for
attention, so to speak. The consumption of sugar, coffee and chocolate helped contribute to a new disease ecology, as did the administration of mercury-based treatments for the “new world” disease, syphilis, that further damaged the teeth and gums.

Historians of science and medicine such as Roger King, Colin Jones, and Christine Hillman have pointed out that one important consequence of Fauchard’s work was the redefinition of the culture of dentition. That is to say, by giving the practitioner a new name—the dentist—and writing a multi-volume work that spelled out the anatomical as well as prescriptive treatments for practicing dentistry, Fauchard helped to professionalize the discipline. As one historian put it, “A scientific culture of mouth care, circulating in print, was establishing itself on a terrain formerly within the realm of custom and oral tradition.” What was once a secretive craft, passed on to apprentices through word of mouth (it is hard to avoid the pun), was now manifest as a science inscribed in the pages of a learned book ostensibly available to any literate person. This was characteristic of the processes of legitimizing science in the Age of Enlightenment: to circulate its tenets and procedures through print with both textual descriptions and copious illustrations.

Practical textbooks became an important feature of the educational landscape at this time. Treatises by Joseph Hurlock, A Practical Treatise upon Dentition (London, 1742), Thomas Berdmore, A Treatise on the Disorders and Deformities of the Teeth and Gums (London, 1768), and John Hunter, The Natural History of the Human Teeth (London, 1771) and A Practical Treatise on the Diseases of the Teeth (London, 1778), provided the most exact and precise descriptions of the proper treatment of irregularities of the teeth. Lectures on dentition and the oral cavity were included in anatomical and surgical lectures given to medical students in the late 18th century, but formal lectures on dentition were first developed by Joseph Fox at Guy’s Hospital in London that started in 1803 and continued until his death in 1816. With a canon established and instruction provided, an appropriate intervention on an individual’s oral health was now linked to a learned, literary and cosmopolitan culture in contrast to earlier associations with traveling quacks and mystical healers.

So what was special about the creation of the specialty of the dentist? The emergence of a new professional identity did not immediately revolutionize the practice of dentistry. However, practitioners now had a better understanding of facial anatomy; they developed new theories (not necessarily new therapies) about the causes of tooth decay, in part shifting from the idea that it started as an internal inflammation of the pulp and worked its way out to investigating external acids that worked upon the teeth. By the late 19th century, this had worked its way into modern chemico-parasitic theories regarding bacterial effects on caries, pioneered by the American chemist-turned-dentist, Willoughby Miller, with his 1890 publication Microorganisms of the Human Mouth (Philadelphia, 1890). The turn toward a scientific dentistry in the 18th century also resulted in new dentures, particularly “incorruptible” ones made of porcelain such as those made by the famous Wedgwood pottery, manufacturers of fine jasper vases and tea cups. Procedures for the cosmetic correction to mal-aligned teeth were also pioneered in Britain by Joseph Fox. In addition to his position at Guy’s Hospital, he was vice-president of the Royal Jennerian Society, the institute for vaccination for the elimination of smallpox founded by his friend Edward Jenner, and a member of the Royal Institution, where Humphry Davy was professor of chemistry. Fox was part of the group of London chemists who in the early 1800s performed experiments on respiration that included breathing the new gas of nitrous oxide which, in a well-documented history, is later used as an anesthetic, first in dentistry. But Fox’s 1803 publication, Natural History of the Human Teeth, is considered the first scientific treatise on orthodontics, that was later developed by the distinguished American dentist Edward Hartley Angle, who at the end of the 19th century published his classification of malocclusions and went on to found the Angle School of Orthodontia in St. Louis.

There may not have been a therapeutic revolution in dentistry until long after the profession was established, just as there was none in medicine as a whole until the “laboratory revolution” at the end of the 19th century; but what I merely wish to point out is that the early identity of dentistry was aligned with the principles of scientific inquiry. It began to define the mouth as a more complex domain of investigation rather than just a home to bad teeth. Its practitioners started speaking a philosophico-medical language that was familiar to a fashionable, urban clientele. However, cosmopolitan culture in the 18th century was small. The majority of Europe’s population lived in the countryside. In the provinces, as Christine Hillam has shown in her study of dentistry outside of London in the mid-eighteenth to the mid-19th century, those who worked on teeth “emerged from the ranks of the watchmaker or goldsmith, others from the world of the hairdresser or patent medicine vendor. There was no one to give these enterprising men a proper training; they were self-taught or had picked up hints from the advertising leaflets of their rivals. Subsequent generations considered them very ignorant and so, of course, they were by later standards. Indeed, a dentist in 1877 commented...
that “In London, at the commencement of the century, there were not, I believe, a dozen Dentists … [while] in the provincial towns they had no existence.” He was being rather strict about the identity of the dentist, but it is notable that the problem of identity was compounded by the fact that there was no regulation of the practice of dentistry. In England, the General Medical Council did not establish a Dentists Registry until 1879, that was meant to restrict the practice of dentistry to graduates with a License in Dental Surgery issued by the Royal College of Surgeons. Few were prosecuted for illegal practice, however. It was not until the Dentists Act of 1921 that the situation changed.

But, referring back to the earlier period, if dentistry—one of the new scientifically-defined medical specialties of the 18th century—was essentially city-based and established its authority among the learned minority, what exactly did this mean for the contemporary concern over the oral health of the majority? The emergence of the dentist—a product of the rise of scientific medicine—tells us something about the culture that puts value in the languages of science. Patrons of science were elite, and paid handsomely to be informed (if also entertained, in the appropriate settings) about the secrets of nature unveiled through the experimental investigations of the “natural philosophers,” who in the 19th century would come to be called scientists. Their investment extended to medicine, where physicians were mainly paid to tell their patrician patients what they wanted to hear. The point is that as medicine and dentistry become more associated with science, they enter with science the privileged arena of credulous knowledge catered for the interests of the rich. Fauchard, who coined the word dentist, died a rich man owing, his biographers say, to his lucrative Parisian practice. However, the historian of medicine Colin Jones points out that a contemporary of Fauchard’s also died rich, despite falling into the category of a mountebank of the old regime, collecting fees for removing teeth while traveling the countryside. His argument is that we should not read scientific dentistry as an inevitable “triumph” over alternate forms of treatment. But Jones does not pursue the patients’ point of view. It may be, as I have already suggested above, that the new dentist was—at least throughout the 18th century—unable to do much beyond what quacks could do. So what cultural forces are at work to differentiate them? More importantly, how does this differentiation work to create different kinds of patients with different views about the practice of dentistry?

As in many areas of medicine, the creation of a new kind of medical practitioner summoned the corollary creation of a new category of patient. The new dentist of the 18th century distinguished himself from earlier tooth-drawers by emphasizing preventive therapy (advice on oral hygiene) rather than dexterous tooth extraction. But that information is of service only for the right kind of patient: those who could afford and follow the advice. The moment that dentistry was obtaining parity with other scientifically-informed professions was the moment that disparity was created among the patient population, at least in terms of which mouths became the object of scientific intervention. The way that toothache was treated depended both on who the practitioner was and who the patient was. The creation of these different cultural categories—the culture of the scientific dental practitioner and the culture of the rural, as opposed to the cosmopolitan, patient—moves beyond an historical narrative to engage with fundamental ethical questions about healthcare. I would like briefly to reflect on the fashioning of “the dentist” and “the patient” as a way of illustrating how these different cultural categories emerge and how they come to occupy different ethical worlds.

**Patienthood**

Specialization in medical practice is a thoroughly examined topic with contributions from economic history, medical sociology, and from professional practitioners themselves. But the emergence of the dentist as a specialized medical practitioner seems not to fit very neatly in conventional analyses. Dentition was not merely an outcome of the division of labor that inevitably branched off from increasing volumes of medical knowledge about the body, but was also concerned to create a product. That product was not just a healthy mouth, but a happy patient. In interesting ways, dentistry emerges as a medical specialty that simultaneously works to compartmentalize the body, to focus only on the mouth, while also transforming the social consciousness of the patient. In fact, some of the (albeit rudimentary) technologies of early dentition created the very category of the dental patient while opening the door for people to voluntarily become such patients.

Christine Hillam makes an interesting claim about 18th century demand for dental services. “Dental practice profited from (and contributed to) the increased fixation with self-image, for few medical or cosmetic procedures of the day could have such an evidently beneficial effect on self-presentation as dental treatment at a time when the acquisition of gentility assumed such importance.” Indeed, as an English traveler to France observed in 1783, “There are two objects of which French ladies are peculiarly solicitous to make a display, their eyes and their teeth: in the brilliancy of the first, and the whiteness of the last, they
think no woman can surpass, if equal them. Of late years however, the English women are become more careful of their teeth than they were used to be ...."10 Assessing contemporary cultural attitudes about the transformation of the mouth from grotesque site—owing to which teeth were practically never represented in portraiture—to a site symbolic of technological triumph, purity and brilliancy, helps us to understand the humor of Rowlandson as well as the self-pathologisation of patients.1 As we learn from the psychology of cosmetic medicine, what is being “treated” is often a complex psychosomatic attitude linked to self-esteem and sexuality rather than organic pathology.11

The 18th century dental patient is akin to a 20th century cosmetic surgery patient, where certain socio-economic conditions and a cultural privileging of one kind of faith in medical intervention come to shape the clinical encounter. This analysis fits with our understanding of the medical marketplace. It helps to explain how Paris became the leading production center for toothbrushes, for instance.12,13 This whole cultural context helps illuminate the dynamics of the emergence of dentistry and the social conditions to which dentistry was responding. It is easy to assume the pre-existence of a pathological state—a disease—about which there is eventually enough information for a practitioner to specialize in its diagnosis and treatment. Yet, as the medical historian George Rosen argued in his book on the creation of the specialty of ophthalmology, there are conditions separate from the existence of a disease that give rise to a medical field, namely relating to professional turf wars and technological imperatives.14 More recently, the medical sociologist Sarah Nettleton referred to the emergence of dentistry in a more theoretically-framed way. “That is,” she writes, “that mouths, dental diseases, and teeth are not pre-existent natural entities, but rather objects realized through the discourse that surrounds them.”15 Not dissimilarly, the historian Colin Jones posited that in the 18th century the “...mouth was becoming the imaginary site around which revolved both a nascent academic industry and a new and broader commercialism.”1

These claims might seem odd. What does it mean that the mouth was not a “pre-existent natural entity” or that it was an “imaginary site”? Their words are misleading. It is hard to argue the non-pre-existence of the mouth or claim that it is imaginary. What they are suggesting, however, is that a pathological condition only becomes the object of medical attention—is only recognized as existing—once the medical profession comes to “imagine” or develop the language and tools to define and analyze it.16 And because pathologies bring people with them to the clinic, people become transformed into patients. But by extension of this theoretical framework, neither is the patient a “pre-existing natural entity.” Some people decide to become patients while some people don’t. Sometimes it is about money; sometimes it is about fear; sometimes it is about vanity. As sociologist David Armstrong has written, “The transition from person to patient did not signify the simple and absolute distinction between health and illness; people made their own personal judgments and decisions about illness—a judgment that might well not accord with medical opinion.”8 Whatever the circumstance, “patienthood” is an identity defined through social relations, and as such can be examined as a cultural category separate from a pathological entity such as caries or crooked teeth.

The idea that patients are “constructed” as categorical beings is not new: scholars have long demonstrated how schizophrenic, autistic, hysterical, etc., patients become labeled by medical specialties that often redraw the boundaries of illness and disease. The different editions of the International Statistical Classification of Disease and Related Health Problems (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) are always doing the job of what the philosopher Ian Hacking calls “Making Up People.”17,18 One reason I find the category of the dental patient interesting, however, is because there should be no such category. As suggested, categories are necessarily about inclusion and exclusion, yet every single person in the world who has teeth should be a dental patient. Whose teeth never require attention? Can such a purview—an extension of the “clinical gaze”—be claimed for any other medical discipline? Regardless of whether the person “volunteers” to become a patient or not, everyone should have the right to be seen by a dentist. I suggest that it was this realization—that shifted attention from a kind of person to an entire population—that established the core ethical mission of dentistry.

This consciousness developed in the 19th century in the context of government support for public health reforms. It is not until one can do something that one realizes one should do something. In the 1830s, dentists became engaged with charitable institutions. In London, dental dispensaries were established such as the London Institution for the Diseases of the Teeth (1839) that provided free dental treatment to nearly 6,000 poor in its first four years. Other dispensaries followed elsewhere in London (1855), Birmingham (1858), Edinburgh (1860), and Liverpool (1860).19 In 1841, J.L. Levinson wrote an appeal in the Lancet seeking to establish a bond of association among all the dentists who still practiced for their individual interests, calling for a Faculty of Dental Surgeons and framing a code of ethics. Some inspiration for this came from developments in America, where the first dental journal,
At the beginning of the 20th century, however, things looked like they were starting to change. The call was renewed that “dental science exists not for the dentist but for the people.” In 1910 George Newman, Chief Medical Officer for the Local Government Board of England, noted that “the centre of gravity of our public health system is passing in some degree from the environment to the individual and from the problem of outward sanitation to problems of personal hygiene.” Indeed, attention to what went into the body rather than what went out was an important feature of preventive medicine. As M.F. Boyd wrote in his 1920 book, *Practical Preventive Medicine*, “the mouth and nose are the portals of entrance of the greatest importance from the number of infective agents which are introduced through them.”

Sarah Nettleton discusses much of the early 20th century interest in dental public health. She draws on the work of the French philosopher Michel Foucault who is known for his theories about the relationship between knowledge and power. Put simply, the more knowledge one acquires about an object the more power one has that affords greater degrees of control over the object. He used medical knowledge about the human body as one example where he interprets the promotion of public health as an apparatus of state power and control over the population. He plays on the pun of the word “discipline” to mean a collective order of specialized knowledge (an academic discipline) and the act of imposing order on a subject (like disciplining a child). The widely understood moral of Foucault’s message is that we should be cautious and critical about expert knowledge, its normative judgments about the objects of its investigation, and its power to control things. Nettleton applies this to dentistry and can be interpreted to conclude that the reason people fear the dentist is because of its “disciplinary power.”

Fear, vulnerability and control are often leitmotifs of dental folklore. While not taking a Foucauldian approach, the cultural historian David Kunzle points out that in most representations of tooth-pulling produced from the seventeenth to the nineteenth centuries, it is the poor who are depicted as patients. He calls this an act of “disempowering and humiliation of those already powerless, humble, and, *ipso facto*, innocent.”

If the analysis is not about political oppression, dental-phobia might then be implicated in analysis of sexual oppression. Jill Rait, the professor of historical theology at Duke University, reminds us that in Christian theology the *vagina dentata* has been subjected to Jungian interpretation to represent “the destructive side of the Feminine, the destructive and deadly womb, [that] appears most frequently in the archetypal form of a mouth bristling with teeth.”

*American Journal of Dental Science,* was launched (1839), followed the next year by the first dental school, the Baltimore College of Dental Surgery, and the American Society of Dental Surgeons (both in 1840).

One objective here was to start regulating dental practice for the protection of patients as well as to promote a professional identity in order to gain the trust of the public. Some thought that dentistry had limited public impact because it had such limited visibility in the hospital. Keeping the practice geared toward wealthy patients was not in the interests of the profession. As one writer in the dental journal *Forceps* wrote, “Diseases of the teeth are not confined, either to the paying orders or to the metropolis and large provincial towns, where dentists are more plentiful than blackberries in their suburbs, but occasionally affect inhabitants of the country, where they of necessity come under the care of the general practitioners, and the poor of the metropolis, who must go to a parish surgeon who knows little of the subject, or to a hospital where the student knows less.” Yet collectivism and political action were not immediately forthcoming. Because of the absence of any reference to dental hygiene in the *Report of the Sanitary Conditions of the Labouring Population of Great Britain* (1842) or the landmark Public Health Act (1848), few perceived an urgency to the reform and purview of dental practice.

In many ways, the medical and political scene was set; the ethical agenda prescribed. Yet, in the words of medical historian Edna Robertson, dental public health was a “dog that didn’t bite.” Public health policy, it has been argued, was mainly in the business of fighting infectious, life threatening diseases. Since dental diseases were not recognized as affecting mortality rates by the medical profession, officers of health or indeed the public, there remained an indifference to dental community service and state provision. As the dental advocate from Cambridge (who opened the first children’s dental clinic in the UK in 1907) Dr. George Cunningham wrote in 1887, “It is our duty as well as our right to agitate for the due recognition of preventive and remedial dentistry as an essential part of state medicine and public hygiene.” Yet he grew despondent when he read the lectures on public health offered by the Medical Officer of Health for Glasgow, James Burn Russell, that talked at length about sewers but said nothing of the mouth and teeth. In a rather measured tone a few years later, Cunningham reflected on the progress of public health reforms, noting that “The growth of the science of public health is certainly one of the most notable features of our age, but the importance of the teeth as affecting health has not yet been adequately recognised.”
But I digress. Rather than trying to graft the practice of dentistry onto analyses of disciplinary power relations, it fits our purposes better to examine the ways that teeth were made into an objective measure of the health of the population. That is to say, we need to inquire how the mouth attained the same status as the sewer—as the site of important public interest.

A Site of Important Public Interest

New models of epidemiological data collection and various movements to survey and assess the health of the population, particularly school children, led to increased awareness of the need for oral health intervention. Dental epidemiology was used in early 19th-century Britain to ascertain the age of children working in factories—notoriously difficult information to obtain at the moment of factory reforms to regulate child labor. This appears to be one of the earliest methods whereby teeth were used as an index for determining other biological information—in this instance, maturity. Toward the end of the 19th century, a dentist from northern Britain collected data regarding the prevalence of caries among children and started a campaign for compulsory dental inspection in schools, that eventually led to the School Dental Service in 1898. This led to a massive increase in epidemiological data on dental diseases across Britain from which a report by the Medical Research Council in 1925 was able to observe an uneven distribution of the prevalence of caries. The authors of the report speculated that the condition of the children’s teeth could be linked to “some quality or impurity of the drinking water,” in accord with an observation made by Frederick McKay of the US Public Health Service who was looking into the problem of mottled enamel in teeth. These questions and data led to Harry Churchill’s chemical investigations that, in 1931, identified those “impurities” as the presence of fluoride, leading to another well-known history.

Oral hygiene was further recognized as a measure of the health of the British population by the National Insurance Beneficent Society. This institution represented the Friendly Societies that were asked to administer the workers’ compulsory health insurance scheme established by the National Insurance Act of 1911. In 1921, the Society solicited the help of dentists to provide inexpensive services, noting “the ill effect of bad teeth upon a person’s general health.” Thus, the medical management of the mouth was a cost-saving strategy, recognizing that bad oral health portends more expensive illnesses.

In America, charitable interests were also a driving force in the evolution of dental public health. As Clifton and Lois Dummett have shown, the Illinois dentist Charles Edwin Bentley was a pioneer in the Oral Hygiene Movement of the late 19th century. He directed his attention to promoting educational programs in public schools and stressing the importance of oral hygiene in relation to child welfare. He agreed with others, such as Dr. George Hunt, editor of Oral Hygiene and dean of Indiana Dental College, recognizing health disparity as a consequence of economic and sociologic conditions of American society and endorsed plans for the state sponsorship of free dental clinics. He called upon the dental profession to oversee these clinics as a matter of civic responsibility: “...for any group is of value only in proportion to its contribution to the public welfare,” wrote Bentley. “Our work, heretofore, has been largely confined to developing a culture of our own, let us grasp man’s higher privilege and devote our earnest efforts to the benefit of our fellows.”

This sentiment, what the historian of the American Dental Association Robert McCluggage called “the idealistic motive” and what I am referring to as the “ethical core” of professional identity, was echoed by others. “The primary obligation of the profession is public service,” stated Homer C. Brown, President of the ADA in 1913. The editor of the Association’s Journal repeated the message, writing that “Our duties relate to the community as well as to the individual.” Indeed, others were more explicit in putting the ethical responsibility to promote education and allegiance to the improvement of the human race at the center of a professional identity. In a number of speeches and publications on the status of medical and dental education offered around 1927, Frederick Waite, a medical professor at Western Reserve University declared: “A profession, especially one of the learned professions, is different in its ethical status, from a craft, a vocation, or a business…. The guiding idea of a profession should be altruism, the giving of the best service permitted by the particular qualifications of that profession.”

Clifton and Lois Dummett once wrote that: “Traditionally, the dental profession took pride in its entrepreneurship and its independence,” and they wrote of the profession’s “confidence” and “self-reliance.” But in the early 20th century with the increased attention in “social aspects” of dental practice, particularly relating to public health, there was newly-perceived need to reform the professional identity in order to win over the trust of the public. By the 1940s, this was of national importance. The Great Depression, the world wars, and the calculation that millions of people were not receiving adequate medical care and dental treatment stimulated direct action by President Truman. In 1948 the first meeting of the National Health Assembly was convened to investigate ways that health services could be
extended to all US citizens through federal health insurance. As many will know from another Clifton and Lois Dummett book, Harold Hillenbrand was called upon to represent dentistry.37 Hillenbrand was serving as general secretary and executive director of the American Dental Association, and he assembled a team of academic and private practice dentists to write their section of the final report. Recognizing the importance of preventive dentistry but noting that twenty two states had no public health dentists, the report made a number of recommendations about community dental health education and the need to recruit more dentists to the profession.

Yet, the Oral Hygiene Movement met with various forms of professional and social resistance from those who viewed it as paternalistic and an encouragement to pauperism. Even in a recent American textbook, public health dentistry is still referred to as “a new subject.”38 Just as with the case of Britain in the 19th century, the dental public health movement in early 20th-century America turned out to be a “dog that didn’t bite.” Why not? And what does this say about the ethical core around which the profession attempted to establish its identity?

Three main problems seem to have stood in the way of the social mission that was “dental public health.” First, in some respects, the challenges and short-comings of fulfilling the ethical mission of providing dental public health is a consequence of dentistry’s own success. It amounts to what I call the “professionalization paradox.” Dentistry simultaneously built a convincing case that it was necessary to pay attention to the oral health of every individual and therefore it was a necessary component in the health care of the population; but in order to recruit the practitioners to meet this demand, the social status and prestige of dentistry needed to be elevated. It is difficult for a medical profession that requires such lengthy and expensive specialized training to be molded in the form of public service. This was a challenge recognized by the American Dental Association. In the words of its historian, “the Association has tried to vindicate the professional and scientific claims of dentistry upon the public while laboring to raise the social and professional level of its practitioners.”35

Second, many efforts to promote awareness of oral hygiene met with derision from critics who smelt interest-laden commercialism. There was an ethical tension in the public promotion of its own knowledge and services. After Charles Edwin Bentley offered a speech on the importance of establishing dental examinations in public schools, an incredulous Chicago reporter inquired about “what graft” lay behind such an apparently philanthropic gesture.4 In the 1920s, the American Dental Association rejected support for the promotion of public health publicity materials by the Dental Welfare Foundation because its members were manufacturers of dental education materials, and they later even rejected disseminating their message through paid advertisements in the press.35

Finally, its association with the politics of health insurance tied it to the concerns of private practitioners for their own future. In the 1940s, when President Truman rekindled the debate about compulsory health insurance (after Roosevelt gave up on it to save Social Security), the American Dental Association joined the AMA in issuing warnings proclaiming that this would amount to the end of private practice. “This legislation is a threat to the American way of life,” thundered ADA President Walter Scherer. “Our states’ rights, our personal freedom, the sacred human relationship that has always existed between professional men and their patients, is being threatened.” This was treading on delicate ground, however, lest the public interpret this sort of reaction as being “anti-social.”35 Following the second quashing of the compulsory health insurance scheme and the interest shown by the US Public Health Service in community fluoridation programs, the whole approach to (and ideology of) dental public health seems to have assumed a different form. In 1959, Robert McCluggage wrote that the American Dental Association had a “policy of placing responsibility for local problems in the hands of the local profession.”35

At that time it may have looked like regionalism was the likely model for dental organization and public health awareness. But over the course of the second half of the 20th century, a new consciousness has emerged and coupled with a new calling for the profession; namely, global dental health. Alongside the concerns over public health and dental education articulated by the ADA, another dental organization had been developing its own approach to the management of dental diseases: the International Association for Dental Research, founded in 1920. In a fiftieth-anniversary publication of the IADR published in 1973, the writers called upon its members to finally realize the full impact of its own name and truly become an “international” in dental research.39 This year, the current president of the IADR, Deborah Greenspan, Professor of Oral Medicine at UCSF, reaffirmed the call. “Let us continue to [really] put the ‘International’ into the IADR,” she said. In her talk, titled “Oral Health is Global Health,” she wondered whether the profession was focusing enough of its attention on efforts “to control oral disease globally,” or whether health problems were being compartmentalized. “In most of the countries of the world,” she wrote, alluding to the enormity of the challenge, “manpower or capacity is woefully inadequate for the task.”40 Indeed, it is not at all dissimilar to
the difficulties that faced the mission of dental public health a century ago. There were challenges that we can learn from by examining this history. Perhaps the most important message is that for any profession to develop an identity for itself that matters to the world, it needs to be built around that core ethical principle of providing service to humanity. Greenspan’s call reminds us that this is still the core professional ethic in dentistry.

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Ethics versus Legal Informed Consent—
A Distinction with Little Difference

Edwin J. Zinman, DDS, JD*

Abstract

The core principles of dental ethics and legal standards of care have similar foundations. Both are dedicated to place the patient’s best interest as primary and the practitioner’s interest as secondary. Similarities between ethics and the law demonstrate that most often there may be distinctions but little core differences. Informed consent principles illustrate the comparison between dental ethics and the law.

Speaker Introduction by
Dr. Morton G. Rivo, Program Chair

When concepts of ethical behaviors become codified, they often become law. Dr. Edwin Zinman will help us understand this process. He is well prepared to do so. Dr. Zinman is both a dentist and an attorney. He received his dental degree from the University of Pittsburgh in 1962, and subsequently qualified as a periodontist at New York University College of Dentistry. He practiced periodontics in San Francisco for several years before graduating from the University of California, Hastings College of the Law in 1972. Since then, Dr Zinman has been engaged in the practice of law, with a particular interest in dental and medical malpractice. He is recognized as an expert in his field; as a practitioner, author, lecturer, and teacher. He has consulted and taught at several hospitals in New York and California, and lectured in the Department of Periodontology at the University of California, San Francisco. For many years, Dr. Zinman authored the popular column, “Dentists and the Law,” which appeared in ‘Dental Management’ magazine. Our speaker has lectured at more than 300 local, state, and national dental and legal meetings. His topic today is one of great interest to us as dental historians investigating the development of ethical principles and the laws which direct dentists’ professional behaviors. Please join me in welcoming Dr. Edwin Zinman.

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Introduction

Dentists are bound ethically and legally to serve their patients. Lawsuits serve a salutary purpose in terms of benefiting not only an individual patient but also the public at large.

In dental ethics, the question to be asked is if our services are provided primarily on the patient’s behalf or for the benefit of the practitioner? This ethical obligation is codified in the American Dental Association’s Code of Ethics. Service to the public is our primary obligation. Dedication to service rather than for profit is also our ethical duty. We should always treat for need and not for greed. By comparison, if you want to know how to define malpractice, ask yourself a simple question: What is in the patient’s best interest? Not necessarily, What is in the dentist’s financial interest, but What is in the patient’s dental health interest. You will then know not only what the appropriate standard of care is, you will also know how to fulfill your ethical duties to the patient.

Legal and ethical obligations often represent a distinction without a substantial difference since each requires service to the patient as our primary objective. The Code of Ethics of our American Dental Association, and the legal obligation of a dentist, spells out a fiduciary relationship. A fiduciary relationship distinguishes a dentist as a professional versus the commercial interests of a trade. The commercial interest of a tradesman is to maximize profit. A dentist’s interest is to maximize health. Thus, protecting the patient’s best interest is both legally and ethically required.

The dental profession’s concern for ethical erosions of core values culminated in the American College of Dentists and the American Dental Association jointly sponsoring an Ethics summit on commercialism in March 2006. The summit’s session recommendations are reported in the California Dental Association’s January 2008 article entitled “Beginning the Discussion of Commercialism in Dentistry.”

Reasonable Care versus Customary Practice

As dentists, we have core value principles. “Honest Abe” Lincoln advised: “Always do the right thing; this will gratify some people and astonish the rest.” What is done, commonly or customarily, may not always be reasonable or prudent care. What is both reasonable and careful care, irrespective of how few or how many may meet that standard, is the legal standard of care.

Just because some dentists’ over-treat does not make it right, legal, or laudable. For example, Gordon Christensen, DDS’ editorial entitled “Veneer Mania” in July 2006 JADA lamented that over-treatment with ceramic veneers is at an all time high. Standard of care is not 100% perfection, nor is it ideal dentistry. “Reasonable” is defined as: reasonable care, based upon reason. By reason, in dentistry, we apply evidence-based reasons.

Ethical Disclosure versus Informed Consent

Dental negligence includes rendering substandard care. Nonetheless, the ethics of our dental profession—as policed by ethics committees—rarely discipline dentists for substandard care. Lawyers therefore help police the dental profession. Informed consent includes advising the patient of treatment alternatives and treatment options. This is not only an ethical obligation, but also a legal obligation that requires that a patient be informed of the ABC’s of “alternatives, benefits and complications.” A patient has a right to know these ABC’s from the dentist. Too often, what happens is that the dentist might say, “I’m going to be doing mucogingival surgery with autogenous grafting,” and the patient replies, “Wonderful,” but really has no idea what the dentist discussed. Informed consent has to be in lay language, so that the patient can understand what the risks are because, ultimately, it is the patient’s decision. The patient may understand that it will be a beneficial result: to eliminate periodontal disease in the maxillary anterior region. In addition, the dentist or a periodontist may believe it is desirable to eliminate the periodontal disease. Nonetheless, if periodontal surgery causes significant gingival recession, the patient may complain, “I wanted to look like a star, but Lassie wasn’t what I had in mind.” Therefore, we have to do what is in the best interest of the patient by informing patients of our treatment consequences.

Comparing the California jury instruction of informed consent for alternatives, benefits, and complications with the Code of Ethics of our American Dental Association and respective state dental societies, all require this same disclosure, even if these risks might occur despite the best of care. However, if these risks are reasonably avoidable with due care, then the dentist causing these risks to manifest is negligent.

Informed consent includes alternatives as well as complications, so alternatives to those procedures include those that you do not perform. Let the patient know that there are alternatives so that the patient can make those choices. In addition, the patient must be told of the consequences of doing nothing.

In sum, unavoidable risks represent a maloccurrence. On the other hand, malpractitioners cause reasonably avoidable risks.
What the patient has to be told is that which a reasonable patient would want to know. What does the patient want to know? Not necessarily what the dentist would want to know, or benefit from the procedure. Explain procedures in lay terms because the patient will not understand a lot of technical jargon.

Do not use the famous Dilbert cartoon standard “If it’s not immoral, it probably won’t work.” That is not, of course, the ethics of our profession in which the patient’s best interest is required. Even if some or many practitioners do it wrong does not make it right. Thus, the majority does not rule in unreasonable treatments such as maximally invasive veneer preparations into dentin rather than minimally invasive preparations into enamel.

Warren Buffett said it well: “The fact that everybody is doing it is probably the worst excuse in the world.” In one study, 90% of corporate whistleblowers were fired or demoted. Twenty-six percent of the whistleblowers required psychiatric or medical care. Nonetheless, most had a strong moral fiber to blow the whistle on misconduct. Only 16% said they would never do it again. Eight-four percent stated, yes, they would do it again, despite being fired, demoted, or having medical or psychiatric problems. Sometimes you have to swim against the corporate tides to serve society’s best interests.

FDA MedWatch Reporting

Companies that manufacture dental products do not always test for long-term risks. Thus, you as the practitioner and all of your patients become the ultimate guinea pigs and sometimes pay a high price for undisclosed risks. Therefore, in any new technology, choose a product that has peer-reviewed research behind it.

Marketplace testing—despite the FDA’s requirement that manufacturers conduct post-marketing monitoring—has not always kept up with FDA mandates. FDA approval is only a minimum standard and provides no guarantee of product safety.

We all think of ourselves, as ethical practitioners, but even the FDA will not know of a problem unless it is reported to them. The FDA, by their own MedWatch statistics, admits that it is only between 3% as in one study, or 10% in another study that complications of a product or drug are ever reported to the FDA. Our profession should take more responsibility. If there is a complication of a product, although you do not know what the complication is, it will help other patients if we file MedWatch complaints with the FDA. It is not being a whistleblower for the world to hear since MedWatch reporting is confidential. Rather, it is just calling a manufacturer’s attention to a product defect causing an adverse event which the manufacturer should correct.

Non-FDA Approved Drugs

When I began practicing law 30 years ago, I frequently litigated Sargenti paste cases. Unbelievably, Sargenti formulations are still in use today albeit lacking FDA approval as a “New Drug” with proven safety and efficacy. The American Association of Endodontists’ position paper (1998) states that it is below the standard of care to even use Sargenti paste. All American dental schools advise against the use of Sargenti paste. Thus, dentists who use Sargenti paste represent a negligent customary practice rather than the standard of care. We, as dentists, must practice prudently to minimize, not maximize, risks. The law requires reasonable care as the standard of care in order to minimize risks.

In a recent case, a California pharmacy sold non-FDA approved Sargenti powder to an Alabama dentist. The dentist not only filled the patient’s root canal with toxic Sargenti paste (Figs. 1 and 2), but she filled the inferior alveolar nerve canal as well. The patient complained of persistent burning dysesthesia pain and paresthesia. The dentist blamed the symptoms on local anesthesia injection and thus concealed the true cause of the patient’s neuropathic injuries. The patient in her lawsuit alleges the dentist fraudulently informed the patient that the overfill was completely absorbable by the human body and would be gone in time. Also, the patient alleges that the dentist concealed that such a gross amount of Sargenti overfill would not likely absorb. However, even if it were to eventually absorb, the chemical neurotoxic damage to the inferior alveolar nerve from the mummifying paraformaldehyde content of Sargenti paste would remain. This patient now has permanent painful dysesthesia. As Dr. Stephen Cohen, author of *Pathways of the Pulp*, advises, “No one should be embalmed before their time.”

In a seminal article, Dr. Anthony Pogrel demonstrated that the surgical removal of endodontic material...
from the inferior alveolar nerve canal within the first 72 hours—before the chemical effects can do further dam-
age—is likely to result in a 100% reversal. Time is very critical. But this dentist—rather than admitting her error and advising of the potential for permanent damage and referral for immediate microsurgery, blamed the patient’s pain and discomfort on the local anesthetic rather than on her injection of toxic Sargenti paste into the inferior alveolar nerve canal. Slight overfills might occur even under the best care, but a gross overfill with a toxic substance such as Sargenti paste maximizes the risk of permanent, irreversible injury.

Today, dentists have to inform patients about the risks of endodontic therapy. Since it is considered a violation of the standard of care to use Sargenti paste, then so is asking the patient to consent to its use. Asking a patient to consent to negligent care is like asking the patient to consent to assault and battery. Thus the consent is voidable and contrary to public policy.

**Litigation Incidence**

When you go into court, you will to be judged by your records. Remember the three R’s of malpractice prevention: The first is Records, the second is Records, and the third is Records. It is all three D’s: Document, Document, and Document.

There is a current myth that there is a litigation explosion. However, the total number of lawsuits against dentists is down, although the monetary awards in some individual verdicts may be up.

A 2007 trial in Los Angeles involved an implant that had been placed so deeply it not only went into the inferior alveolar nerve canal, it also exited out the other side (Fig. 3). As a result, that patient has permanent pain. The jury verdict was for $1.7 million. The salutary lesson in that case was that correctly-interpreted 3D imaging would have avoided the resulting permanent burning painful dysesthesia by guiding the implantologist’s correct anatomical placement. The standard of care incorporates technological diagnostic improvements. Implant surgical protocols require a safety zone of 2-3mm of implant placement superior to the inferior alveolar nerve canal. The dentist should have correctly used 3D imaging to minimize the risk of over-drilling.

There are many safe and effective implant systems. Implants are the state of the art, the standard of care, and they are beneficial when the proper system is placed in conjunction with 3D imaging. Perhaps your patient needs a system that you cannot provide. Perhaps you are using an implant system that is inappropriate for your patient. Use your professional judgment if you are going to inform the patient of alternative implant systems. You have to determine what is appro-

![Fig. 3—3D Radiograph of Implant into IANC](image)

priate for the patient as long as that implant system will be effective and indicated for that patient’s need with minimal risk. That is what informed consent is all about, protecting the best interest of the patient.

**Admission of Error**

Dentists get into difficulty and/or trouble when they fail to admit a mistake. The ADA Code of Ethics requires that you must inform the patient if faulty treatment has been provided. That is our ethical obligation. We must report instances of gross or faulty dentistry. Although we believe we are all ethical dentists, reporting faulty care dentists is honored in the breach more than in the observance—including reporting to peer review.

The number one genesis of dental negligence litigation is if the patient feels the betrayal of trust because they find out from some other dentist what really happened.

Five states require mandatory notification of adverse events to patients. California is not on the list. It is only law in eighteen states. Thus, in 10% of the states there is, by law, a mandatory obligation to report adverse events. Aside from being sued for malpractice, it is a statutory obligation to report in those states.

Eighteen states have “I’m sorry” statutes. It is not an admission of negligence if you tell the patient you are sorry for what happened. This has been codified in those five states; so you are legally protected if you tell the patient you are sorry. It is not an admission of wrong-doing, but rather a demonstration of compassion. It is permissible to advise a patient, “I’m awfully sorry for what happened. I am sorry that I slipped with the drill, severed half your lip and you lost a pint of blood. Go to the hospital, plastic surgeon, or oral surgeon. Have that injury repaired immediately. Send me the bill, and once again, I’m awfully sorry.” That scenario is not an admission of negligence. Rather it is an admission of your compassion for the patient. Do not
hesitate to reveal rather than conceal. Truth in dentistry is the best policy.

Increasing numbers of hospitals and professional liability insurance companies have adopted policies of frank disclosure of professional negligence and apologies for such errors. These policies have resulted in greater patient trust and forgiveness by the patient. Consequently, these fully-informed patients file fewer lawsuits compared to patients who belatedly learn from another professional the true cause of their injury and thus feel their trust was betrayed.

Senators Hillary Clinton and Barack Obama are joint sponsors of “The National Medical Error Disclosure and Compensation (MEDIC) Act.” Program participants would be required to disclose the substandard error to the patient and negotiate fair compensation. The dentist would be legally protected for apologizing when disclosing the negligent act or omission. Insurance carriers’ cost savings anticipated under this plan through lower administrative and legal costs will be applied to premium reduction of professional liability policies if Congress were to pass the proposed Senate bill.

Saying that you are sorry has a proven track record in non-dental settings. The Pearl Outlet17 merchant members queried purchasers why they purchased pearls. Many replied that the purchases were designed as apologies to wives or girlfriends. The Pearl Outlet then hired Zoogby International to research those persons willing to admit that they were sorry for their mistakes. Research found that persons who make more money were more willing to say, “I’m Sorry” than people who rarely or never apologize. The study showed “a person’s willingness to apologize was an almost perfect predictor of their places on the income ladder.” Thus, the link between income and willingness to apologize demonstrates that successful people are willing to learn from their mistakes and apologize to assuage a troubled relationship. This research proves that our ethical and legal obligation to have frank and candid disclosures of error to our patients is a practical bridge over troubled waters.

Conclusion

In many schools, entering freshmen take a pledge of honesty and integrity. Here is the UCSF SOD pledge:

“To uphold the honor and integrity of the dental profession and to contribute to its progress; and
“To continue to advance my knowledge and skills throughout the remainder of my education here at UCSF and beyond.”

These pledge principles are expected of dental professionals as part of our ethical obligation to our patients throughout our professional career. When you fulfill the best interest of the patient, then you will do good for your patient and do well by the dental profession. Accordingly, protecting the patient’s best interest remains our paramount goal both ethically and legally.

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Early Struggles to Identify Ethical Standards in Dentistry: Dr. Benjamin Brown and the Amalgam War of the 1840s

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Abstract

Dr. Benjamin Boyer Brown was one of the leading physicians and dentists in St. Louis during the 1830s and 1840s as well as one of its most esteemed citizens for his charitable and educational works. He was also one of the founders of organized dentistry, first editor of the Dental Register of the West, as well as a respected researcher and educator in dentistry, and a member of the American Society of Dental Surgery, a forerunner of the American Dental Association. This society, declared the use of amalgam to be not only unethical but malpractice, and members were forced to sign a pledge not to use it. Although many dentists opposed this decision and ignored the pledge altogether, Dr. Brown was morally unwilling to remain quiet. He vocally opposed the decision of his colleagues to ban amalgam on ethical grounds. In spite of his appeal for reason and his high profile, he was one of the few dentists to be expelled from organized dentistry. He moved to California during the height of the gold rush to begin a new life. Dr. Brown’s experience illustrates several issues in dental ethics that remain with us today.

Introduction

In examining the role of ethics in dentistry, it is appropriate for this academy of the history of dentistry to consider the earliest and most divisive ethical dilemma faced by our dental profession, just as it was becoming organized. At a time when untrained charlatans claimed to the public to be at least as adept as the educated professionals in providing dental care, and not just extractions but fillings too, it became important for the educated dentists to find an issue that clearly put them on a higher plane. Therefore, the first article in the constitution of the earliest national dental society stated in 1840 its object to be “the promotion of union and

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harmony among respectable dental surgeons, and to give character and respectability to the profession, by distinguishing between the meritorious and skillful and the impudent empiric." Rightly or wrongly, the focus of the most influential leaders in organized dentistry—men including Chapin Harris and Eleazer Parmly—was on the use of amalgam by charlatans. As you will see, Harris and Parmly’s response in what has become known as the Amalgam War was probably not only overzealous but dictatorial. The reaction by the dental community shows a diversity of approaches for dealing with a new ethical standard of practice with which many did not agree.

There was but one dentist who would not back down while debating the issue entirely in terms of ethical principles. He had nothing to gain personally but the vindication of a standard of practice based on scientific research with the goal of benefiting his profession, and ultimately his society. For this impertinence, he was found guilty of malpractice. This dentist was Dr. Benjamin Boyer Brown. His name is unfortunately almost unknown today, yet his story is of great relevance, perhaps even central, to understanding the early history of dental ethics because of the principles he stood for and the battles he fought. These offer important insights into the evolution of ethical standards in our profession. To fully appreciate this account, it is helpful to know something of this man and the practice of dentistry in that age. Dentistry was regarded as a branch of medicine; and to be a competent dentist, it was first necessary to be a competent physician. Dr. Brown was both, and much more.

Dr. B. B. Brown of St. Louis

Born in December 1809, Benjamin Brown (Fig. 1) was one of eight children raised in the hamlet of Kingston located west of Harrisburg, Pennsylvania. His parents were Henry Brown, born in Waterford, Ireland, and Michal Magdalena Boyer born in the Bahamas. He received training in medicine and dentistry in Philadelphia where he attended the University of Pennsylvania. At the age of 23, he spent half a year in Alabama before traveling up the Mississippi River to St. Louis where he arrived on June 1, 1833. As he wrote in his diary, “My object in coming to St. Louis was to establish myself in the practice of my profession, dental surgery. I was well received by the medical profession, which was not numerous at that time.”

St. Louis in 1833 was a small town with a population under 5,000 and fewer than ten in the medical or dental profession. Dr. Brown’s unpublished diary gives a rare insight into the daily life of a dentist-physician of the time. After marrying Eliza Ritter in 1834, he settled into a routine of arising early and driving his buggy around St. Louis and into the surrounding countryside, making house calls of both a medical and dental nature, six days a week. Returning home about noon, he had his young children wash the dust off his buggy while he wrote his clinical notes and worked in his laboratory. He saw more patients in his medical/dental office during the afternoon. In common with most educated dentists, he noted in a letter to his friend, Dr. Chapin Harris, “Gold and tin are the only substances used by me for filling teeth. I prefer gold, and hence, urge its use in all cases where the patient can incur the expense.” Gold foil was by far the most accepted filling material. It was used in a single piece carefully folded and compressed into place. Tin foil was softer and tended to discolor. Occasionally tin foil was used as a liner under a gold foil filling.

In his diary, Dr. Brown noted cases of syphilis and kidney inflammation that he set out to treat. As he later wrote, “syphilitic diseases and the abuse of mercurial medicines [which were very common at the time] constitute the most prolific source of...the loss of bony structures of the...maxilla.” He became very proficient at the manufacture of obturators and presented a comprehensive paper on the subject in 1845. He also developed an effective technique of arresting hemorrhage using an assortment of pre-made cones of linen coated with paraffin with which he could apply pressure to deep wounds.

Fig. 1—Dr. Benjamin Boyer Brown (1809 – 1863).
medicine chest, two operating chairs and extensive customized equipment. As his practice became busier, he reduced his house calls. In common with almost all dentists of the day, he advertised (Fig. 2), sometimes with testimonials. One such testimonial was from his patient, the abolitionist newspaper editor, Elijah Lovejoy. Living in a slave state where Lovejoy was vilified, yet still publicizing this man, showed the independent nature for which Brown would be known. Before his murder in 1837 by an enraged mob, Lovejoy’s testimonial to Brown stressed the great skill, the gentlemanly manners, and the willingness of Dr. Brown to visit and treat the poor of the area without charge every morning. It was precisely his refusal to submit to prejudice that would eventually bring Dr. Brown into conflict with the prevailing standards of the dental profession as we shall soon see.

Dr. Brown was one of the founders of the Missouri Medical Society in January 1836. He was recording secretary for this Society which formulated a practical plan to establish a medical school, as gratefully acknowledged in a letter from St. Louis University President Verhaegan. The Medical Department of St. Louis University became the first medical school west of the Mississippi River, and the first one in the United States that was affiliated with a Catholic university. On August 7, 1839, the Medical Department of St. Louis University* conferred a doctor of medicine degree on Dr. Brown, the first recorded medical degree from this institution.10

In 1843, Dr. Brown traveled to the Baltimore College of Dental Surgery to receive an honorary doctorate from this first dental school in the world. This degree was one of 24 offered that year to prominent dentists in the United States, Eleazer Parmly having received one the year before.11

Dr. Brown was one of the founders of the Mississippi Valley Association of Dental Surgeons, organized on August 13, 1844. When this Association decided to establish a quarterly journal of their own in 1847, Dr. Brown was selected as one of the two editors of their new periodical, The Dental Register of the West (Fig. 3). It was the fourth regularly published dental journal in the United States when it first appeared in October

*The Medical Department of St. Louis University grew slowly between the year of its founding and 1855. That year, claims of grave robbing and unacceptable experimentation were publicized by members of the Know Nothing political party, a blatantly anti-Catholic group. The university decided to sever its ties with the Medical Department which now became the St. Louis Medical College. In 1866 it united with the new St. Louis Dental College, the first combination in the United States of a dental school with a medical school. In 1891, the college was bought by Washington University of St. Louis where it remains an integral part of that institution.
that year, and continued in print for 75 years. The first two co-editors were Dr. Brown in St. Louis and Dr. James Taylor in Cincinnati. Dr. Taylor had been another founder of the Mississippi Valley Association of Dental Surgeons and had, in 1845, founded the second dental school in the United States, the Ohio Dental College in Cincinnati.

Dr. Brown’s views on dental education were far ahead of his time. In the first issue of his journal, he expressed the view that in his experience the conventional preceptorship of 3 to 12 months was entirely too short. He supported a 5 year period of study with the first three years consisting of time in the operating room, the laboratory, the lecture room, and the library, covering a broad spectrum of medicine and dentistry, and the last two years focusing on more advanced topics.

Two of his earliest students were his nephews, William and Bernard Gildea from Pennsylvania. They completed their lengthy studies in the early 1840’s at the St. Louis University Medical Department and ultimately would emigrate to California. Two later students were Samuel B. Fithian and Henry D. Stratton, both natives of New York. These latter two also apprenticed with him but completed their formal dental education at the Ohio Dental College from which they graduated in 1849.

In addition to his interests in dentistry and medicine, Dr. Brown was very active in the community. He found time to organize the volunteer fire department, become a founder of, and participant in, the Franklin Society—a debating and public speaking association, serve on the School Board from 1841 to 1844 where he organized the establishment of public schools including the first high school in St. Louis in 1843, and he also served as a director of the “Mechanics Institute of St. Louis”—an alternative school for apprentices and minors.

Dr. Brown also had a lifelong interest in geology, anthropology, and natural history. He was one of the founders, in 1837, of the Western Academy of Science, to which he donated specimens while also participating in field trips. He maintained an extensive library of scientific as well as medical and dental books. For several years, he kept meticulous meteorological records in St. Louis as a correspondent for the Secretary of the Navy, information that was also published.

All the foregoing information would suggest that Dr. Brown was clearly an eminent dentist and a prominent citizen of St. Louis in the mid-1840s. Yet events were concurrently taking place that would soon destroy his professional standing as he came face to face with a code of ethical standards that was unacceptable to him. It is this conflict that is of particular interest to us in understanding the evolution of dental ethics. And the conflict revolved around the use of dental amalgam—a restorative material he did not even use. Amalgam still elicits controversy 160 years later, though with far less malevolence within the profession than in the 1840s.

Rebel in the Amalgam War

The controversy began in 1833, the same year that Dr. Brown arrived in St. Louis. Late that year, the Crawcour brothers arrived in New York from Paris by way of London. They introduced into the United States a dental amalgam composed of silver and mercury that had first been advocated as a restorative material in Paris by Auguste Taveau a few years earlier. During the next two years, the Crawcour brothers met with great monetary success due to seeking out wealthier patients through advertising, luxurious dental offices, conscientious attendants, and above all offering an impressively named amalgam they called “Royal Mineral Succedaneum” which would be painlessly inserted into a carious lesion without the expense, without the bothersome excavation process, and without the lengthy and often painful procedure of forcing gold foil into place as practiced by their competitors. Their amalgam was composed of 50% mercury and 50% coin silver (which at the time was 90% silver and 10% copper).

Opposition to the Crawcour brothers began almost immediately. On December 3, 1834, Eleazer Parmly (Fig. 4) and his friend Solyman Brown organized the world’s first dental association, the Society of Surgeon
Dentists of the City and State of New York. In 1835, Parmly presented a paper dealing with the qualifications of good dentists and published an article denouncing amalgam, beginning his passionate lifelong opposition to this material.

During the next 15 years, there was a sustained and increasingly determined opposition to the use of dental amalgam by many of the most prominent dentists. The opposition was based on several factors. It was recognized that the available alloys would undergo shrinkage. But also there was the consideration of monetary loss to dentists using the cheaper material, the recognition that the emerging profession of dentistry needed to be protected from untrained charlatans, and a professed belief that the mercury found in dental amalgam would result in serious medical consequences. It was the last reason that could most easily be conveyed to the public then, as now.

It was well known that mercury could cause excessive salivation, swelling of the tongue, inflammation and sloughing of the gingival and oral mucosa, necrosis of the alveolus, and loosening of the teeth, in addition to neurological problems and even death.

In his 1840 opening address to the first class of the Baltimore College of Dental Surgery, Chapin Harris (Fig. 5), the founder of the college, made his views clear. He stated, “An amalgam of mercury and silver has been highly extolled by a few practitioners, both in this and other countries; but by most of those who have had teeth filled with it, bitterly denounced, so that...it has nearly gone into disuse. It is certainly one of the most objectionable articles for filling teeth that can be employed, and yet, from the wonderful virtues ascribed to this pernicious compound by those who used it, thousands were induced to try its efficacy.”

Harris was wrong in stating that the use of amalgam had nearly been abandoned. Indeed its use seemed to be increasing steadily. This fact was very much on the mind of those who formed the first national dental association, the American Society of Dental Surgeons in 1840. One of the first official actions of this society, in 1841, was to set up a committee composed of Chapin Harris, Eleazer Parmly and his brother, Jahial Parmly, Solymant Brown, and Elisha Baker. These prominent dentists were to investigate the use of all mercury-containing restorative materials. They reported back that the “use of all such articles was hurtful to the teeth and every part of the mouth, and that there was no tooth in which caries in it could be arrested and the organ rendered serviceable by being filled, in which gold could not be employed.”

The students of the Baltimore College of Dental Surgery were indoctrinated to repeat the condemnation of amalgam in their own writing. Robert Arthur, the first graduate announced in a book written for the public in the mid 1840s, “The cement is still used to considerable extent, is much more injurious than any which has ever before been employed…. The fact that its use is still countenanced is only another proof of the ignorance of the public with regard to the subject of dental surgery; for, in almost every case, it so soon fails that...it is useless for the purpose intended to be effected by it..., it becomes porous, it soon becomes black .... The mercury...produce[s] all the injurious effects of this article...upon the general system.... The use of this pernicious article for the purpose of filling decayed teeth should be abandoned, and...public confidence should be withdrawn from every practitioner who, under any circumstances, makes use of it.”

At the meeting of the American Society of Dental Surgeons in Baltimore on July 12, 1843, Chapin Harris introduced a motion declaring the use of amalgam to be malpractice. This motion was carried. A new committee composed of Solymant Brown, Eleazer Parmly, and J.H. Foster was appointed to receive information on the use of amalgam. The resulting report stated that there was only a small proportion of cases involving the use of amalgam that showed the harmful effects of mercury, seemingly independent of the dose, but dependent on a susceptible constitution of the patient.

In 1845, the Society met in New York where a committee was appointed “to call upon each of the

Fig. 5—Dr. Chapin Harris, circa. 1850.
members now in this city, with the view to ascertain from each member whether he has used any amalgam in the course of his practice as a dental surgeon, or approves of its use.” Dissention now began to be heard within the Society. Dr. Elisha Baker stated that although amalgam was generally “a vile and nasty substance,” it could be used beneficially in teeth that could not be filled any other way.

Of 42 members in New York that the committee questioned, 31 declared that they were opposed to the use of amalgam and had never used it, 5 members—including Dr. Baker, declared that they had used it but would stop if required, and 6 members—including Dr. Charles Allen, said that they used it on occasion and would refuse to sign a pledge to cease.

Not satisfied with anything other than absolute conformity to their viewpoint that a professional dentist must be entirely opposed to the use of amalgam under all circumstances, the Dental Society now set up another committee composed of Chapin Harris and four others to come up with a plan of action. They concluded “that any member of this Society who shall hereafter refuse to sign a certificate (Fig. 6), pledging himself not to use any amalgam, and, moreover, protesting against its use, under any circumstances, in dental practice, shall be expelled from this Society.” Members who would not return the pledge certificate within 60 days would be dropped from membership.

At the same meeting, it was decided to publicize the Society’s views on amalgam. Letters were sent to editors of newspapers and periodicals throughout the United States declaring:

“One of these base deceptions by which individuals calling themselves dentist[s] are grossly imposing [on] the community [is] the practice of stopping decayed teeth with amalgams...by the use of which thousands of valuable teeth are annually destroyed & immeasurable evils result to the community at large which can never be repaired.

“The Society has declared by unanimous resolutions that the use of the above named amalgams for stopping teeth is malpractice....

By order of the Society
E. Parmly, President”

“I, ______, hereby certify it to be my opinion and firm conviction that any amalgam whatever, whether used under the name of mineral paste, adamantine cement, succedaneum, diamond cement, Chinese cement, lithodeum, albaster cement, or any other way designated, is not only unfit but dangerous when used for plugging teeth or their fangs.

And I pledge myself never, under any circumstances, to make use of it in my practice as a Dental Surgeon.

And furthermore, as a member of the A. S. of D. S., I do subscribe and unite with them in their protest against the use of the same.

Given under my hand and seal this, — day of ——, 184—.”

Fig. 6—Text of the Pledge Certificate issued by the American Society of Dental Surgeons, August 1845.

Of the total membership of 134 in the Society who received the pledge in the fall of 1845, 78 stated their support, 53 failed to respond, while three others refused to sign it altogether. Dr. Brown was one in these three. He had been a member of the Society since 1841, the first member from west of the Mississippi. When Dr. Brown first read the resolutions of the Society in the fall of 1845, he immediately wrote to the recording secretary, Dr. Amos Westcott, to register his opposition to the resolutions.

He stated that “the Society has transcended its powers, has violated the compact which ushered it into existence, by enacting resolutions which are arbitrary, unjust, and unconstitutional.” He added “I do not use any amalgam, or cement, whatever.... In my own practice, Gold has always been preferred, and most extensively used; Platinum, Tin and Lead have also been used, but only to a limited extent, particularly the latter.... When the Society recommended the profession to abandon the use of Amalgams and cements for the purpose of filling teeth...the recommendation was right and proper...but, when the Society declare the use of these objectionable materials to be empiricism, it goes one step too far.” He concluded “my membership of the Society does not, I humbly trust, rest upon such a doubtful foundation, as to subject me to the liability of expulsion, unless I sign a certificate, and make a pledge.”

Dr. Westcott was not impressed. He responded, “If the American Society of Dental Surgeons have no authority to proscribe quackery among its members, it has no object, and the sooner it ceases to exist the better. Yours is surely a new objection...and one in my judgment, as having not the slightest foundation.... I shall therefore, unless I receive new instructions...carry out most strictly the original order.” Dr. Brown followed up with a letter of July 14, 1846 to Chapin Harris whom he still considered a friend. He made known his opinion...
that “the belligerent reviews...published in the Journal of the American Society of Dental Surgeons from time to time, relative to amalgams...I conceive are uncalled for, to sustain a tenable position, nor are they calculated to advance the interest and dignity of the Dental profession.”

Since so many members failed to respond to the Society’s 1845 letter, they were given more time, as was Dr. Brown, and they received another certificate to sign in December 1846. Both the Virginia Society of Dental Surgeons and Dr. Solyman Brown questioned the right of the Society to demand details of practice from its members, with Dr. Solyman Brown concluding that “no one ought to be required to pledge himself not to use any article, as his conscience might demand that he should use it.” A few months later, Dr. Solyman Brown resigned from the Society claiming many years prematurely that he had suddenly left the profession of dentistry altogether.

Dr. Benjamin Brown now sent another, more forceful letter to Chapin Harris. He let him know the core ethical issues that greatly troubled him: “Every formula, which requires the members of a learned profession to be pledged, like lost drunkards at a temperance meeting, is in my humble opinion, an outrage upon the profession itself, and revolting, in the highest degree, to the personal dignity of the gentleman and the scholar.... Each member of this learned body must practice in accordance to the dogmas of science, as received by the learned, at the same time, however, exercising his best judgment in reference to the adoption, or non-adoption, of any remedial agent which research, together with careful experiment, may have placed within his reach.... I am ever disposed to respect the opinions of those who differ with me, when I am satisfied that those opinions are the result of a conscientious and scrupulous examination of all the facts.... The wisest head often draws wrong conclusions from the best of premises...and the most cautious experimentalist, is led at times into irretrievable difficulties; but, my dear friend, in all this there is no quackery whatever.... The dark cloud of error can alone be dispelled by able and gentlemanly discussion, carried on in a spirit of candor and forbearance towards every member of the profession.... This amalgam war, as it is now waged, can end in no useful purpose to the profession; indeed, it has in some of its details, already assumed the disgraceful characteristic of...personal recrimination.

He concluded, “The Society may take such action as shall please it best in reference to myself. Even if it had the power to require pledges of me, as a man I am bound, absolutely and without qualification, to refuse to give them. But I...shall not quietly submit my standing as a Dental Surgeon, to be compromised by the unconstitutional efforts of my associates. I have to request that you will act as my proxy at the approaching annual meeting of the Society.”

**Killed by Bad Dentistry**

In the spring of 1847, before the annual meeting, the New York Tribune published an article concerning the death of a man in Springfield, Massachusetts, following a protracted fatal illness supposedly arising from an amalgam filling placed in Paris a few years earlier. Under the title, “Killed by Bad Dentistry,” Dr. Eleazer Parmly took this opportunity on May 26 to write the editors of the newspaper, Horace Greeley and Thomas McElrath, a lengthy letter concluding, “I again say, fearlessly, that I have no confidence in the professional honesty of any man who will use it [amalgam]—saying, as many do, that it is better than gold. If it is better, I hereby challenge the whole of them to come out in the public prints of our City, and show the profession—their deluded victims, and an abused public—wherein it is better than gold, and what authorizes the base material ever to be used when gold can be employed for saving teeth.”

At this point, Dr. Elisha Baker and several other New York dentists held a public meeting to condemn Dr. Parmly and “demand a rigid examination of the calumnious charges made by Mr. E. Parmly against all who have adopted the established practice of filling with amalgam teeth which cannot otherwise be preserved.” An impartial physician was summoned to interview relatives of the deceased, as well as his last dentist and his physician. The patient’s physician assured his questioner that there was no possibility that ingesting the amalgam caused any injury and remarked that the idea that he was killed by an amalgam filling as “too ridiculous to be entertained for a moment.” This reply was published in the New York Tribune under the title, “Mr. Parmly and his amalgam war.” Charges and countercharges between Dr. Parmly and Dr. Baker continued for several months, and were published in the New York Dental Recorder throughout the spring and summer of 1847.

**Casualty of Conscience**

It was in this climate that the annual meeting of the American Society of Dental Surgeons for 1847 was held in August at Saratoga Springs, New York. About 30 members were present. They devoted themselves almost entirely to the amalgam controversy. The Recording Secretary, Amos Westcott, read the names of 21 members who refused to sign the pledge. The first five dentists were expelled for refusing to discontinue the use of amalgam. Another six dentists were expelled for simply refusing to sign the pledge. Evidently Dr.
Brown’s appeal to his friend and proxy, Chapin Harris, was futile. His case was discussed on the evening of August 4th. The resolution with respect to Dr. Brown read, “Resolved, that Dr. B.B. Brown [be, and he] is hereby expelled from the A. S. of D. S., for refusing to comply with their positive mandates, by refusing to sign the protest of this body, relative to the use of amalgams for filling teeth.” Not surprisingly, Dr. Elisha Baker was also expelled at this meeting.

Besides the 11 expelled members, the resignation of one member, Dr. Nathan Keep, future founder of the Harvard Dental School, was accepted, when it became apparent to him that he could not negotiate a compromise. The consideration of the membership of ten others was set aside until the following year. Among those to be considered in 1848 was Dr. Charles C. Allen, editor of the New York Dental Recorder. Dr. Allen announced to the Society in 1847 another attempt at compromise: “Two years since, I felt exceedingly unwilling to abandon the use of amalgam, but as many of the members of this society who have used this article more than I have, and for whose opinion I had the highest regard, then decided to use it no more, nor to encourage its use, and as I did not wish to impose the slightest obstacle to the success, union and harmony of the society, I cheerfully consented to do the same, hoping that all the members would feel the importance of making mutual concession, if they would be a happy, useful and prosperous society.” Even this concession was not accepted as a specific enough pledge on his part, and Dr. Allen resigned a few months later.

Needless to say, Dr. Brown was upset with the humiliation of being expelled for malpractice by his colleagues and those such as Chapin Harris, whom he considered friends. Moreover, the public manner in which this was done demanded, at a minimum, a public response. His response occupied several pages of his journal under the title “Comments on the action of the American Society of Dental Surgeons.” He stated, “It is a matter of the deepest importance to every member, to preserve the character of the profession, as well from the tyranny of the few, as the charlatanism and quackery of the many. We shall ever vindicate it from the absurd idea, that a Dental Surgeon cannot practice, with honor, unless it be under the sanction and obligation of a written PLEDGE.

“The ‘American Society of Dental Surgeons,’ at its last annual meeting, adopted resolutions which are hostile to the harmony, and to the spirit and purposes which originated that Institution. No member of a liberal and learned profession can view such principles in any other light, than as a gross and premeditated outrage…. But consummated, as it was, by a very small minority of ALL the members of the Society, the act, we venture to aver, finds no parallel…. To show the purely malignant and tyrannical character of the whole procedure, we shall instance our own case. We do not now, and have not for many years, used any ‘amalgams,’ and then only for experiment…. We have fulfilled every moral and professional obligation towards our associates, and that we have ever labored to advance the interests of the profession, and the character of its members…. We refused to acknowledge the right of our associates to introduce a new test of membership, and to apply it, in the most offensive and indecent manner, to ascertain the fitness and capacity of their associates…. We refused to sign a ‘PLEDGE’ to do what we had not done, and what we did not intend to do. We refused, in order to vindicate our own dignity, as well as the dignity of the profession, and to preserve our self respect, as one of the members of a learned association…. We were among those who fell, without an opportunity of vindicating ourself in person, ‘Bowie knifed’…yet circumstances of a peculiar character have prevented our total annihilation, and we are allowed, by a good Providence, still to survive the shock, and hope to live long enough to see the outraged honor of the Dental profession, fully vindicated.”

It is impossible to say exactly how much the very public expulsion affected the practice of Dr. Brown. His diary suggests he had fewer patients for at least a part of 1848, although the population of St. Louis had grown almost tenfold during the 15 years since his arrival. Certainly his reputation in dentistry and science remained secure. In 1848, he was elected vice president of the Mississippi Valley Association of Dental Surgeons. And in 1849, he was among the first members elected into the American Association for the Advancement of Science, founded just one year earlier with a membership of less than 100, and which has today grown into the largest scientific organization in the world, with more than 140,000 members.

A New Beginning in California

In the Missouri Register of St. Louis in April 1, 1849, Dr. Brown thanked his patients and recommended Dr. Fithian for future dental care. Dr. James Taylor stated in the Dental Register, “California Fever—We are sorry to announce that our worthy colleague, Dr. Brown of St. Louis has been taken off by this very prevalent disease. We understand he departed about the 10th of April, not this life however but for the Sacramento diggings…. We believe that it is generally known that the doctor is fond of Mineralogical as well as Geological study and we are informed his removal to California is more for the purpose of extending his research in this department of science, than for the
accumulation of gold…. With such emigrants, California must become the most flourishing part of the United States, and Dental Science there keeps pace with the improvements of the age.21

Dr. Brown’s nephew and former student, Dr. William Gildea, had already emigrated to California in 1845 where he became the second dentist—and by far the most educated one—to reside in what was still Mexican territory. According to one contemporary account,22 he was about to investigate the source of the gold nuggets some children had presented him when he died of malaria in early 1846 having been greatly appreciated for his humanitarian medical service to all races.23 By 1849, the discovery of gold had completely transformed California. But, as might be envisioned, Dr. Brown was not a typical 49er. He had made careful plans to bring his entire family and his extensive medical-dental kit to California. To do this he purchased several cattle and 16 oxen to pull three large prairie schooners, one carrying only his professional supplies and many books.24 Besides his wife and 5 young children, he was accompanied by his former student, Dr. Stratton, and three other men to drive his ox teams. Both Drs. Brown and Stratton renewed their subscriptions with payments in advance to the Dental Register before they left St. Louis.

In spite of his careful planning there were serious problems along the route. Dr. Brown contracted cholera in St. Joseph which caused a delay of two weeks during which he cured not only himself but several other 49ers. In fact many sought his medical care along the route that took them by way of Fort Laramie, Fort Bridger, Salt Lake City, and the Humboldt River to Carson Canyon on the east side of the Sierras. His men had a hard time handling the oxen here and as he approached the summit at Carson Pass on October 10, a severe snow storm accompanied by a freezing wind caused the loss of all his livestock except two oxen. Two wagons had to be left behind, his prized medical supplies abandoned on the side of the mountain. For two days, Dr. Brown’s party had to survive on coffee and dried apples. A government relief party was sent out from Sacramento to rescue the numerous emigrant trains that were stranded in the mountains.25 They encountered Dr. Brown’s family at Lick Springs and were told the Doctor had gone back for his wagons with a new ox team he had been lent. He found his wagons plundered and returned with little. It was Dr. Brown who sent Dr. Stratton ahead to Sacramento to appeal for more oxen and forage needed by the estimated 300 emigrant wagons still in the mountains. With fresh supplies finally arriving for all, the Brown party continued on the trail the last 100 miles which brought them safely to Sacramento in late October.

Dr. Brown acquired a block of land in Sacramento where he assembled a prefabricated house which had been sent around Cape Horn. The garden of his residence, on H Street between 7th and 8th Street, was impressive enough to win an award from the State Agricultural Society in 1855. The spring of 1850 was noted in Sacramento for a severe flood. It was followed by a still more severe cholera epidemic that killed approximately 800 including 17 physicians in the total population of approximately 7,000 over a four-week period.26 Although more than half the population fled, Dr. Brown remained to take care of the sick and dying. He administered the same treatment he had used with some success in Missouri. This was the intravenous injection of a buffered saline solution. On October 11, 1850, he acquired two mining claims, one for himself and another in the name of his son, Benjamin Jr., who would grow up to be a dentist like his father. He noted in his diary that “the prospect is fair for a good yield of gold.” There is no subsequent mention of Dr. Brown’s prospecting success, if any.

Dr. Brown continued in the practice of medicine, and to a lesser extent, the practice of dentistry, as circumstances dictated. He listed himself as a physician on the census rolls of 1850 and 1860. He was a member of the State Medical Society of California and served as acting President of the Sacramento Medical Society in 1856.

In August 1859, Dr. Brown’s wife died, and he fell into a deep depression that interfered with his ability to practice his profession with the same vigor he had shown earlier. His health began to suffer. Then on July 2, 1863, he died at the age of 54. The Sacramento Union printed his obituary and noted that he was one of the earliest and most prominent physicians of the city, but that he had met reverses in business and health. He died ironically of cholera.

Vindication

The very public and harsh treatment of amalgam-using members in their professional organization did not reduce the use of dental amalgam during the years Dr. Brown lived in California. Experimentation continued. Rather than admit the Society’s mistake, Dr. Harris issued an ironic resolution in 1850 stating that previous resolutions had indeed accomplished the object for which they were designed, and therefore the pledge was no longer necessary for membership. This resolution was unanimously accepted, but more resignations followed. In 1853, Dr. Chapin Harris, who had in the meantime taken over the management of the Society’s journal, found himself formally accused of failing to pay a printer’s bill for three years, blatantly
overbilling the member who brought this to his attention, and then returning the Society's official letter of complaint without reply. A formal declaration of reprimand was issued, stating, “This society views the action of Prof. Harris as very ungentlemanly, uncourteous, and insulting to this Society, and deserving of censure.” Dr. Harris attended no further Society meetings. Dr. Eleazer Parmly stepped down as President of the Society, and was replaced by Elisha Townsend, who had been surreptitiously experimenting with amalgams.

Although Eleazer Parmly and Chapin Harris would never condone the use of dental amalgam, several members began to publicly state that although they had signed the “pledge,” they had used amalgam all along. Calling it a “harmless substance,” Dr. William H. Dwinelle—a regular attendee of their annual meetings—wrote in 1852, “In 1844 and ’45, I tried many experiments with an amalgam of mercury and silver…. Since then, I have made it a practice to particularly examine amalgam and treated teeth…. I am no advocate for amalgam, but am willing to receive a good hint from any source, and shall pursue this subject farther some time.” Many years later he added, “In the early days of the profession there was an intense prejudice against amalgam; and it was carried to such an extent that some members of one of our early associations were ostracized and expelled because they used amalgam. One association went so far—I am ashamed to say, for I was a member of it—as to require each member to sign a pledge. Many men—to their credit be it stated—submitted to expulsion rather than be so restricted. It is a curious fact that some who in that early day were the most persistent in restricting dentists in this respect were men who…confessed that “they had never used the ‘dirty stuff’ at all, which shows how well qualified they were to judge of its merits. I have been in the habit of using amalgam through most of my professional life…because I feel it to be the best under many circumstances…. I should hold myself in contempt if I refused to be governed by the evidence of my own senses.” He later added, “I think we are too apt to be governed by prejudices…and thus allow the interest of the profession at large to be sacrificed to personalities.”

In 1851, Dr. Townsend had announced to the Society that he considered the time had come to encourage more liberal policies in the Society. By 1855, the Society concluded that it would be unable to re-invent itself or hide its divisive past. A committee composed of Dr. Taylor and two others argued for “a more liberal, less exclusive, and more national organization; one that shall unite the profession at large.” Accordingly, it was decided at a special summer meeting of the American Society of Dental Surgeons in Philadelphia that the time had come to dissolve the Society. Although this fact is seldom noticed, there was no opposition since Dr. Townsend had already organized just such a dental association, the American Dental Convention that held its inaugural meeting in the same city the very next day, August 2, and many Society members joined, and many more, including Chapin Harris, would soon join too. Harris noted that he had never expected to see such harmony among its members. The Convention, that held annual meetings until 1876, strived to establish a truly democratic organization with a minimum of structure, not even having a treasurer. Its well-attended meetings were planned to avoid all controversy and promote a feeling of equality and fraternity.

In 1856, the year of the official dissolution of the American Society of Dental Surgeons, Dr. Brown in California discussed his personal views on ethics, quoting from an address given by Dr. Joseph N. McDowell, a friend in St. Louis who had founded the second medical school there: “On the subject of medical ethics, gentlemen, I have but little to say that cannot be said in a single word. Be the gentleman! Allow not opportunity to pass, that you do not endeavor to convince your neighbor physician that you will be his friend; that your course will be with him both honest, upright and honorable….. The code of honor should be the physician’s code…. Attend to your own business, and do not too much concern yourselves with the business of others. Do not, by stealth, secure the patients or the family practice of your brother doctor; nor by insinuation, nor by innuendo reflect upon his honor, his integrity, or his intelligence…. Leave all such meanness and like insinuations for the heartless hypocrite who may lie, but cannot deceive; whose objects are too transparent not to be observed; whose only wish is the elevation of himself upon his neighbor’s downfall.”

Back in 1848, Dr. Brown had described himself, in the graphic words, as being “Bowie knifed,” by his colleagues, but still retaining the earnest hope that he would “live long enough to see the outraged honor of the Dental profession, fully vindicated.” He did live to see the beginnings. In 1859, Dr. John McQuillen organized a so-called “National Delegated Association,” better known as today’s American Dental Association. Delegates appointed by the various existing dental associations (but not including the American Dental Convention) met on August 3 at Niagara Falls. A constitution was written, based on that of the American Medical Association. Permanent structure was given to the association by the establishment of several standing committees dedicated to
various sub-specialties of dentistry as well as to
dental education. It was this structure that ensured
the enduring presence of the ADA over a period
approaching 150 years.

The ADA published a “code of dental ethics” in
Boston in 1866, having benefited from the lessons of its
forerunners. Centrally located in this code were these
statements, “In his dealings with patients and with the
profession, the conduct of the dentist should be in ac-
cordance with the Golden Rule, both in its letter and in its
spirit…. One dentist should not disparage the services of
another to a patient…. The welfare of the patient is para-
mount to every other consideration.” The ADA and this
code gave permanence to Dr. Brown’s resolute belief
that the standards of dental ethics should be based on
honor and respect, and treatment grounded in an
enlightened approach to scientific research.

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Painless Parker’s Legacy: Ethics, Commerce, and Advertising in the Professions

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Abstract

This presentation will review the life and contributions of Dr. Edgar Parker, the infamous and controversial pioneer who specialized in a precarious straddling of the ethics of the commercial marketplace and the ethics of care. Something of a Rorschach test, he was alternatively referred to as a charlatan, the first people’s dentist, a renegade, a crusader, a quack, the Henry Ford of dentistry, and “a menace to the dignity of the profession.” He eventually owned and managed thirty dental offices, several in San Francisco, as well as the Parker Dental Circus. Because many young, twenty-first century practitioners have little problem with slick advertising, it seems appropriate to revisit Painless Parker’s career and contribution to the current state of affairs.

Thank you for that wonderful introduction. You know, you all have talked about your qualifications, what you’re not, and what you are—I’m not a historian, actually, and I’m not really an ethicist or a philosopher, and I’m not a dentist. So that puts me in kind of tough shape. I do have a lot of amalgam fillings in my mouth, though, and students and faculty have accused me of being a little goofy from time to time. Goofiness probably qualifies one for a presentation about Painless Parker as much as any other quality.

I hope this material will be interesting to you. It’s been very interesting to me, and I want to thank, publicly, Dr. Arden Christen because his books were nearly my sole source of information. Ninety-five percent of my research for this presentation—or at least the Painless Parker component of it—came from Dr. Christen’s books, and they’re wonderful. The story of Painless Parker is compelling, but it’s more than that; it’s also a story of the early United States around the turn of the 20th century. It’s good reading, well worth the time, and I recommend Arden’s books to all of you.

So here’s Painless: I’m sure you’ve seen this photograph (Fig. 1) of him wearing his famous necklace with 357 teeth that he extracted in a single day. I want to start my presentation by reviewing Parker’s life; and we will only have time for a sliver of it. The fellow was an incredibly interesting guy with an incredibly interesting life, and I’ll use that statement as a segue into two things. One, I want to present to you a model of commercial and ethical dentistry; and then secondly, I want to discuss the history and current state of advertising in the professions.
Let’s begin by examining how dentistry and commerce have been combined, merged, and thrown together over the past century, as this is an important yet confusing matter for dental students and professionals alike. Painless Parker’s career serves as an apt metaphor for the entire conundrum. Here’s a quote from Parker himself:

“I like being a dentist and a salesman at the same time.”

### Commerce and Care

We’ll start with the model (Fig. 2) that I will use to organize the essential elements of this presentation.

The model is derived from ideas that I first encountered in an essay by David Nash in the *Journal of Dental Education* in 1994. I’ve evolved it a little bit from Nash’s original article, of course. The model is about the inevitable tension between the world of commerce and the world of care. We live in a commercial market economy—a capitalist competitive market economy here in the United States—and there are a lot of good things about that market economy. At the same time, doctors also live in something I call the “World of Care,” or the “Ethics of Care.”

First, the left hand side of the chart: There, profit’s the goal, money is primary. We know profit’s the goal because in business school they made us memorize the idea that the primary ethical obligation of the officers of a publicly held company is to what? Enhance shareholder value. The way you do that is to make a profit. As a result, officers in a corporation cannot make decisions that go against profit because there’s a fiduciary relationship between stockholders or shareholders and the company officers. The officers have an ethical obligation to make a profit. They must make decisions that will support that obligation. Money is primary to the enterprise. The customer is seen as a means to that end. That’s what customers are for. They exist in order for the company to make a profit, and relationships—here’s the key idea in this chart: relationships are competitive in the commercial, competitive marketplace. Companies obviously compete with each other, and they try to beat each other out of market share. For example, if a drug company makes a discovery, it doesn’t share that discovery with competitors. Instead, they lock it in with a patent or a copyright, so that they get as much benefit added to the bottom line from that dis-

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<tr>
<th>Commerce</th>
<th>Care</th>
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<tbody>
<tr>
<td>Profit is goal (proprietary)</td>
<td>Care is goal. (fiduciary)</td>
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<tr>
<td>Money is primary</td>
<td>Money is derivative</td>
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<tr>
<td>Customer as “means”</td>
<td>Patient as “end”</td>
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<td>Competitive</td>
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<td>between companies</td>
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<td>between buyer and seller</td>
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<td>Endorsements, anecdotes</td>
<td>Science, empiricism</td>
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<td>Caveat Emptor</td>
<td>Buyer can’t fairly compete (Trust)</td>
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<td>Widgets, things</td>
<td>Life or death, health</td>
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Fig. 1—Painless Parker in 1952 (age 80), wearing a necklace made from 357 teeth that he extracted in a single day.

Fig. 2—The Ethics of the Commercial Marketplace vs. the Ethics of the Doctor’s World (Care).
covery. They don’t share it with the public, either, even though this would be nice. This kind of situation came up recently when bird flu was a threat. One of our biomed companies produced a vaccine and was unwilling, at first, to share it, for obvious reasons, even though the public would have benefited.

Just as important, and maybe more important in this discussion, is the competitive relationship between buyer and seller that most people don’t think about. When you go down the street this afternoon to buy a shirt or a pair of shoes, you are engaged in a competitive relationship with that seller. Right? What’s the competition about? Each party is trying to make his or her best deal. You’re trying to get as much of those shoes as you can and pay as little money as you have to. On the other hand, sellers are trying to sell you as little as they have to, and trying to get as much money as they can. It’s a friendly competition, it has friendly components, everybody is nice and polite, and the competition is no secret. It’s not a shock to anyone here—everybody knows about the competitive buyer/seller relationship and is used to it.

This implies that caveat emptor is in force. The buyer must look after his or her own interests. You cannot expect the seller to look after your interests when you’re a buyer. No shock to anybody, right? That’s how the game is played. So, the buyer must do research, must investigate, and must figure out if this is the right product for him or for her, or if this is the right place to get it, and so forth. And, on the commercial side, mostly we deal with things. Things, not our bodies or our health.

Over on the care side, the basic goal is different: rather than profit as the goal; care is the goal. There’s a fiduciary relationship between doctor and patient, and the overarching goal is care of that patient. If that fiduciary element is not in place the whole model falls apart. On the right hand side, “The Ethics of Care,” the doctor’s office, money derives from that caring relationship, at least conceptually. So far in dentistry in the United States, the derivative nature of profit for dentists is working. You do a good job for your patients, you take care of them well, and you’re going to make a nice living. I don’t know if that’s going to last forever; nobody knows. But, so far-so good. The patient, in this model, is seen as an end, not as a means to making money. The patient is an end, in and of him- or herself. Care of patients is the point of the enterprise. Now, here’s the big difference: Rather than a competitive relationship between buyer and seller, on the doctor’s side we have a cooperative relationship, both between doctors, and between doctor and patient.

I’ve heard wonderful examples from faculty members about how things work in dentistry in San Francisco, when they were practicing as dentists, and they called on colleagues for help. Their colleague helped them with open arms. They called upstairs to their endodontist, and that endodontist ran downstairs and helped them finish out a difficult root canal procedure. I’ve heard lots of stories like that. One general dentist told me that he bought a new piece of endodontic equipment and his endodontist volunteered to come in on weekends to teach the general dentist how to use it. That’s highly cooperative. The reason for the cooperation is what? Well, back to the goal: The reason doctors cooperate is that the overarching goal is care of the patient. Patients get better care if doctors cooperate with each other.

But the bigger force is this: Relationships are cooperative between doctor and patient. This is the big difference between the two sides. In the buyer/seller arrangement, there’s a competitive relationship between buyer and seller, and the buyer must watch out. On the doctor/patient side, the relationship is cooperative, and the central reason for this cooperation is that it’s not a fair fight. I’ve been working at a dental school for 20 years now, and I still can’t read an X-ray. If you tell me that I need a root canal and I don’t have any symptoms, I have no way to evaluate that statement. I could tap on my tooth, I guess, but I don’t really know why you do that and don’t understand what it means. So, what I have to do in this situation is decide if I trust you or not. If I don’t trust you, I’ve got to go to another dentist, one of your colleagues, another member of the same profession, and decide if I trust him or her.

This basic trust is essential to this relationship. It’s crucial. And it doesn’t exist on the commercial side. Added to that is the fact that in the doctor’s world we’re talking about very significant things: the loss of a tooth, or the loss of a lingual nerve, or even the loss of a life. There’s much more at stake.

My model is not perfect, and there are flaws in my argument, obviously, but the basic point here is that these two sides are incompatible. Dentists, nonetheless, must live in both worlds at the same time. They must figure out how to navigate and balance one foot in each of the worlds of commerce and of care. If you don’t take care of the commercial world, you go out of business. Your landlord wants the rent. She doesn’t want to hear that you took care of a lot of poor patients this month and didn’t charge them much. That’s not going to work. Dental supply houses want their money. They won’t give you implants for free.

One of the challenges of being a doctor—and a dentist in particular—is that you’ve got to manage this tricky balance. I think that this balancing act causes enormous difficulty and confusion in dentistry; and I want to get young dental students off on the right foot, no pun intended.
That’s the basis for the rest of this discussion. Painless obviously approached the challenge in his own unique way.

**Painless Parker**

Now, here’s a photo of Parker in his early days. (Fig. 3) He started hustling as a very young man. Later on, this stovepipe hat got three bullet holes in it—dangerous bullet holes; he didn’t put them into the hat himself and he didn’t hunt with Dick Cheney.

He was born Edgar Parker and he spent his early days near St. Martin on the Bay of Fundy in Canada. Later on, he did some dentistry in this area, up to Fredericton, and then across the Maine border a few times, and over to Nova Scotia. He went to college for a while in Nova Scotia, and then took off and essentially wandered the rest of his life. He practiced all over the United States, eventually in Los Angeles, winding up his practice in San Francisco.

When Parker said, “peddling,” he meant “peddling.” That word had a special meaning in 1890. In those days, “peddlers” got a wagon and some horses, loaded some things that people in the country might need, and then traveled out into the rural areas to sell people the things that they couldn’t get for themselves locally. That was called “peddling.” He did that as a child to earn money, and he enjoyed it. His parents were mortified when he came home looking strange with pockets full of money, and they were mortified that their son was a peddler. It was a big status problem for them and an embarrassment.

His parents made this observation: “He has an engine inside of him that’s too big for his frame, and he is shaking himself to pieces.” I don’t know if any of you have children like this, where you wonder who the parents are, but this is a pretty good metaphor for Painless Parker. The guy was on fire. The early developmental markers were there.

He went to seminary—I think at the request of his parents—and was promptly thrown out. He then went to Acadia College where he eventually faked mental illness so he could get out of there. He acted really crazy; he even drooled, and his tongue came out, and he ranted and was delirious until they finally sent him home.

This photo shows how he looked in his early hustling days, when he was moving around Maine and New Brunswick, where he originally learned how to sell dentistry on a stage. (Fig. 4) He had a certain look that he cultivated, and I’ll describe that look later.

Before dentistry, he signed on as a sailor. His father and his father’s whole family were sailors and shipbuilders, so it was easy for him to obtain a good job on a sailboat. He made several trips to Barbados and South America, and got dragged behind a horse, tearing up his face. He even spent some jail time in South America. As you might imagine, this was a frightening experience. He got dengue fever and was assaulted once in Buenos Aires, quite severely, and broke three vertebrae. Later in his life, a physician
attempted to treat the vertebrae by jumping up and down on his back in sea boots until Edgar passed out from the agony. He was unable to walk for quite a while, and was in terrible pain for most of the rest of his life.

On one occasion in New York, he fell through the ice on a lake, couldn’t find his way out, and was lucky to survive when someone rescued him. So, the guy lived a tough life, full of adventure and risk. Here’s a quote that provides a feel for the quality of his life during his twenties:

“In Sitka,” which is in Alaska where he spent some time in those young days, “I resigned myself to a bachelor winter. The time might have gone peacefully enough, had not the heart of one of the members of the Flora Dora Chorus seem to melt one night when she saw me. I, as usual, was clothed like a Mississippi riverboat gambler, leaning against the bar when she came in. Her name was Agnes, a former carnival wrestler, several inches taller than myself, powerfully muscled, handsome, and fast on her feet. Our acquaintance began when I happened to remark what splendid occlusion she had, as she bared her teeth in a smile at me that evening. I never intended to pursue the acquaintance further, because her steady escort was the bartender of the place, a man of terrifying size and ferocity named Sam. Her heart was on her sleeve, but she was dangerous as a water buffalo when aroused.”

She did actually wrestle him to the floor that night.

Parker’s mother was a believer in Mary Baker Eddy and Christian Science; and because she did not believe in allopathic medicine, forbade him to go to medical school. He had a good opinion of doctors and was impressed with the doctors in the hospitals he’d visited in South America and Barbados. He saw them strutting around in white coats looking sage and wise and powerful and that impression never left him.

His mother had taken medicine off the table as a career, so he went to the New York College of Dentistry and promptly got himself expelled. While he was there, to make ends meet, he opened up his own dental practice. Administrators discovered his practice and threw him out of the school. So, he came back home, thought about what to do, and eventually applied to a different dental school. When graduation week arrived at Temple his name wasn’t on the list of those scheduled to graduate. So, he made the trip out to the dean’s home, and confronted him in his garden and argued his case. The dean eventually gave in and told him, “All right, I’ll take a chance on you, as long as you agree to never disgrace the college.”

There were so many quotes from Parker that I could have put into this presentation… I had to choose just a few. Here’s another one:

“If it’s possible to preach the gospel with the accompaniment of cornet and drum, why would it be unethical to hold a public dental demonstration?”

And really, the answer to that question is back on my original chart about the ethics of care and the ethics of commerce. There is a difference. But a lot of people don’t understand that difference. They say, “If they can do it downtown in the financial district, why can’t I do it in my dental practice?”

Here’s another Parker quote:

“When you stand up in a wagon or appear on a street corner and give a dental hygiene demonstration, some people will think you’re crazy. However, when you separate them from their cash, then who’s crazy?”

One of the key points that Arden makes in his book—and it comes across loud and clear—is that Painless Parker was really just like the rest of us. He had an angel on one shoulder and a devil on the other. You know, there were two parts of the guy, and he desperately, for a long time, wanted to be what they called an “ethical” dentist, or a “professional man.” He tried, for a period of time, to do that, and he just couldn’t pull it off! It didn’t work for him for a variety of reasons.

His wife was constantly trying to get him to “go straight,” but he was always drawn back to the carnival atmosphere. He loved circuses; he actually bought a dying circus at one point and ran it himself for a while. He put a lot of effort into polishing this dental act that he had, which would take place on a stage. He hired people to play musical instruments loudly on cue. He would invite anyone who had a toothache up on the stage to have the tooth extracted. He guaranteed that the “procedure” would be painless. When he was ready to extract the tooth, he gave a signal, and the band would strike up suddenly and very loudly. The sound startled everyone, including the poor, unsuspecting patient—which is a hypnotic distraction technique—and then Parker would put his knee on the patient’s chest, push in with his knee, and when the patient opened his or her mouth to gasp for air Parker would yank the tooth out, hold it in the air, and walk around triumphantly. (Fig. 5)

He also used something that he called “hydrocaine.” He and a pharmacist created an anesthetic using cocaine, and they named it “hydrocaine.” If the “patient” experienced pain, Painless would refund the dollar extraction fee along with an additional five dollar compensation. That was the guarantee. And that’s how he talked people into getting up on the stage, partly. I think sometimes he had shills come up first. Nobody knows how much of his act was real and how much of
it was phony, of course, but the performance was very good, indeed.

Wherever he went in those days, he would put a rocking chair on a soapbox, get a spittoon, and was ready to practice. Later in life he yearned for the old carnival days. Even when he was an established dentist with 36 offices on the West Coast, he still occasionally set one of those chairs up and treated people off the street. (Fig. 6)

Dr. Christen’s book has photos of Parker’s offices in Brooklyn at about the turn of the twentieth century. In huge letters on the side of the buildings it said (Fig. 7): “I am positively IT in painless dentistry.”

There are other wonderful old photos of Painless, his staff, and his mobile dental chairs in Arden’s book along with rumors that other dentists at the Painless Parker offices called themselves “Painless.” There also are photos of Painless on top of an elephant clad with advertisements and a dental assistant blowing a bugle from the back of a pick-up truck outfitted as a dental office. (Figs. 8, 9, 10)

Parker was one of those people who was really rich, then really poor, and then really rich again, and really poor again. He’d lose his money, and then he’d make more money. He also had seven or eight family members who depended upon him for their wellbeing. He took care of them and paid all their bills; his parents included. He was one of those “up and down” people.

Parker had five dental offices in the San Francisco Bay area. One of them, at 1802 Gary Street at Fillmore, is just five blocks or so down Fillmore Street from our dental school, the Dugoni Dental School of the University of the Pacific. One of the reasons I originally got interested in Painless is because he had that practice in our neighborhood and because, when I arrived in San Francisco twenty years ago, several older faculty members remembered Parker quite well.
Painless’s given name was “Edgar.” There were lots of Parkers around in those days, and at some point, authorities told him to cease and desist with claims of “Painless” dentistry. So he went over to City Hall in San Francisco and had his first name legally changed from “Edgar” to “Painless.” From then on out, he was referred to as Painless Parker, and no one could stop him.

In San Francisco there is something called the “Court of Historical Review” that goes back in history and retries people who were famous or infamous in cases where they may not have gotten a fair shake in real life. This court retried Painless and found him not guilty of practicing veterinary dentistry without a proper license. He called it “Hippodontia” at the time, and there are photos to prove that he did it. (Fig. 11). There were also rumors that he removed a tooth from a lion. He reported that he was so scared of that escapade that couldn’t control himself, but others had the animal tightly restrained so that the procedure could be accomplished.

Painless would have referred to you in the audience as “the ethicals.” That was the term he used for mainstream dentists. After years of trying to join with mainstream dentistry but being pulled toward the more commercial side of things, he gave up and decided that mainstream dentists were “phony.” His view was that formal dental ethics were in place primarily to maintain monopoly status. He had spent years riding from town to town practicing mobile dentistry, with a cart and a wagon and maybe an assistant. He would show up with his little routine. He would make an announcement in a prominent place, he’d rent a vacant lot, and he’d do dentistry—until the one local dentist in town discovered what he was doing and found a way to get rid of him. Typically this involved sending the sheriff to arrest Painless, or to demand to see that he’d paid his $2 fee for a license in the State of Whatever-State-It-Was. Painless rarely had such a license and the state agencies did not make it easy for him to get one. He eventually decided that the dentist in each town had monopoly status and intended to do whatever was necessary to keep it.

Parker also felt that mainstream dentists kept patients in the dark, didn’t talk to them about their real needs—about hygiene and home care, and weren’t aggressive enough about getting people to the dentist’s office for routine care. He felt that they preferred to treat the wealthy and not the common person. He felt that they charged exorbitant prices, and he also observed that dentists were poorly organized and very inefficient. They worked like crazy, and didn’t make much money. He decided to fix those problems by himself.

At that time, especially in Los Angeles and San Francisco, he was a target of what he called “Organized...
Dentistry.” There were literally hundreds of lawsuits filed against him in San Francisco. At one point, when he opened his door in the morning, he felt as if there’d be a snowstorm of subpoenas coming in. He responded by hiring a private investigator and an attorney and kept them both on retainer full-time. The private investigator was hired to find evidence that he was being set up, which apparently was known to happen.

He won almost all of the lawsuits and settled a few others, according to Parker. But, he liked the free advertising that he got from the lawsuits—they kept him in the news. He also enjoyed the adversarial process. He liked a good fight.

He loved publicity and understood its value to his career. Once, at the Palace Hotel in San Francisco, he was invited to join a group of the city’s best, brightest, and most powerful people for a monthly roundtable discussion. These were people from commerce and law, and people from high society. At one of those meetings another dentist accused him of various unethical acts. In particular, he said “You shouldn’t be doing dentistry out in the street because it’s unsanitary.” Now, this was something of a new idea at the time. And the visiting dentist said, “There are microbes that you’re introduc-
ing into these patients’ mouths that are bad for them.” So, he left the meeting, humiliated, and as he was walking down the street, he walked by a costume shop, went in and bought a costume. He hired a stranger off the street to dress up like a microbe, in green, with antennae and all. The two of them came back into the meeting, and he accused the microbe of being dirty and dangerous, and attempted to banish the microbe from the room. The “microbe” wouldn’t leave, so Painless wrestled the microbe to the ground—and apparently won some local hearts that day. Painless loved and understood the free advertising that any kind of attention provided.

Regarding the evolution of advertising and commercialism in dentistry, it appears that there has been a historic intent, especially since Parker’s time, to restrict commercialism, and that it’s been chronically unsuccessful.

If you survey the ads that dentists produce and promulgate, you can see the trends. You find ads that highlight things like “Strict sterilization” or “Digital x-rays, 90% less radiation,” and “Mercury-free dentistry” or “We service the nervous.”

The definitive essay about all this is by Larry Jerrold and Hengameh Karkhanehchi in the Journal of the American College of Dentists. This essay traces the profession’s reactions to commercialism in its evolving ethics codes over the years.

The first American dental ethics code in 1866 was three pages total, and with regard to advertising, it said that it was unprofessional to resort to public advertisements, claims of low prices, claims of superiority, special techniques, and house-to-house solicitation. In 1899, about 30 years later, codes added that it was okay to announce your name, your occupation, and your place of business. That was at about the same time that Painless Parker practiced. In 1922, the code said, “Nothing prevents a practitioner from announcing his specialty on a card.” In 1924, specific prohibitions about claims of superiority, fixed prices for things that must vary necessarily, deception, misleading practices, using the word “company” in your advertising, or “corporation” or “association” were added. Announcing that you had special methods was also declared to be unethical by the 1924 ADA code. Reports of cases to the public as a way of advertising was prohibited, as was the use of solicitors.

Many of these prohibitions are still in effect, of course. For example, guarantees or warrantees are still prohibited. The 1927 code allowed for modest-sized ads in print; you were supposed to use type that was similar to that used by others in whatever directory you published your ad. The 1927 code also said that large display signs or peculiar lighting—anything that reminds one of the charlatan—should be deemed unethical.

At the time Parker died, the 1950 code actually said, “The use of advertising in any form to solicit patients reflects adversely on the dentists and lowers the public esteem of the profession.” Even though that code was written more than a half century ago, many dentists, and perhaps the majority of older dentists currently see things that way. The 1950 code went on to say that “Announcements may only be sent to other professionals or to patients of record.”

A legal challenge in Arizona eventually changed everything. A law firm named “Bates” challenged the rules prohibiting the professions from advertising. The case was adjudicated by the United States Supreme Court in 1977. Bates was a Phoenix area law firm that created a marketing plan to grow their practice. They relied heavily on paralegals and large volumes of routine work along with economies of scale. They did trusts, wills, and quickie divorces, that sort of thing. The State Bar of Arizona sued them to stop the advertising.

The Bar argued that, “If lawyers or attorneys can advertise, that’s going to have an adverse effect on professionalism,” and that, “Advertising is inherently misleading to potential clients and the public, and it does irreparable damage between the professional’s need to earn money, and the obligation of service.” Now, that logic makes perfect sense to all of us in the room here, right? Those were the state bar’s arguments.

The Supreme Court’s answer to those arguments was that prohibitions against advertising in the professions were actually rules of etiquette rather than ethics. The Supreme Court said, essentially, “If you can disclose your fee to your patients in the office then you certainly can disclose it to them before they come into the office. Is the information going to change in some way? Why couldn’t you tell them ahead of time? If you’re going to tell them at some point, why can’t you tell them before they come? And the Court pointed out hypocrisy within the profession: “You doctors reject the idea of advertising, and yet you structure your social life and your civic life in ways that help you get patients. You teach your students: ‘That’s how you get patients.’ You become a member of the Rotary Club, and you make sure you go to the church meetings, and you go to parties where there’ll be people you might see, you go to schools and help out.” Much of this behavior is to help dentists attract new patients. The Justices wrote that “concealing information is ludicrous and self-deceptive.” They also wrote, “Don’t underestimate the public. What you need to do is educate them. Make sure that patients have a clear understanding of fees prior to the provision of services.” They said that by not advertising, the profession is not reaching out and serving the community. This is an argument that
Painless Parker had made 80 years previously. Parker said that advertising could increase the public’s use of professional services, which would be a good thing. The court also observed that it’s the responsibility of “ethical” dentists to manage colleagues who overreach. It’s the responsibility of the dental profession to manage our unethical colleagues. So, like it or not, the Bates ruling opened the door to advertising by the professions in the United States in 1977.

Since that time, advertising has simply become ubiquitous. It’s everywhere. It’s on video screens, in buses, and at gas pumps; it’s on billboards; it’s all over automobiles; and it’s even coming to us on eggs. Our fruit is already labeled with advertisements. This drives older professionals crazy, but many 24-year old dental students don’t hold that same view. They’re used to encountering advertising everywhere. It’s a normal part of everyday life. Older professionals have a hard time telling them about the evils of advertising unless we do it very carefully, and probably in a more modern and limited way, because advertising is here to stay.

I have examples of all kinds of medical advertisements, advertisements for joint replacement, minimally invasive hip and knee replacement surgeries, even a manufacturer’s recall for a hip joint. I have an ad for a heart scan and a lung scan—if you get the heart scan, you can get the lung scan free. There are all kinds of transplant and enlargement ads out there.

The newspapers recently reported a study published in the Journal of the American Academy of Dermatology that found that it takes longer to get an appointment to have a suspicious mole checked than it does to schedule a Botox treatment. Something’s certainly out of whack.

So what rules are we left with? The “bottom line” in advertising now is the following phrase: “False or misleading in any material respect.” Dental students love to memorize things, so I make them memorize that. Any communications must not be “False or misleading in any material respect.” That’s the overarching guideline—the big idea. Ads that deceive or mislead are prohibited. Proclaiming professional superiority—that you have something that’s superior to your colleagues—is prohibited. Making a guarantee is prohibited. “Painless dentistry” is prohibited. And solicitors are prohibited.

Sadly, all of these rules are violated, though, and routinely. I have collected dental ads that violate every one of these prohibitions. I have examples of ads that highlight “fillings with no mercury or metal,” snore prevention devices, phrases like, “offer expires,” “our operators are standing by,” and “fast and easy credit,” There’s plenty of sex in dental advertising, as well.

Some ads are objectionable because they diminish other professionals. I’ve got examples of that, too. These scare patients; and you’re going to have patients who show up in your office and say, “Do you use digital X-Rays? Because I heard they’re safer.” There are ads for “mercury-free fillings.” Other ads offer “98% less radiation exposure with our digital X-Rays.” Another advertises “biologic dentistry.” Many ads play on patient fears, and many people fear dentistry, of course.

It seems to me that advertisements for free teeth whitening are potentially deceptive. Not everyone is a good candidate for teeth whitening, right? Teeth whitening is variable and not going to work well for everybody. I could see patients coming in because of the free whitening offer only to be told, “Oh, I’m sorry, you’re not a good candidate.” That situation comes close to a “bait and switch” situation—or at least something that is not completely honest.

I have one ad that even says, “Did you use all your dental insurance this year?”

Advertising is an obvious symbol of the difficult situation that dentists face in every day practice. They have a primary obligation to take good care of patients who do not know much about dentistry, root canals, or streptococcus mutans. At the same time, dentists also have an obligation to make the rent. They have one foot in the cooperative world of care and the other in the competitive marketplace. Painless Parker’s life and career provides a cautionary tale. If we don’t take care to manage this tricky balance, we are all liable to suffer. An overly commercial profession simply will not work.

Bibliography


An Ethical Lesson Learned from the Equestrian Sculpture, “The Torch Bearers,” at the University of Madrid Dental School

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Abstract

As dental professionals, we continue to learn ethical lessons throughout our careers and beyond. We may experience them in our day-to-day involvements with peers and patients, or they may present themselves under more unusual circumstances. In October, 1974, at the University of Madrid Dental School, the senior author had a deeply impressionable experience minutes before he helped to present a course to Spanish dentists in operative dentistry. His co-presenter was Dr. Miles R. Markley of Denver, Colorado, a National Consultant in Restorative Dentistry for the U.S. Air Force. Their ethics teacher that day was Dr. Gerardo Zabalo, Dean of the dental school. His object lesson was delivered at the base of an equestrian, aluminum, larger-than-life sculpture, “The Torch Bearers” which faced the school. The sculptor shows an old, wrinkled man, lying prostrate, with only enough strength left to raise a lighted torch upward. Reaching down to receive the torch is a robust, energized young man, who is sitting upon a sturdy stallion.

The lesson which Dean Zabalo taught that day was simple but profound. The lit torch of ethics, learning and values is essentially transmitted from generation to generation, as young students learn from

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their elders, accept the torch from their retiring leaders, keep the torch brightly lit as they mature in their profession, and, then in turn, hand it over to those young professionals who will replace them. This process will continue, age after age. Thus the torch of learning and thinking is passed on. In the world of education, human contact and the continued sanctity of the scientific written word must be paramount. Students must be taught how to read, learn and think. Computer technology used exclusively as a mode of teaching and learning can never become a viable substitute for our traditional interactive methods which emphasize human to human interaction.

Fig. 1—Dr. Miles R. Markley, Denver, Colorado (left) with Professor (Dr.) Gerado Zabalo (Rubio), Dean, at the University of Madrid School of Dentistry, October 14, 1974. Dr. Zabalo served as dental Dean at the University of Madrid for 23 years (1954-1977). 1-4

On Monday morning, October 14, 1974, three dental professionals from diverse backgrounds stood in front of the Complutense University of Madrid Dental School in Spain: Professor (Dean) Gerardo Zabalo (Rubio), Dr. Miles R. Markley, Denver, Colorado, and I, Dr. (Colonel) Arden G. Christen, Zaragoza Air Base, Spain. We had just engaged in a detailed discussion concerning our plans for presenting a four-day participating course in operative dentistry to 50 practicing Spanish dentists. (Fig. 1) The program, that was to begin within the hour, was entitled, “Restorations of Silver Amalgam Reinforced with Pins.” 1-4

Between 1960-1970, I had intermittently studied under Dr. Markley when he was a National Consultant in Restorative Dentistry to the United States Air Force Dental Corps. 4 Within this period, he had taught a range of his self-developed skills and procedures to military dentists. When Dr. Markley had completed his tenure in this position, he went on to teach prevention-oriented techniques to dental professionals worldwide. During his professional life, Dr. Markley emphasized the importance of using rubber dams, making conservative cavity preparations, placing pin amalgam restorations, and following the basic principles of preventive dentistry.

In addition, Dr. Markley stressed the dentist’s obligation to uphold the highest standards of ethical and moral behavior in relating to their patients. In short, they must know and abide by what they “ought and ought not to do” in any given clinical situation.

In late April 1973, Dr. Markley and I presented a “Theoretical and Practical Course in Operative Dentistry” at the 2nd International Congress of Dentistry in Barcelona, Spain. As I was stationed in northern Spain at that time, I was able to accommodate his schedule. 4

The Dean’s Lesson

With our current program soon to start, Dr. Markley and I were especially eager to review our lecture notes on clinical dental practice. Being aware of our need to move on, and speaking through our interpreter, Dean Zabalo said, “Before we go into the building, I want to show you something. It will just take a few minutes.”

We crossed the street where we observed a full-sized equestrian statue directly facing the dental school. (Fig. 2) 5, 6 Again, the Dean spoke, “In Spanish it is called the Los Portadores de la Antorcha. In English it means, ‘The Torch Bearers.’ Before we begin this course,” he continued, “I’d like to tell you how I perceive this splendid work of art.” So, we listened.

“This unique statue, made of aluminum, was sculpted by an American artist, Anna Hyatt Huntington. 5-6 She presented it to the University of Madrid as a gift from your country.”
The Dean continued, “The Universidad Complutense de Madrid, one of the oldest universities in the world, was established in 1499 with a Papal Bull (charter) by Pope Alexander VI. Since the sculpture’s installment in 1955, Anna Huntington’s symbolic work of art has become the University’s official emblem: the passing of the torch of knowledge within Western civilization from one generation to the next. Because of its proximity to the dental school and due to the message it conveys, this monument has become a metaphor of the dental profession. If you study its detailed features, you may see what I mean."

In front of us stood a larger-than-life mass of aluminum, molded into the following scene: a striking, powerful stallion, with his left hoof elevated is captured in a stately, prancing pose; a nude, muscular young man, who appears to depict the life forces of strength and energy, sits upon the horse and leans downward with his right arm extended; an exhausted, nude man lying at the statue’s base, with his torso partially draped over a rock. As he lifts his left arm horizontally, he passes a vertically-positioned, lighted torch up to the spirited youth.

The Dean continued, “As I encounter fledgling dental teachers, I bring them here to see this work of art; and I interpret it for them. In my opinion, the man on the ground represents the older dental faculty member and the man astride the stallion is the young dental student. Eventually, the senior professional must pass on his torch of knowledge and expertise to his junior counterpart. Because modern dentistry is only one generation away from extinction, it is vital that we current leaders, educators and practitioners bequeath our knowledge, skills and high ethical standards to those who follow us.” Staring at us intently, Dean Zabalo knew that he had made his point.

Years later, Dr. Robert J. Nelsen, developer of the dental water turbine contra-angle handpiece, similarly stated, “There is no glory in handing down to the following generation a torch whose flame has gone out.”

Anna Hyatt Huntington, Creator of “The Torch Bearers”

Anna Hyatt Huntington (1876-1973), a famous and talented American sculptor, was born on March 10th in Cambridge, Massachusetts. Her mother, Audelia Beebe Hyatt, was an amateur landscape painter while her father, Alphaeus Hyatt II, was a professor of paleontology and zoology at the Massachusetts Institute of Technology and later, at Boston University. Anna’s early acquaintance with her parents’ fields of expertise both led to her own artistic bent and her keen interest in animals and their anatomy. During her youth, Anna became an accomplished equestrian. In her 20s, she studied with Hermon Atkins MacNeil and Gutzom Borglum (famed sculptor of Mt. Rushmore) at the Art Students League in New York City. Additionally, she spent many hours visiting farms, zoos, and circuses, where she sketched and prepared clay models of animals. For several years (in her early 30s), Anna studied her craft in France and Italy. By this time, she had already developed her reputation as a sculptor of animals. In 1912, she was listed as one of the top twelve U. S. women who earned a minimum of $50,000 annually.

In 1923, at age 47, Anna married the wealthy philanthropist, Archer Milton Huntington (1870-1955). Archer, a devotee of Hispanic culture in America, wrote numerous volumes of poetry, travel notes, and translations from the Spanish language. His endeavors and accomplishments significantly influenced his wife’s artistic work.

Eight years after Anna and Archer were married, he purchased 10,000 acres near Charleston, South Carolina. There, he constructed Brookgreen Gardens, which currently display one of the largest late 19th and early 20th Century statuary collections in the U.S. On these grounds, Anna was able to work undisturbed.

In 1927, at the age of 51, Anna contracted tuberculosis and for the following ten years suffered intensely. During this trying time, she resolutely continued her demanding work. Eventually she recovered from this disease.
When Anna was in her 60s and 70s, she became increasingly distressed by modern art and by what she considered to be “the tasteless machine age.” Dejected, she believed that her style of sculpture was obsolete and would soon be forgotten. Anna was convinced that she had “outlived herself.”

In her 91st year, Anna completed her last major work: an equestrian statue entitled “General Israel Putnam’s Escape at Horse Neck.” During the last year of Anna’s life, she suffered several dozen small strokes. As a result, she was forced to stop working at her studio and subsequently died on October 4, 1973.

Anna Huntington was one of the most prolific American artists of the 20th century, having produced 262 works including hundreds of models cast in bronze and others cast in aluminum. She was active in her career for more than 70 of her 97 years.

How “The Torch Bearers” Was Created

Anna Huntington conceived the idea for this statue early in 1949. Using the principle of symbolic allegory, she sought to portray the triumph, or “victory,” of cultural values through the ages. By 1953, she had completed the clay model; and the following year she finished the final plaster form and had it cast at a foundry. In 1955, Anna donated the original, fifteen-foot-high aluminum cast to the University of Madrid. When she created this work, she envisioned “the heroism of the Spanish people, who have held for centuries to their ideals.”

“The Torch Bearers,” installed on the campus of the University of Madrid, was mounted on a twelve-foot round-stone base that rests on a wider, circular concrete slab. Inscribed vertically on the base is a poem, composed by Archer Huntington. The English translation reads:

“Man bears the holy torch fidelity,
Across the glazed and burning sands of Time.
A woman’s soul uplifts maternity
Starlight to mark a course no less sublime!

“O desperate endeavor of the soul!
It is a holy path these two have trod,
To light the way to one eternal goal,
And stand before the gorgeous door of God!”

While this poem presents its own unique interpretation of “The Torch Bearers,” the statue speaks to its viewers in varied, subjective ways. Some critics have observed the sculpture as symbolizing the permanence of culture. To others, “the two figures suggest the idea of the old and new generations striving to preserve that which they most cherish.” One writer describes the work in the following way:

“The theme of the torch of enlightenment being passed from one generation to the next is epitomized by the vigor of the man on horseback grasping the torch from his fallen comrade.”

Myrna G. Edens, in her classic interpretation of “The Torch Bearers,” states, “It represents ideals of the cultivated tradition, including the victory of heroism, the permanence of culture, the continuance of civilization and creative imagination.”

At Anna’s behest, three replicas of the original statue were produced. One, cast in bronze, was unveiled in April 1956 at the Palacio de Belas Artes, in Havana, Cuba. A second, reproduced in aluminum, was presented to the city of Norfolk, Virginia in November, 1957, and stands in front of the Norfolk Museum of Arts and Sciences. Another aluminum replica, dedicated in August 1963, was placed on the grounds of the Museum of Art, Science and Industry in Bridgeport, Connecticut.

Postscript

For 26 years, Dr. Markley and I kept in regular contact. At times, when we reminisced about our mutual experiences in Spain, Dr. Markley would comment on the “The Torch Bearers” statue and the significant impact it had on him. Throughout his life, Dr. Markley continued to give courses in operative dentistry, both in Spain and worldwide. His long-term influence on Spanish dentistry, both ethically and practically, has been nothing short of astounding! Today, a significant number of his self-developed, professional principles—based on ethical and moral considerations—are being taught in Spanish dental schools and are widely practiced by dentists throughout Spain.

Miles R. Markley, DDS, Denver, Colorado, died on January 31, 2000, at the age of 96 after suffering from the complications of a stroke. (He had predicted that he would live past the age of 100). As a tribute to Dr. Markley, I was chosen to write an “In Memoriam” that was published in Operative Dentistry. One section reads:

“Dr. Markley was a chairside general dentist with a conscience. During his first five years in practice, he noted with great concern that he was not producing durable restorations. As he studied his failures, he concluded that the G.V. Black-type of cavity preparations and the amalgam restorations that he had been taught to place in dental school could not provide the longevity that his patients deserved.”

As a result of his unwillingness to accept “less than the best,” the young Dr. Miles Markley developed a more
efficient, durable and rewarding method of producing restorative dentistry. One of his favorite lecture themes was “preservation of the natural teeth for a lifetime of service.”7,8 He was never complacent about his professional knowledge and skills—there was always more to be learned and accomplished. His lifetime of dedication to dental excellence has convinced me and countless others that we can only truly learn from those who “walk the walk,” and pass their torch of well-honed knowledge and experience to those who follow.

Afterword

While in the process of completing this paper, the authors were introduced to a thought-provoking book by Sven Birkerts, published in 1994. The Gutenberg Elegies: The Fate of Reading in an Electronic Age was recommended to us by a distraught assistant librarian from a junior college in North Texas.9 He explained to us that a drastic, unexpected change was currently occurring within his school. The incoming chief librarian was making some radical changes in the department with the goal of eliminating books and converting the entire system to a computer-only format. As a result, the assistant librarian had taken a special interest in Birkerts’ view of reading and its primary, ongoing role in education. Being avid bookworms who view such a drastic change with horror, your authors purchased and read Mr. Birkerts’ book. Birkert laments the prevailing tendencies among both public and private schools to stress electronic education at the expense of book learning. (Currently, dental faculty complain that an increasing number of students are ill-equipped to comprehend, analyze and apply the concepts in their reading assignments with clarity and purpose.) Birkert firmly believes that since computer literacy is now the front-runner within education, the English language is becoming increasingly impoverished.

Reading, writing, and face-to-face communication, means that have served as the primary source of strength in Western civilization, are now being sacrificed in the name of computer literacy. He argues that the future of books, reading, and writing are at stake.

However, this is not to say that online communication is lacking in purpose. In countless ways, it has revolutionized our methods of obtaining and sharing the wisdom of the world. Today’s students are becoming increasingly computer literate and they are continuing to develop the multi-layered, multi-track ability to categorize and deal with the world of facts. However, Birkert cautions that those with multi-track sensibilities seem less likely to think and perform the single-track tasks demanded by the silent, written word. For example, when current dental students want snippets of information, they typically search for them by tapping into “Google,” “Wikipedia,” “Ask Jeeves,” or other search engines. In truth, many of these sources are inadequately linked to the world of dental research and practice. Naïvely, many students blithely accept this unauthoritative information and seem content to search no further. Also, since computers force students to read at a pace set by the machine, individuals have virtually no time to contemplate and creatively process ideas. Rather, computers drive a system of mere rote learning.

The ultimate question is, “Should we relinquish our traditional teaching and learning methods and completely delegate them to a machine?” Nothing can replace the transmission of knowledge and high professional standards that are passed from teacher to student. In a live setting, the faculty shares professional knowledge gained from experience, study and thought. In this milieu, knowledge, ethics, and values pass from the experienced leader to the inexperienced follower. As a result, a torch of knowledge is passed on to the next generation. In our view, this is the essential message of the equestrian sculpture, “The Torch Bearers.”

References

Dental Ethics in a Larger Context: One Point of View

Sheldon Baumrind, DDS, MS, Professor of Orthodontics and Director, Craniofacial Research, Instrumentation Laboratory, University of the Pacific School of Dentistry

Abstract

Since the end of World War II, the practice of dentistry has been largely transformed from a “calling” into a cog in the ever-expanding “Healthcare Industry.” In the process, the distinction between professional ethics and the ethics of commerce has been attenuated and, to a large extent, lost. Today’s dentist is faced with an inherent conflict between the pledge of the health professional to hold the patient’s interests primary (and above all, to do no harm), and the self-protective commercial principle of caveat emptor. Pressures towards commercialism come from the government and the insurance industry, the increasingly unfavorable ratio between professional fees and the cost of production, and the high cost of dental education. Viewed simplistically, much of dentistry today has an outward form resembling commodity production. Recognizing the substantial forces tending to attenuate ethical standards in our profession may aid us in resisting their encroachments.

Einstein once said that the special responsibility of the elderly is to tell the truth as they see it because they are presumably better insulated than their younger colleagues from the dangers of reprisal. So I will exercise that prerogative even though some of what I say may be at variance with today’s notions of political correctness. Of necessity, some of the thoughts I express may be less than fully integrated, but I will try to express them without attempting premature synthesis in the hope that what I say may be a stimulus for further discussion at a later time.
I believe that in some ways my non-professional status in the field of ethics carries with it an advantage as well as a limitation—it allows me to assume a personal, and even subjective, stance in this presentation. So while I will observe and comment, I do not necessarily feel constrained to provide answers.

As a thoughtful person and a health professional, I must first ask myself the meaning of the term, “ethics,” and why the study of ethical conduct is important. By definition, ethics is the branch of philosophy involved with the study of the values and customs of individual persons and groups of persons. It deals with such concepts as right conduct, doing good, and acting responsibly with respect to others, the community, and oneself. I shall advocate the position that the primary drivers of ethical conduct are social and biological and that what is “ethical” is not static through time but rather alters under different social and historical conditions. In addition to its importance in optimizing the living conditions of individuals, ethical conduct is important because it is necessary for the preservation of our social, economic, and political structures and, ultimately, of the entire human species.

There are some rules of ethical conduct that, on surface examination at least, seem self-evident—categorical and absolute—in which there appear to be clear right and wrong answers. Take, for instance, at the societal level, the Ten Commandments—or at the professional level, the principle that one should not cheat on examinations. Yet most of the important substantive issues in ethical conduct that puzzle ordinary mortals like us are matters of degree. What is considered ethical and appropriate in one set of conditions or in one historical period is considered unethical and inappropriate in another historical period or under other objective conditions. An example of secular difference through time may be seen in the Code of Hammurabi, Governor of Mesopotamia, circa 1760 BCE.

229—If a builder build a house for some one, and does not construct it properly, and the house which he built fall in and kill its owner, then that builder shall be put to death.

Perhaps one could argue that capital punishment for this “crime” was less unreasonable in a period when the principal of “an eye for an eye and a tooth for a tooth” was an advanced concept aimed at supplanting vendettas that destroyed whole tribes. But look at what comes next!

230—If it kill the son of the owner, the son of that builder shall be put to death.

I present this abstract from one of humanity’s earliest written codes of justice as a dramatic demonstration of the principle that what is deemed appropriate and ethical in a society is subject to change through time. Clearly, the perfect symmetry of this solution would be considered unacceptable in any “developed country” today.

The Code of Hammurabi was formulated and implemented just about 2000 years before the birth of Christ; and this conference takes place approximately the same number of years after his death. We are meeting in the Marines Memorial building in San Francisco, a reminder that we live in a culture that, like every other culture extant, has a military force that utilizes its power in the interests of our country. Those presumed interests currently include a military campaign 7000 miles from here. Fighting is in progress today within 50 miles of Hammurabi’s palace.

During wars such as this one, ordinary citizens of our country rise to great levels of bravery and self-sacrifice in the interests of their brethren and their country. But in the course of their heroic deeds, at great personal risk, our best and bravest do terrible things to other ordinary people from different tribes. Their actions include deadly injury to a substantial number of admittedly innocent people that is counted as “collateral damage.” We consider such injury to be regrettable; but we also consider the actions that caused it to be well within the bounds of what is called “ethical.” The plaques and memorials we see celebrate the actions of people who have done amazingly self-sacrificing and altruistic things. Yet the same people are doing quite terrible things, not in their own interest, but in the interest of their buddies and their clan. Their actions are considered among the most laudatory of acts—worthy of “the highest honors a grateful nation can bestow;” and certainly highly “ethical.”

I have cited two conceptions of appropriate conduct. I consider both questionable in a moral sense, but each has been considered ethical by others in a specific historical context. And the only way I can rationalize what I see is in terms of some sort of historico-biological determinant. Indeed, it might be a useful metaphor to view the drive toward ethical conduct as if it were a biological “gene” for species preservation whose expression is modulated by local socio-economic and culture-historical conditions. Viewed analytically, ethical conduct is a precondition for the development of civilization. Without consensually accepted ethical rules, you can’t have a society.

I do not believe that ethics is a luxury or optional add-on of “advanced” societies. Rather, it is a necessary socializing alternative to the “law of the jungle,” an environment in which solitary human individuals acting in isolation from each other would have little chance for survival. That is why I take the question of
ethical conduct very seriously, both as a citizen and as a professional. And because I consider dental ethics to be a sub-set of societal ethics, I have felt constrained to examine our small area in the context of the over-arching whole.

I have the impression that the major interest of many in attendance involves not the kind of global issues I have noted above but rather the very practical problem of developing standards of conduct among aspiring pre-doctoral dental students. Hence there has been considerable concern with the development and application of formal rules of conduct in the areas of dental ethics and dental etiquette. Since I do not have a formal role in the teaching of ethics to pre-doctoral dental students, I have a different primary focus, that of identifying explicitly some the most important contradictions that I believe exist in my encounters with my patients, my co-professionals, and the general public. Hence, this presentation has become a bit more introspective and idiosyncratic than those of my fellow speakers.

We dentists constitute a community that started as a trade, developed after much struggle into a profession, and has now become a cog in the Healthcare Industry. My late friend and mentor, Dr. Sidney Horowitz, past Associate Dean at the Columbia University School of Dentistry, once told me that he and I and many like us “became professionals to avoid going into business only to find ourselves in business.” Permit me to explore, perhaps from a slightly different perspective, the distinction between a “business” and a “profession” that Dr. Peltier presented for our consideration yesterday.

The idea of what we call a business is historically older than the concept of a profession. It refers to a conventional commercial transaction between a buyer and a seller, each of whom can be expected to have full knowledge of the nature and condition of the materials being exchanged. Everyone knows what a horse or a house or a wagon is. Under such conditions, buyers are considered competent and responsible for knowing and protecting their own interests and sellers are morally entitled to focus exclusively on advancing their own interests. This concept is encapsulated in the motto caveat emptor, “let the buyer beware.”

But as civil society developed, it became evident that there was a class of transactions, mostly involving services, whose full implications were too specialized, complex or arcane for the buyer (or “customer” or “client” or “patient”) to understand fully. Medicine might have been the first field in which this development occurred, but in time other disciplines such as law, engineering, teaching, and dentistry came to be included in the group of occupations that collectively are called “the professions.” In these complex interactions, the professional “seller” of the service and the “buyer” (now called a “patient” or “client”) have an inherently unequal relationship. Therefore, the rules of the game were changed through societal intervention in the interests of the community. The community arrogated to the “professional” certain special rights and privileges including relatively high social status, relatively high compensation for his/her work, and a partial or total monopoly (called a license) on the delivery of the specialized services. In return for these special considerations, professionals were required, when engaged in their professional role, to place the patient’s/client’s interests prior to their own personal interests.

In most developed countries, it is widely believed that this social contract is the best yet developed for protecting the interests of the patient and the community at large. But it clearly does have some paternalistic features that can tend to impinge upon the autonomy of the patient. And I am not so naïve as to believe that the distinction between the criteria of business and those of the professions is quite that sharp and absolute. I, for one, do not fully understand the complexity of the innards of my car and my computer. For this and other reasons, this classic relationship between patient and doctor has been under attack in recent years in the market-driven and highly individualistic culture of the United States. Nonetheless, I believe that I have fairly represented the distinction between professional and commercial transactions. And I also believe that the distinction is still substantially valid.

There are some issues in the area of ethics in dentistry about which there exists, at the present time at least, no tension or uncertainty in the thinking of concerned dental practitioners and teachers. For example, there is no tension, no dilemma, about the question of students cheating. We are all against it, just as we are against poverty and exploitation. On the other hand, substantive problems in ethics tend to involve contradictions in principle, with all their ensuing uncertainty. They involve our looking into ourselves as well as looking out at the external world.

There is an innate tendency among human beings to seek absolute answers, to seek the one “correct answer,” to define sharply what’s right and what’s wrong.

But for most of the problems we are considering in this colloquium on ethics, the answers are not absolute; rather they usually involve finding an optimum point along a continuum. That continuum is the parabolic curve “between the horns of a dilemma.”

Take for example the question that arose early in our meeting concerning the propriety of using research data from studies that had conducted unethically and without proper protection of subjects—an allusion to
information obtained from experiments conducted on prisoners and concentration camp victims. And, our speaker answered, I’m sure quite correctly, that examination of most such data indicated that they weren’t very useful. Of course we should not use data if they are bad, but what if they are good—indeed, what if they are the best available? At that point, the real conflict for the clinician is between the interests of the patient currently in the dental chair (which I believe should always be the primary concern of the ethical dental clinician) and the damage that future patients might incur from the implied sanctioning of the transgressions of the improperly conducted past “experiment.” In those circumstances, it seems to me that the appropriate answer for the dental clinician treating a particular patient may be different from his/her answer as a citizen whose primary focus is on the interests of the community in general.

I believe that many of the ethical problems we face, like the one cited above, are true dilemmas in the sense that they have no unique solution in the milieu in which we presently operate. I illustrate this condition with a favorite story of mine that is supposed to be funny, but to me is deadly serious. It’s a story that Woody Allen relates at the end of the movie, “Annie Hall.” It’s about a man who visits a psychiatrist and immediately explains, “I’m not the problem, Doctor; it’s my brother. He goes around the house all day making clucking noises like a chicken.” And the psychiatrist thinks and says, “Well, that sounds like a pretty serious delusion. I think there’s probably nothing you can do with a person that far gone but institutionalize him.” And the client replies, “But we need the eggs.”

From my perspective, most of the ethical issues that really trouble us deal with this sort of competition between competing principles, each of which has something going for it. In most of these situations, to some extent at least, “we need the eggs.” Hence the key problem for me is to identify areas in which there are conflicting ethical principles and to consider how we should approach issues in which there are partial rights and partial wrongs.

Since no perfect solutions are possible in situations of conflicting principles, we must learn instead to look for solutions that are optimal. And whenever optimal solutions are sought, much depends on the perspective from which one operates. It is necessary to understand that different decisions will legitimately be considered optimal at different times and/or in different cultures.

Without even pretending to present solutions or extensive analyses, I would like to list a number of the most important contradictions that I believe contemporary dentistry faces in our country. They include:

- The conflict between the dentist as a professional and the dentist as a businessman
- The conflict of economic interests between the dentist and the patient
- The difference between viewing “dental ethics” from the perspective of public health administration and from the perspective of the wet-fingered dental clinician
- The difference between the dentist’s role as a professional and his/her role as a citizen
- The constellation of problems facing dental schools and dental educators as they struggle to survive in a culture that seeks to optimize the quickest possible return on economic investment.

I shall touch briefly on each of these—just sufficiently to convey a sense of what I consider to be the issues at stake.

The conflict between the dentist as a professional and the dentist as a businessman

During the 60 years since the end of World War II, the practice of dentistry, like that of medicine, has been largely transformed from a “calling,” as Dr. Charles Bertalami, now Dean of the New York University College of Dentistry, described it several years ago, into a cog in the ever-expanding Healthcare Industry. We have become part of an Industry! And in the process, the distinction between professional ethics and the ethics of commerce has been attenuated and, to a large extent, lost. I argue that today’s dentist is faced more strongly than ever before with an inherent conflict between the classical pledge of the health profession to hold patients’ interests primary, and above all, to do no harm, on the one hand—and the necessary, personally self-protective commercial principle of caveat emptor.

Among the forces driving deleterious changes to our profession, there has been a massive increase in pressures towards commercialism, especially from the federal government and from the insurance industry. There have also been increasingly unfavorable changes in the ratio between professional fees and the cost of production. When I started in dentistry in 1950, I opened my office in Berkeley on $1,500, and my overhead was 23%. As an older observer, I shudder to think how much it costs to open a dental office nowadays. Overhead has risen until it approximates 75% in some practices. To me, such a nut seems a strong impediment to altruistic thought. It’s very hard to give away your services, especially when you are still paying off your student loans. I may seem to be belaboring the obvious, but I think this needs to be said.
The conflict of economic interests between the dentist and the patient

Almost all dental care in our country is delivered on a fee-for-service basis. This fact sharpens the conflict of economic interests between dentist and patients and is another impediment to altruism. And it does not help that, viewed simplistically, much of dentistry has an outward form resembling commodity production. When I opened my first office sixty years, one of my first patients presented with bilaterally missing lower first bicuspids. I proposed two fixed bridges to replace them, that being at that time, the standard of care. At his next visit, my patient said to me, “The doctor down the street says that he can do the whole thing for half as much money with a removable partial denture.” Certainly this was a crude response from a crude and unlettered patient. But it did serve to emphasize to me that our perception of our patients’ interests may be very different from his/her own.

Much later, but when I was still a general dentist, another patient told me, “You know, when I get home at night, I’m really exhausted and my kids come at me, and I need to be able to put my legs up on the cushion, and I’d love to be able to watch a television set. But I don’t have a television set, and there is a competition between getting one and getting the two posterior full crowns you have recommended. What do you think I should do?” And I will say for myself that I told him I thought that having the crowns placed belonged between his first television set and his second. But I hasten to add that I made this magnanimous statement in the tenth year of my practice; I am not quite sure I would have made it as easily during my first year when I was really struggling to pay the rent.

The difference between viewing “dental ethics” from the perspective of public health administration and from the perspective of the wet-fingered dental clinician

There is a very real discontinuity between viewing the entire subject of oral health from the perspective of the chairside, fee-for-service clinician treating individual patients one at a time and the overarching perspective of public health dentistry. This is especially true when the two are competing for limited public resources. Although we do not often think about this contradiction, it is very real. For example, I believe it is substantively true that the NIDCR is not much interested in clinical dentistry as it is delivered in the offices of private practitioners—notwithstanding some relatively small pilot projects currently being started in that area.

Viewed from the perspective of large governmental and commercial organizations, clinical dentistry has, primarily, the character of a craft. The highest ethic of the practitioner is to protect the interests of the patient who currently occupies his/her dental chair. The clinician’s technical focus is on producing an “ideal” restoration or a “flawless” fixed bridge, etc. The focus of public health dentistry, to the contrary, is almost statistical—to reduce the community DMF rate or the average use of smokeless tobacco in the community, following the Benthamite principle of “the greatest good for the greatest number.” Large scale mitigation of pain of dental origin by flying visits of teams of exodontists may be a triumph of international relations for public health dentistry. But may look very much like a social failure and an abandonment of proper standards of care to the serious clinical practitioner whose goal it is to preserve the dentition of his patients, considered one at a time.

The difference between the dentist’s role as a professional and his/her role as a citizen

The fact that we, as professionals, have certain uniquely valuable skills does not logically or properly lead to the conclusion that we have a special responsibility to underwrite the costs of providing those skills to the public. The uniqueness of our ability to treat dental caries does not mean that we have a special responsibility to subsidize the cost of treating dental caries for worthy but underprivileged members of the community. As citizens, we do have the same responsibilities that other citizens have, and we may indeed choose to provide pro bono services. But the state does not have a moral right to ask us to provide professional services at greatly reduced fees merely because we have these special skills.

The constellation of problems facing dental schools and dental educators as they struggle to survive in a culture that seeks to optimize the quickest possible return on economic investment

At the wonderful private institution at which I currently teach, we are highly dependent upon the largesse of the 49% of the alumni who provide financial support on an annual basis. The fact that so many graduates are willing to support their dental school on a continuing basis is itself testimony that the school operates on a humane and enlightened basis. But sometimes the same strongly-affiliated alumni can seek a quid pro quo that is more directed toward their personal
interests than to the highest interest of the school or the public. Other dental schools, private and public, face the same problem, and some have handled it less successfully than ours—as recent newspaper stories attest.

We all know that dentistry has massive social value but also that dental education (like higher education in general) is expensive and in need of financial support beyond the tuition fees that students can reasonably be expected to pay. This is a component of the long-standing national debate about public support of education that has confronted our country since its beginnings. In earlier years, this problem was solved by heavy, mandated public-sector support of higher education; the major state universities of our country are the consequence of that strategy. But more recently, public sector support for higher education (and for dental education in particular) has dwindled to a truly alarming degree. This objective social reality has lead to an ethical dilemma that heavily impacts the administration of all dental schools. Shall the schools seek to maintain their moral purity completely, disdaining the potentially corrupting influence of private sources of support that may have motives other than purely social, in which case a number of schools will almost certainly be forced to close? Or shall the schools, as components of the recently amalgamated “Healthcare Industry,” accept and even solicit assistance from the other components of the industry, (i.e., manufacturers of dental supplies, equipment and therapeutic devices sold to the public directly or through dentists) even though those entities have interests that may differ substantially from those of dental education? Since closing dental schools would clearly be contrary to the public interest, educators are forced to accommodate in order to survive. It is again a question of “needing the eggs.”

To illustrate this dilemma, our school recently entertained a large number of visitors to the annual ADA meeting. The meeting at our school was subsidized by a number of commercial firms, who had their advertisements scattered obtrusively through the building. Thus the school was involved in implied support of these merchandisers and their products, including several products whose efficacy has been questioned. We all know this is “not quite right,” but we cannot continue to educate new dentists without those eggs! We can’t educate people without a facility, and we can’t pay for the facility without the support from corporations that sometimes exact onerous conditions. A major traditional source of support for public dental schools has been the state governments. But state support of dental education is now so restricted that even at the University of California San Francisco School of Dentistry, a major state institution, the current budgetary contribution of the State of California is down to 17%. Needless to say, that creates serious ethical problems for the school administration as it maneuvers to fill the gap.

**Summary**

Since the end of World War II, the practice of dentistry in the United States has largely been transformed from a “calling” into a cog in the ever-expanding “Healthcare Industry.” In the process, the distinction between professional ethics and the ethics of commerce has been attenuated and, to a large extent, lost. Today’s dentist is faced with an inherent conflict between the pledge of the health professional to hold the patient’s interests primary (and above all, to do no harm), and the self-protective commercial principle of *caveat emptor*. Pressures towards commercialism come from the government and the insurance industry, the increasingly unfavorable ratio between professional fees and the cost of production, and the high cost of dental education. Solutions to the problem are complicated by the fact that much of dentistry has an outward form resembling commodity production.

In this brief critique, I have directed attention to a number of consequential ethical problems that I believe confront dentistry, but I have proposed no solutions. That omission has been intentional, because I really don’t have any optimal solutions to present at the moment. Indeed, I don’t know whether workable solutions exist. But if solutions are to be found, I believe they will require many more open discussions like this one. Our profession and the public will have to learn to sustain the anxiety and uncertainty of looking at the state of health care in our country as it really is, rather than as we wish it were.
Ethics in Dentistry Colloquium Addendum: Discussions and Questions

The decision to record the proceedings provided many hours of spontaneous and lively discussions. The following section should provide an appreciation of the depth and currency shown during the panel discussions. I have taken editorial liberty in paring down the extensive transcription to a somewhat coherent and manageable format. I wish to acknowledge Dr. Morton G. Rivo for his assistance in this endeavor.—The Editor

Colloquium Delegate: How do you see bioethics influencing the code of professional ethics?

Dr. Albert R. Jonsen: That is a great question, “How do I see bioethics influencing professional ethics?” The first thing in answering that question is to explain what bioethics might mean. It is, as many of you know, an intellectual effort—some might call it a discipline—that began about 30 years ago with a very specific sort of problem in mind, namely, “How does one manage the potential developments of technology in the health sciences in relationship to human values?” It is a question of advancing technology, which is, in itself, valueless. It simply moves things ahead scientifically; and the question of its application, then, becomes a moral question. Some of the early questions that intrigued bioethicists were questions surrounding transplantation, application of genetic knowledge, and so forth. The word “bioethics,” which was actually just created in the year 1970—it was just made up by someone—the term “bioethics” gradually seemed to take over all of the field of what were called “medical ethics” at the time, or “professional ethics.” In addition, it left out of serious consideration many of the things that were in the old professional ethics in the codes and so forth. The study of that element has been largely left out of this growing field of bioethics. However, as the field of bioethics has grown, it has brought to the fore some very specific moral injunctions. One of the strongest is the importance of the autonomy of the patient. Originally seen in the context of how one manages technology—that is, technology should not dominate decisions, but rather, technology should be weighed by those who would be affected by them in terms of their benefits and risks. The importance of the autonomy of a patient becomes a very central idea in bioethics. It was not a very central idea in the codes. Rarely does one see mentioned in the historical codes any part for the choices and the autonomy of patients. Therefore, as we think about codes today, the role of autonomy has to be, I think, much more completely integrated into our understanding of the patient-physician relationship. Most of the codes in medicine, and in dentistry, are still largely codes of professional behavior toward others, not codes of relationships between patient and practitioner, even though the AMA does try to define its first codes as a set of rights and duties—that does not get very far. It rather becomes, essentially—if you are going to be a good doctor, you have to be kind, you have to be competent, and so forth. It does not say you have to pay any attention to what your patient wants. In the original code of the AMA, there was a chapter devoted to the responsibilities of patients toward doctors, which was eliminated around 1912, I think, because people said, “What right do doctors have to dictate duties of other people toward them?” Therefore, that was left out, and generally, that is how I begin to answer your question. It would be to say that the idea of autonomy that has emerged in bioethics could be an adjunct or a way of thinking about the expression of the codes of professional ethics.
Colloquium Delegate: You seem to have painted a picture of professional ethics as being not as we would like them, maybe 150 years ago, and perhaps much better now. Why did it evolve like that? Were general standards of behavior from one person to another that much worse then than they are now? Is there a generic reason for it?

Dr. Albert R. Jonsen: I think there are many reasons for it, probably not a generic one. In my mind, perhaps the most important one is the growth of the concept of personal freedom within ethics—a concept which is really an Enlightenment idea, an 18th century idea, and which was really not part of standard moral philosophy and literature of the past. The freedom of an individual becomes an idea that begins—just like the idea of autonomy that I just mentioned—as you delve into the principle of freedom, or into the idea of freedom, the idea of there being standards to which all persons must bow down before it fades away. I am not by any means saying that the idea of freedom is incorrect and ought not to be part of our thinking; but it is very hard to reconcile a strong sense of personal freedom with a sense of moral obligation and principle. That is why, I think, the philosophical school called utilitarianism has been pretty much the dominant way of thinking over many years. Utilitarian means, simply, my self-interest is the essential feature of ethics, and my main problem is how I can exercise my self-interest without being squashed by others whose self-interest I am fighting. The idea of standards and principles—even, for example, even a form of utilitarianism that recognizes the importance of moral principles, does so for utilitarian reasons. It says, “The reason we should have moral principles, is that without moral principles, we would not get anything useful achieved.” Therefore, it is a utilitarian reason. Much more can be said in response to your question, which I hesitate to do at this point.

Colloquium Delegate: My question is whether it is ethical to use data that was collected from studies—such as the Vipeholm study—which do not meet current ethical standards?

Dr. Ernest Newbrun: As I said, I am not an ethicist, but I believe the Vipeholm study—which cannot be reproduced, but the data that we have from the Vipeholm study has been reproduced in animal studies. At the time of the Vipeholm study, animal studies were not sophisticated. Now, we know how to infect an animal model with a cariogenic Strep. Mutans, so we have standardized that animal model. We even have feeding machines for rats—and so we can control the frequency of the feeding. All the data and findings from the Vipeholm study have been confirmed. We do not really need to quote it because we have animal data. The animal model gives us some clues as to the process in humans; we are still more comfortable with having human experimentation. In that case, I think the results are validly sustainable, even if they do not conform to our retro-spectroscope idea of how studies should be conducted. You open up another issue, and that is, of course, the German doctor studies, most of which did not really contribute to medical science at all. I think that is very different from the Vipeholm study. Then, of course, you may say, well, what about the Tuskegee syphilis study which was also unethical? About the finding, which was, how does syphilis progress when there is no intervention—and for answering that, perhaps Professor Dr. Jonsen would venture to comment on whether it would be ethical to accept any of their findings from a bioethical viewpoint?

Dr. Albert R. Jonsen: Dr. Newbrun, you mentioned earlier that I had said to you that, as usual, ethicists disagreed on subjects. This is one in which there is a range of very broad agreement and a lot of disagreement. The range of broad agreement is that, if there is unethically obtained data, it is not ethical to use it subsequently if it is possible not to use it. Because, and there are two issues involved in that statement that show how complex it is. First, to say, “Unethically obtained data” is frequently difficult. As you pointed out, Ernie, the Vipeholm studies were done at a time when some of the standards for ethical experimentation were not in place and not clearly understood, and therefore it may be difficult to say that they were done unethically. In addition, circumstances of that trial—such as the absence of serious harm—make the charge of unethical design difficult to sustain. The same thing is true of the Willow Brook studies, with children in the United States, where there was no discernable harm. The problem with much of the Tuskegee studies is that the results of Tuskegee, in terms of the natural history of syphilis—of untreated syphilis—much of that is now so totally integrated into the science that it can’t not be used. Early on, it became a basic set of data that was integrated into the pathophysiology of syphilis. Therefore, the question would come up, if there were a specific point that is obtained unethically, and if you can gain the information in some other fashion—such as you mentioned, through animal work—then it is not appropriate to use it. There is one place—it is commonly agreed that there is one place in the Nazi studies where there might, in fact, be otherwise unobtainable data. The question would be, “Should that data be used?” and those were the studies with regard to hypothermia which could not be repeated today.

Colloquium Delegate: Another area is polio testing. You could say that coming out with the Salk vaccine
started to liquefy. The other one said, “Well, that’s could pronounce the patient dead was when the brain patient dead—the first man said the only time you because it turned on when you pronounced the 

citation. The first one insisted that you could not—

tals, and you do, indeed, implant them in patients,’” whereupon the first physician replied, “Well, we’re rigorous, but we’re not stupid.”

Colloquium Delegate: Another ethical dilemma that has a more current application would be in periodontics. For example, with the knowledge that periodontal disease and cigarette smoking has a causal relationship to periodontal disease; what happens to the periodontist or the general dentist who has a patient of long standing who has this, perhaps—this information is pretty well substantiated—so what do we do in that instance with our patient? Do we let them know that their periodontal disease, there is a causative association there? What does that mean to the clinician?
**Dr. Ernest Newbrun:** I did practice periodontics for over 20 years on a part-time basis because my main obligation was teaching at the university. Certainly, I had patients who were smokers. What you state, of course, has been documented in epidemiological clinical studies of the relationship of smoking; and I think every periodontist and every general dentist has an obligation to inform the patient who is a smoker of the role of smoking in decreasing host defense, decreasing repair mechanisms of the fibroblasts, and I have watched patients go downhill. I did not try to do smoking cessation therapy in my office, but I provided them with phone numbers and addresses of the American Heart Association, the American Lung Association, and Kaiser Permanente—all of these provide smoking cessation programs. I think it is an obligation now of dentists, particularly periodontists, to inform their patients. I have also lost patients because of that because I clearly told them the relationship, and some of the patients told the GP, “I don’t want to go back to him” because they could not quit, and they had a guilt feeling about it. Therefore, it is an ethical obligation on the part of the practitioner to inform the patient, but you should realize that in doing so, sometimes the patient is so dependent—I mean, it is a drug dependency—that they do not want to hear it. They get it, probably, from their spouse, from their relatives, and they do not want to hear it from you. I think you do have an ethical responsibility to inform them, but it is not easy to change people’s habits and you may lose patients in doing so.

**Dr. Morton Rivo:** Your opinions on the issue of tissue transplantation.

**Dr. Albert R. Jonsen:** The transplantation issue is one that has places, historically, in dentistry, too. Tooth transplantation—a very interesting piece of dental history. I was able to discover an advertisement in the New York Gazette for 1787 in which a dentist—or in which a practitioner—is advertising that he will pay so many dollars per tooth for people who come and donate their—sell their teeth to him for transplantation. However, transplantation in medicine, in surgery, began to raise quite serious questions in the 1960s. The first, most serious, one to arise had to do with taking an organ from a healthy patient. The original renal transplant from live donors usually had to be from identical twins, because of rejection. Therefore, you would be doing surgery on a healthy patient in order to get the organ to put into the one who needed it. That raises some interesting questions about the old practice of tooth transplantation as well—getting teeth from healthy people. The transplantation issue moved from that one to the question of taking organs from donors who were dead, and that is Dr. Baumrind’s comment there. Vigorous debate over the issue of death by brain criteria, which has slowly been settled, retains problems today. We are now into a new era of transplantation ethics, which is transplantation tourism. People are going to other countries for organs, because organs are scarce everywhere; but when you go to another country, you may go to a place where organs are obtained in an unethical fashion—the most notorious of which is the Chinese practice of taking organs from executed prisoners. In many other countries, particularly countries like India and Pakistan and so forth, if you go there to get an organ, it is an organ that has been bought from usually someone who is so poor it is the only way they can continue to live is by selling a kidney or part of their lung. This area has continued to have quite serious ethical issues involved in it. Maybe Ernie knows some application of this in the field of dentistry.

**Dr. Ernest Newbrun:** Well, I think you have covered the use of teeth. There have been, instead of heterogeneous transplants of teeth from another donor, there are, of course, procedures where they’ve taken third molars—unerupted third molars, for example—and put them where they extracted the first molar. One of the problems with tooth transplants is that very often, the root then becomes resorbed. Perhaps the future is in developing tooth germs and using stem cells to culture a tooth for implantation. But I think that is not in my lifetime.

**Colloquium Delegate:** I just wanted to switch the focus a little bit to raise a new perspective. Professional societies all seem to write their codes of conduct for their practitioners, and these codes change through time. I think the implication there is that, as the cultural values change, you’re asked to behave in new ways, and that ultimately the reason for this—part of the reason for this has been mentioned twice: to gain the public trust. I am just wondering—there seems to be a time lag in the way we change our behavior and the public perception of our changed behavior—to trust you as their practitioner. Historically, that is an interesting lag—a cultural lag—I feel like. I am just wondering what kind—and this is maybe a comment instead of a question—but what kinds of studies are there on the impact from the patient’s point of view of codes of conduct? It also just strikes me as interesting that these things are written for practitioners to behave in certain ways, but what kind of direct appeal is there to the consumer or the patient.

**Dr. Ernest Newbrun:** I have to profess, I am not aware of any studies or data on how a profession’s code of ethics—or code of etiquette, for that matter—has any
effect on the patient’s perception of a profession. We know that there are surveys done periodically of how people trust doctors, lawyers, dentists, the religious minister, et cetera—and rankings. I am not sure that that ranking has anything to do with the code of conduct or ethics of that profession. It has to do more with the consumer’s perception of those practitioners. That is my intuitive response on that. In fact, that most of the public are unaware of any code of ethics unless a person is, you know, publicly brought before their profession for contravening that code. In general, my impression is that the public is not aware of that, and, as I say, my concern is that there is too much emphasis in the ADA code of ethics and code of etiquette on the issue of justifiable criticism should be avoided, rather than the responsibility to the patient.

**Dr. Albert R. Jonsen:** I am in agreement with Dr. Newbrun on this point. To the best of my knowledge, there are really no studies on the impact of codes of ethics, either on the practitioners in the field or on the public. I have never seen them. There have been some sociologists who you think would be doing studies like that, very interested in codes of ethics. Eliot Friedson has written three or four books since the 1950s on codes of ethics in the health professions, but his work is still rather speculative. What there is is the fairly broad kind of study that one might find in a good social history. Paul Starr’s, *History of Medicine in the United States: The Transformation of American Medicine*, makes a lot of socio-historical statements with the kinds of evidence there used that subsequent to the introduction and education in professional ethics, there was a significant increase in respect for the physician in the United States, in the late 1890s through the 1940s. The suggestion is that today that is beginning to decline for a different reason than the original code of ethics had involved. The original code of ethics was designed primarily to change the image of the doctor into the image of a trustworthy gentleman. Today, the issue seems to be the lack of trust being associated largely with the effects of commercialism on the practice of the health professions, and that it is primarily motivated by money and not for the benefit of the patient. I think it is a field that really ought to be looked at, “What is, in fact, the impact of a code of ethics on the people who write it, and read it as professionals, and on the public that they deal with?”

**Colloquium Delegate:** Dr. Newbrun, I really appreciated your example related to the etiquette of criticizing others and colleagues. It is a big issue at our dental school where I make students memorize that phrase you had on your board, you know, “Without disparaging comment about prior services.” We play this game in our ethics course where we try to come up with examples where it is possible that there is no explanation for Dr. #1’s behavior other than malpractice or negligence. I wonder if this group could come up with an example related to your example, where Dr. #2 did not have the right information, did not have enough information, or could have been mistaken.

**Dr. Ernest Newbrun:** The example that I gave of the oral surgeon who finally gets the patient with a severed palatal artery—and also the first case—if you get an accurate history from the patient of the sequence of events, you get a good idea of whether the previous practitioner acted appropriately. What one can debate about is whether the patient does provide an accurate history, and in that case, if it is questionable, yes, you should contact the original practitioner who you feel misdiagnosed, failed to diagnose, or abandoned, like in the second case. It is literally patient abandonment that was one of the components, because, simply the severing of the palatal artery can happen, it is not necessarily malpractice—but the issue was his failure either to adequately control the hemorrhage, or to refer the patient at the moment to have the artery tied off. Therefore, that is what can be debated: “Whether the patient can provide an adequate history, or whether you need to or must go to the original practitioner to get the accurate history.”

**Colloquium Delegate:** A partial answer to that dilemma, which I have seen many times, is that you observe it and you report it to the patient, but you do not pass judgment on it. You say to the patient, “I noticed that some of your teeth are a little mobile, and that there’s bleeding and pocketing. It looks like it’s been there for quite some time.” You do nothing else, you do not say, you do not pass judgment, because possibly this is some rapid, unusual form of periodontal disease that the other chap cannot control. Nevertheless, you have at least done your duty by reporting what you have seen to the patient. Would that be an adequate ethical out?

**Dr. Ernest Newbrun:** Yes, for example, the instance of the self-referred patient, case #1, who notices their teeth are getting lose. What do you say? Because you are not obligated to that GP, he did not even refer him. I think there is a difference between “ambulance chasing,” that means, what I am saying is, saying to the patient, “You need to get to see a lawyer.” I do not think you have to do that. Nevertheless, you have to tell them, “This disease has gone on for a long time, and it could have and should have been diagnosed.” The patient is going to draw their own conclusions; but I think you have to be honest with the patients. As Dr. Jonsen pointed out, in our interaction before this presentation, there is an unequivocal “yes.” You have that responsibility. It is the first responsibility to the patient.
Dr. Albert R. Jonsen: There has been a very vigorous discussion in the last five years or so about medical error. It is a favorite topic of discussion, both epidemiologically and ethically, and it has, I think, been commonly agreed that if a practitioner does commit an error, that the practitioner has a moral obligation to inform the patient that he or she has done so. That is not the case if you, as a person who has seen the patient only in referral, suspect that the other practitioner has made an error. You have no moral obligation to say, “He made an error.” However, you do have to give them the kind of information that will lead them to make sure that it can be corrected.

Dr. Charles Millstein: I think it is interesting to see what happened with amalgam. G.V. Black, at the end of the 19th century, made amalgam a positive restorative material. Today, 100 years later, an argument still exists, what can mercury poisoning do to you? Dentists remove amalgams and replace them with plastics—which are technique-sensitive. Such restorative materials have a higher probability of leakage, increasing subsequent endodontic therapy and prosthetic treatment.

Dr. Peter G. Meyehof: Well, you are completely right in many respects. Amalgam has an excellent history going back for 100 years. Even the early dentists before G.V. Black were experimenting a lot with shrinkage within amalgams. They would make little bars, an inch across, and they could measure shrinkage over a period of months or weeks. They could measure down to a 1/100th of an inch, and a 1/100th of an inch in a one-inch block is about 250 microns, which corresponds to about a 25-micron shrinkage in a typical amalgam, which might be 2.5mm. They were certainly able to measure shrinkage very, very accurately, and they did experiment with many formulas, even before G.V. Black optimized an amalgam. A lot of this research has been forgotten, but it goes right back to the beginning of the introduction of amalgam, really. The same objections to amalgam are constantly coming up, even though there is no study that has shown an adverse effect from a dental amalgam in a population. The hundreds of experiments conducted to find links between MS, autism, Parkinson’s, or Alzheimer’s with amalgams, and there has not apparently been any positive correlation, and yet...I think it comes down to fears in the public manipulated by the newspapers. Horace Greeley sold his newspapers by printing an article “Killed by Dentistry,” and I am sure in a day when Rupert Murdoch can sell newspapers also based on sensationalist headlines, then the media are constantly playing upon public fears. It is maybe our obligation as a profession to counteract those by constantly reminding people of the scientific facts for our particular positions.

Colloquium Delegate: Obviously, when amalgam first came out there were many issues to standardize and elevate the material. Now, we are in fifth, sixth, seventh-generation composites, and we have seen a real elevation of that restoration, as opposed to the silicates and the original Adaptic, which was all macro-fills. My issue is that when you have many different modalities, they all have their advantages and disadvantages. To have a group say, well, we are not going to do this at all, because of my philosophical feeling, even though it may adversely affect the profession in its options for treatment, in its cost-benefit for treatment—I think it is inappropriate to do that. I really think that having all these things available is important.

Dr. Morton Rivo: We know that ethical behavior continually evolves, but that ethicists believe there is always a constant right and wrong. Yet when we describe doctor’s behaviors in the health professions we factor in what we think are our patient’s attitudes and their expectations of ethical treatment. We know that patient’s as well as doctor’s attitudes change with time. At this point, I would like to ask the panel to talk about over-treatment. As an example—and not many years ago—when a patient died, a practitioner could expect the family’s response might be, “I’m sure you did everything you could.” Now, if a patient dies while under a doctor’s care, the response of the patient’s family might be more accusatory. “What didn’t you do, Doctor?” What more could you do?” Alternatively, “What did you do wrong, Doctor?” As a result, many doctors practice “defensive medicine” or what other doctors might consider “over-treatment” in order to protect themselves. Of course, there are many other reasons for over-treatment, and many of them are driven by patients. What are your thoughts about the constancy of ethical values over time? Who determines what is “over-treatment”? Is over-treatment a breach of ethics? In addition, speaking of “over-treatment” brings up the issue of cosmetic treatments. Some say the amount of professional time spent on cosmetic procedures in dentistry today means that much less of the dentist’s time and attention is spent serving the community’s “medical needs.” We all know many patients who we think need dental treatment; yet they neither want it nor value it. On the other hand, people who have little or no need for reparative dental treatment often ask their dentist to fix their teeth for cosmetic reasons and place great value on receiving it. Are cosmetic procedures—are they medical or dental—considered “unnecessary treatments”? Finally, is the dentist or physician who devotes his practice time to cosmetic procedures rather than medical “needs” considered ethical?
Dr. Albert R. Jonsen: I will give the start with a first point—to take up this question of ethics evolving and changing. That is true, and it is not true. Practically the whole mass of literature on moral philosophy for the last 2,000 years in Western culture is an attempt to deal with that question. So, one does not do it in a minute and a half. However, it is true and it is not true in this sense: in every culture—in every literate culture that we know—and throughout all history, there are certain generalizations that go under the title of ethics that are constant. They keep coming up, and it is hard to think of what ethics would mean at all if they were not there. “We have an obligation to benefit people and not harm them.” There are certain statements about telling the truth. These things are constant in all cultures. Respect for your family, your parents, and this kind of stuff. The interpretation of what they mean is what changes culturally. Therefore, around this constant theme, the idea of what is benefit and what is harm changes with circumstances. The beginning of bioethics—what I was talking about earlier today—was largely stimulated by the realization that it was no longer clear what it meant to benefit somebody. If you could keep somebody alive with a ventilator when they had lost consciousness permanently, is it a benefit or not that they be kept alive? It was a question that had never been asked before. Therefore, you would say, “Well, it’s a benefit to be alive, isn’t it? Moreover, I have an obligation as a physician to benefit. It’s a harm to kill somebody; and if I stop the ventilator, it will kill him.” That question stimulated the thought around the meaning of benefit and harm in a technologically more sophisticated age. So I would always try to answer your question by saying, “Yes, that’s true, but it’s not entirely true.” I would just add “Yes, But, However...” The fact is that if you had the case that you describe—the patient with extreme risk factors, and all the technology was done to save that person’s life and failed—that would not be negligence; and the fact is, most lawyers would not take the case because they say, “That’s not a winner case.” On the other hand, there is technology that is beneficial. For example, in the $1.7 million verdict awarded for dental malpractice that Dr. Zinman told us about is a case that, 3D technology, properly interpreted, would benefit the patient to prevent that implant from entering the nerve. Here is an example of an advance of technology that then becomes the standard of care in the appropriate case. In terms of ethics, what is in the best interest of the patient? You do not have to do all the ideal care, just, again, the reasonable care.

Dr. Ernest Newbrun: I think Professor Jonsen has addressed the first issue that you raised about the high-risk patient. Let me come to the second part of your question, which dealt with cosmetic medicine and dentistry. The need for treatment is different for the rich and the poor. This is the social division of dental care that Professor Dr. Dolan addressed. There is this parallel medical model, which I think we should discuss, which is not just the issue of optional cosmetic treatment—whether it’s medical or dental—but what has happened in providing health care for rich versus poor. That is—and nobody has alluded to it—the issue of “boutique” medical care for the rich versus the limited availability of health care for the poor. I think that raises a completely ethical question that is one for the future, because it is here, and I do not think we have developed an answer to it. I hope some of the other panelists will discuss that.

Dr. Edwin J. Zinman: In light of what Ernie said—Michael Moore has an answer in his movie, “Sicko”; Universal Health Care. It is both philosophical and governmental. We are informed in dental school that virtually all of our procedures have cosmetic benefits. If you want to go beyond that, and somebody, on an elective basis, purely for cosmetic reasons—that is their right. In addition, if the patient benefits and the dentist profits, there were nothing ethically that would prohibit that. It is still the patient’s choice and the dentists’ right to proceed and benefit the patient. There are psychological benefits to improving a patient’s appearance. That patient can say, “I can go out in the workplace; I can get a better job; I can find a new spouse.” We live in a cosmetically-sensitive world. In my limited involvement with cosmetic dentistry, I knew that ten years ago a dentist would tell a patient, “Oh, you don’t want teeth that are too white, that’s refrigerator white!” Now, there is no such thing as “too white!” They all want the whitest white, the brightest white. I do not see a division ethically because it is still the patient’s choice. We are not harming the patient if the patient is informed and understands all the options, benefits, and risks and then makes an informed choice.

Dr. Brian Dolan: Let me just add briefly that the culture that creates different categories of brilliancy of whiteness of your teeth and what’s acceptable is also the same culture that shapes our entire attitudes about the moral responsibility of the professionals who act upon us. A colleague of mine at UCSF has worked on the protocol of resuscitative—the resuscitative protocols and the usefulness of them. Outside of extremely particular settings, where CPR can actually be effectively used, most of the time, as he describes it, it is beating a dead horse. It has very little effect. Moreover, he is actually an ER doctor who is drawing on his own experiences. But putting this in historical terms, to ask the question, “How is it that people change their atti-
tudes about how we die?” In the 19th century, you prepared for death, to go “peacefully into the night,” you settled your accounts, and you made appeasement with God, and went. Whereas in the 20th century, certain cultures, like our own, have developed this image that we go in an ambulance, with wailing lights, with somebody pounding on our chest, because of the technological imperative—“Do everything you possibly can because I’m not going to go gently into that good night.” There is a change here which is not necessarily driven by the advances in technology or the medical profession. From the 18th century, the techniques were there, and they are still as bad today as they were in the 18th century, for the effectiveness of that kind of protocol. So, what has changed? Culture has changed and the attitude has changed, and that leads me back to emphasize the psychology—the complicated psychology of the patient and the cultural attitudes of what ought to, should, and can be done, which is the ethical underpinning.

Colloquium Delegate: In terms of care for the needy, I would like to address a question to two of the medical ethicists on the panel. Maybe it is an ethical question and perhaps it is political. The question is this: Take the example of spending for neonatal care. For some indigent families, we are spending over $1 million treating premature infants, some with medical defects that might need lifetime medical care. Contrast that with the fact that that money spent on neonatal care is no longer available to support standard medical care needed by the broader community. The question is, “How do we balance funding for small, high-risk segments of the population with the medical needs of the general population?”

Dr. Albert R. Jonsen: That is a good question. Clinically, I spent most of my medical ethics career in neonatology. I have seen a lot of it. It is a very paradoxical problem, because here is one of the things that technology has done to bring up the question of what is a benefit. There is no doubt that a baby born at 24 weeks has a tenuous hold on being alive—but you can do it, you can bring him through! The problem is not the 24-week baby, but the 28-week baby, who probably will survive, but because of problems like anoxia, may have severe long-term defects. That is the major population. It is not the little tiny ones that you are pulling back from almost inevitable death, but the ones that now will live, but will live damaged. The benefit of neonatology, with its enormous cost, is to save us the future costs that are entailed by that group of kids. The problem is how you allocate your costs and your losses in this enormously complex system. It happens to be a great example from my point of view, and it does not solve the whole problem by any means. The amount of money that is being spent on sustaining life in the last years of life—even if that last year might be the first year—is enormous, and much of it is wasted because it doesn’t bring any benefit at all except a couple of months of incompetent and unconscious life. But people want it desperately. Families do.

Dr. Donald Patthoff: I would like to build on the question of needs and wants. One of the problems in answering these questions is that we have different desires—two different versions of needs and wants in our culture. One—if you think of needs as being a strong want—you can argue there are places for that. In the commercial world, the customer determines wants. In our culture, we believe that everybody should get what he or she wants. If you want enhancements, if you want cosmetics, just because you want them is good enough. In healthcare, wants and needs are something different. Are you saying that the dentist determines a “want,” that the dentist has a right to say, “You need this service”? The difference between a healthcare professional and a legal professional is that the healthcare professional has a right to describe what a “need” is. Patients come into the dental office thinking that you are going to tell them what they “need.” The dentist might say, “No, I’m going to sell you this ‘want.’” The dentist is now acting in a commercial manner as he competes in the marketplace.

Colloquium Delegate: What are the most common encounters where we have a failure to diagnose, treat, or refer to a specialist? Additionally, what are our responsibilities for other treatment needs?

Dr. Ernest Newbrun: The patient obviously has a free choice to accept or reject your recommendations. However, you have to document, document, and document. Even if the patient comes in at midnight and you extract the tooth in question, you still have to record in the chart that you told the patient they needed further treatment. That is all you need to do! You do not need to write the full documentation of everything that is wrong. Now for the question I was asked earlier—the one about the patient who was an unrepentant smoker, and he is going downhill because his smoking is directly related to his chronic periodontal disease. If you document that you gave him the information about smoking cessation programs, and if you advised him to go to a cessation program—whether he goes or not is his choice; if you record that you told him, and you put it in writing so that it is there for future questions—whether the patient remembers it or not, it is in his permanent record. When the patient says, “The general practitioner never told me I needed to go to a periodontist, or that I needed periodontal treatment,” we must assume that patients don’t always give the specialist or
the subsequent treating dentist an accurate medical or dental history. However, if you document it, then the GP is “covered.” He has told the patient, and he has written it down. As we heard from Dr. Zinman’s presentation, not all treating dentists give an accurate and true history either. However, I do want to clarify that I recognize not all patients give a true history, and not all dentists give a true history; but if you document and document, then you have done what is your responsibility.

**Dr. Edwin J. Zinman:** When a client comes to me, they give me a story of what happened; and I say, “Well, I have to review the records.” They will say, “Well, I’ve been going to the same dentist for 15 years, and they’ve never diagnosed, they’ve never probed, and I’ve got this progressive periodontitis, and I’m going to lose half my teeth.” I get hold of the records, and, lo and behold, yes, they have gone to the same dentist for 15 years—but only once every five years, each time for an emergency. That is not a situation where you ever have an opportunity to do a comprehensive exam; so I would just pass on it, just put in the chart: “Emergency treatment only, patient did not want comprehensive diagnosis or evaluation.”

**Dr. Brian Dolan:** While I totally agree with the panel’s recommendations of document-keeping, and that kind of behavior, professional behavior—I also would suggest that there is some responsibility somewhere to find out why they don’t want more treatment and what can be done to either. This is the appeal of the early 21st century. Is it a lack of public education—which is what I was saying in the talk they were referring to—or is it a lack of understanding, that they think it is going to be hugely expensive and they do not have the economic resources to pay, that prevents them from wanting treatment? What is the answer to why they are not getting treatment?

**Colloquium Delegate:** When I was in dental school, there was a concept—“benign neglect.” It was used a lot. For example, it could be that we saw a four-unit bridge: a canine and bicuspid with the molar, number 15 that had root canal therapy. It has a fistula and needs apical surgery. There is a periodontal pocket on one of the roots. This patient has limited funds and is asymptomatic. The patient is able to chew, and reports no problems. The dilemma was whether we should extract that tooth, number 15, and make him a dental cripple, or just watch the case. In that particular case, is, “benign neglect” considered ethical?

**Dr. Edwin J. Zinman:** I think what you are describing is really the patient’s choice. You should give the patient all the options; and ultimately the patient decides after you provide the pros and cons of each treatment including the risk of doing nothing which you should document in the chart. You may have that one patient who is the exception and will borrow money for treatment, but you do not know who that is since you can’t x-ray the patient’s pocketbook. Thus, it is for your patients’ benefit to be adequately informed of all the options including the pros and cons. Ultimately, we are serving the patient. We should let the patient decide what is in his own best interest after he has been informed of all the choices.

**Dr. Ernest Newbrun:** I thought that while we have Professor Dr. Jonsen here, I would ask him to comment on the book by Jonathan Haidt, *The Happiness Hypothesis*, which is based on the idea that our morality of “do unto others” is written into our genes; that it is evolutionary, and has benefited our survival in a social living situation. It is really a question of nature versus nurture. Would you like to comment on this book from a philosophical point of view?

**Dr. Albert R. Jonsen:** I have not read the book. It was reviewed in the *New York Times*. However, I found the *Times* review relatively uninformative. It is a very interesting debate that has gone on within the field of moral philosophy for some years—the nature/nurture debate. What we have now is a whole lot of data from molecular biology and genetics, and interesting stuff from the neurosciences and neuron imaging that gives us a picture of moral behavior that we never had before. We see various kinds of moral decisions, various kinds of moral responses which light up parts of your brain. We know that certain defects in the genome mean that people will not have certain sorts of responses that we call “moral.” That is the data we have coming in, but it does not get to the essential question. Let me put it this way: those things show pathologies. If you have a piece of your frontal lobe missing, you are amoral. We know that; and we know precisely what part of the frontal lobe. You do not feel any moral sentiments; you do not make moral judgments. You do not even act in your own best interests. However, knowing all this stuff about the physical basis of morality still does not tell us what morality is. It still does not tell us how judgments can be made to ensure conformity with moral principles. Therefore, in general, it is an open question with a lot of discussion going on, and we will watch it. Benign neglect is kind of a dangerous term, because it mostly means “neglect.” However, you can turn it into a formulation of the Hippocratic principle of “Do no harm, but be of benefit.” If you are sure that you are being benign, that is, if you really believe that by not acting, you may get a good result, then that makes sense—clinically, it makes sense. You know the old principle, “Don’t do some-
thing; just stand there!” Actually, this is sometimes good clinical advice. Nevertheless, you have to believe that there may be, in fact, a positive result by just standing there.

Colloquium Delegate: Can you address the doctor-patient relationship?

Dr. Edwin J. Zinman: The parallels are as follows: Both in the law and in dentistry, it is a fiduciary relationship. The obligation is always, in the case of a dentist to the patient—to the client—first. We talk about this relationship being a confidential relationship. We have HIPAA, which strongly protects the privacy rights of the patient, although there are always exceptions. In the law, despite the confidential relationship, for example, if a client asks you to do something that would be fraudulent, then you, in your role as an attorney, have to decline. If you are a party to fraudulent or criminal acts that the client participates in, based on your advice, then the attorney-client confidentiality relationship is abrogated and the communication between the lawyer and the client can be disclosed. Recently, there have been indictments of both attorneys and CEOs in lawsuits involving the backdating of stock options. The prosecutors said, “You’ve been participating in a criminal enterprise. You can’t do that.” Another analogy is when a patient requests that the dentist perform treatments that he regards as substandard. The dentist is ethically and legally obligated to refuse treatment. An example is a patient who says, “In my family, they’ve always ended up in dentures, and they’re slipping and sliding, and I want to have good bone support and I’m only 30 years old, so just go ahead and take out all my teeth.” And, lo and behold, they have healthy teeth. There is really no reason to do that. In that case, it would be your ethical and legal obligation to refuse treatment, even though the patient requests it and even though the patient says, “I’ll sign any waiver.” The patient cannot consent to negligent care. It would be a legal nullity. I would like to raise the issue of core values. There is a great book out called Built to Last by two Stanford professors—and they talk about corporations that have survived. They give the example of David Packard, the Hewlett-Packard founder, who discovered an early technical problem. The corporation decided to do a recall and replaced that defective part. They could have just let it go until people complained about it, but they said, “No, our core value is, we are not only concerned with profits, we’re concerned with our core values, what we stand for as a corporation. And we’ll take the loss because our integrity is more important.” There are corporations, and certainly, all of us, as ethical practitioners, want to stick to our core values. In terms of any of our projects, our core values are important to us as a profession. The last thing I would like to add is exactly what Dr. Dugoni was saying about business: “#1, you have to determine exactly what those ethical core values are, and #2, you have to monitor that.” Moreover, you have to review those core values on an annual basis—from an ethical viewpoint—to see if they are upheld. Dr. Dugoni said, “Just delegating responsibility, but not monitoring, is an abdication.” We have to be zealously on guard to maintain and preserve these core values. If we do that as a profession, we are protecting the principles of the profession, and of course, we are serving the public and the patients primarily.

Dr. Morton Rivo: I have a question for Dr. Jonsen. It has to do with considerations that differ between medicine and dentistry. One of the recurring questions in medical ethics—for hospitals in particular—has been the attempts of the hospital to try to recover losses incurred by treating uninsured people. It seems that those patients—people who have insurance—might be over-billed to help cover the costs of those who come into the hospital without funds. In dentistry, we have another spread between the cost of production and ever increasing dental fees. Yet, most dental practices do not provide low-cost treatments to the poor or needy. Only limited public dental treatment is available. Do we consider dental care a right similar to the way many patients see medical care? Could you comment on that?

Dr. Albert R. Jonsen: There is a marvelous quotation in the work of a 14th-century French surgeon named Henri de Montville, and it is in a significant place. It is in his treatise on the fistulas of the anus, but he says that it is obligatory for physicians and surgeons to care for the poor without charge and this is an obligation imposed by God on those who have the skills of care. Here is the phrase that I like very much. He says, “You must treat the poor freely, for the love of God. But the rich, you can charge outrageously.” Well, that is a 13th or 14th-century statement of what I think has very much always been the practice in medicine of cost-shifting. There was a dispute—a considerable dispute in American medicine in the 19th century—over fee schedules which set schedules differently in accordance of the needs and abilities of the patients to pay. You recovered your charitable costs by charging the rich. I do not know that that has ever been justified in any rigorously philosophical way, but it suggests to me an awareness that there was a sense that the care of the ill should be dominated by a principle of justice and fairness, and should not be dependent on people’s ability to pay for it. Apparently, it seems as an early effort at equalization of people. Hospital care, originally, was usually free in late medieval Europe. It was free; supported by the church. And cost-shifting—whatever its
moral justification, of course—is recommended, or permitted, in the old literature, it's always said, you have to do that fairly, too. You cannot really charge outrageously. What you do is you charge enough to recover the costs that you are losing by your charity care. That is the moral injunction. However, the hospital—of course, with hospitals, since Medicare and Medicaid, you cannot cost-shift anymore. That is no longer really a legitimate mode of carrying out this so-called charity care. Here is the point where I become very befuddled myself: I do not know enough about hospital economics to know how it is today. I know that the attempts to create certain centers of profit by investing in certain sorts of technologies or procedures is one way in which many hospitals skim off the top. However, that is being undermined by the fact that in many specialties that use those kinds of technologies, the specialists are going out of the hospitals and setting up their own programs, setting up their own surgical-centers and so forth. In general, I see no great moral problem about cost shifting, if done within limits; but I do not see how it is viable today. I had an uncle in San Francisco, an internist, who used to take care of many nuns at no charge. When Medicare came along, he was very upset, because all the nuns got Medicare and he said, “I don’t have any charity patients anymore! They’ve taken my charity patients away!”

Dr. Sheldon Baumrind: People have pointed out the shift in the basis of ethical decisions through time, and I think that the question of sustaining the poor without charge is not a legitimate load on us professionals at this time. I mean, essentially we have responsibility as citizens to sustain the less well-supported members of the culture. I do not understand how we have that responsibility as professionals. I think that as professionals we are technicians. The fact that someone can build houses efficiently does not mean that he builds houses for the poor without fee. The fact that other people can grow food efficiently does not mean that they provide the food without cost. I understand the historical origins, but I do not understand the rationale today.

Dr. Albert R. Jonsen: I fully agree with you. I kind of got stuck in the 13th-14th century to answer that, or at least the 19th century. After all, this is a group of historians, so why get too contemporary. In the contemporary health policy world, your approach is quite right. Dealing with healthcare today is a national policy question, and has to be dealt with that way, and not through the charity of practitioners.

Dr. Edwin J. Zinman: I will give you the 21st century legal answer, because there have been successful lawsuits against hospitals that charge insurance patients a lower rate than private pay patients. In a recent class action—there was a huge settlement, for example, those who live in the Bay Area might know, against Sutter Hospital which is made up of 15 hospitals. They have agreed to reimburse the difference between what they otherwise would have received through insurance versus what they would charge a private pay patient, which is usually a larger number. They agreed to reevaluate outstanding billings made to those who are of lower socio-economic status who were billed by the hospital. Most of the time these bills were not paid or they received half the amount; they might waive those charges and write them off as a charitable expense. The legal answer is called the False Claims Procedure Act; it exists both in state and federal law, and usually there are lawsuits involving both. The lawyers solved the problem. They said, “Everybody is treated equally, and if you’re willing to lower your fee for some, you have to lower it for all.”

Colloquium Delegate: Could you comment on whether dentistry is a necessary right of the patient who comes to the office and asks for care?

Dr. Edwin J. Zinman: The question is whether the patient, who comes to the dental office, asks for care, and cannot afford it is entitled to it. If that is the case, who is to provide the service and who pays for it? There is also a concept that says that dentistry is an elective service. What is your thought about these things, from an ethical point of view, Dr. Christen?

Dr. Arden Christen: My thought about this comes from my father who was a dentist for 52 years. He said, “Part of your rent in life is to do work for people who can’t afford it.” There is no easy answer, I am sure.

Dr. Edwin J. Zinman: I can give you the legal answer: there is no obligation to treat. Someone can come in, even with an emergency, and you can say, “Well, I’m sorry.” There is no obligation. If we are concerned with treating the indigent portions of the population, the question is, do we do it privately or do it publicly? We should support those legislative acts that either raise the tax or redistribute the tax to the neediest. This is really a political as well as an ethical consideration.

Colloquium Delegate: This question is in two parts. If you were all academic deans, with control over the curriculum, where you would insert the introduction of professional ethics into the education system? Secondly, given the present situation: How best to implement and support the introduction of professional ethics?

Dr. Arden Christen: At Indiana University, we begin with a class on ethics. We teach ethics each year. The idea is the teaching of ethics should flow through the whole curriculum. However, I have noticed as a faculty member that there is extreme competition for course
time from basic sciences and the clinicians. Even with the expanded program, there is still a lot of competition for course time among the faculty. That becomes an ethical issue.

**Colloquium Delegate:** But if you did not have the competition, would you insert the ethics program where it is now?

**Dr. Arden Christen:** We have the class formulate an ethical viewpoint that is published and is put up on a bulletin board right away. However, do not use Indiana as necessarily the guide to the success of programs in ethics, because we had a huge cheating scandal at the Dental School recently which involved almost half of the sophomore class. They broke into the master computer at the school and stole test questions. The main ringleaders are gone. However, when it involves about half of the class, it shows you that—even though talk about ethics immediately in the first year—students do not practice ethical behaviors. We know that the sophomore year is the toughest year at virtually every dental school. If there were ways to incorporate the teaching of ethics throughout the entire four years, that would be helpful. We certainly have the students’ attention now, after the cheating scandals.

**Colloquium Delegate:** At USC, we have a problem-based learning program having ethics as a component. We teach ethics during our introductory orientation, requiring each class to make a statement about ethics. Initially, ethics was taught in the traditional way before we converted to problem-based learning. At that time, we presented our ethics programs in the third and fourth years, with a little bit in the first year. Now we teach ethics throughout the program. The students have formed an ethics club. It is a student-initiated club that they call the Student Professional Ethics Club. The students know more about what is going on about ethics violations than we do; and they can do more about prevention. The club receives support from the American College of Dentists and American Society of Dental Ethics. The goal is for every school in the country to start such an ethics club with our club being a founding chapter. Our students’ club has a council which mediates with students, invites lecturers, and writes articles directed toward their classmates.

**Dr. Edwin J. Zinman:** I would like to add that there is the carrot and the stick. These are all great carrots, but there is also the stick. I’ll give you the parallel in the law, which is that, a.) ethics is a required course in law school, b.) it’s required as part of the state bar exam, and c.) ethics violations represent probably the most prominent disciplines against attorneys. It’s always publicized, so you have the professional embarrassment related to breaches in “moral turpitude.” Those found in violation must take and pass an ethics exam. Moreover, they have to notify their clients of their violations. There is the stick as well as the carrot.

**Dr. Albert R. Jonsen:** “Where it should be taught?” I started at University of California in San Francisco in 1971. At that time, there were very few courses in ethics being taught in medical schools anywhere. The Catholic schools were almost the only places that were teaching ethics in those days: Marquette, St. Louis, and Georgetown. It was really a new thing. The teaching of ethics started almost simultaneously around the country. It was kind of a wildfire. These new students were introduced to medical ethics as you introduced them to patient interviewing. Quickly, this wildfire burned out because it was seen to be quite inadequate. These kids did not know what it was all about. Therefore, the conception grew that you ought to link the ethical teaching to their experience of practice. It became common to do what you have done in Indiana at the dental school, to spread it through the curriculum, using different parts of the educational experience for the relevant ethical parts. For example, if you taught ethics in the first and second year, it would be about things like cheating, which is where they are. It would be about things like dealing with their colleagues, knowing that one of the young people they were friends with was taking drugs, and how do you deal with that? Those kinds of issues became the first and second year kinds of cases. In the third and fourth year, when they started clerkships, became the time to introduce decision-making concepts relative to end-of-life questions. We linked it with those clerkships where they would be dealing with those questions such as oncology, cardio-respiratory intensive care experiences, or in critical care medicine. Questions about informed consent were usually linked to surgery; surrogate decision-making with pediatrics. We built it right into the clerkship. It was not an ethics class as such. The mentor for that clerkship was responsible for the teaching of that segment just as much as they might be responsible for teaching the medicine. We quickly discovered that they could not do that, because they did not know anything about it. Therefore, at the University of Washington, we created a website providing basic instructions in how to handle that problem. If you are supposed to teach what the requirements of informed consent are, you can look it up the night before on the ethics website and get all the information you need to quiz the students the next day. That process seems to have worked well at the University of Washington, so it has spread all the way through medical teaching. Relatively little is taught in a straight-forward, didactic fashion. When I was at University of California, we did
something different. It was before we went into this idea of spreading it through everything. We established a two-week, concentrated course in the fourth year, advertising it as, “In a couple of months, you’re going to be responsible for patients, and here are the things you’ve got to know as you go into internship.” That was successful too, but it was still remote from practice. At California Pacific Medical Center where we have no medical students—we have residents in medicine—we really link it into their experiences. They bring the cases to the case conferences in ethics that we have a couple times a month, and then we discuss them. I think that is by far the best way to do it, through the curriculum and through designing the ethics intervention according to what they are doing at that time.

Dr. Peter J. Meyerhof: Well, it just seems to me that cheating scandals and many other violations of ethical principles in dental schools may have nothing to do with being ignorant of the principles of ethics, or being able to pass an exam in ethics. There are competing motivations that drive people to break ethical principles that may have nothing to do with their ignorance of ethics in the first place.

Dr. Arden Christen: Well, I was practicing as a dentist at the Air Force Academy when there was a cheating scandal. They had had three or four of them, and all the military academies have them periodically. From what we were told, the following day, at least in the military, judgment is fast. There were moving vans at six different faculty houses—they were gone; all the cadets that were involved were also gone by the following day. The commanding officer brought us all together and said, “Yes we have cheating scandals, but the system works.” In the military academies, judgment is fast.

Dr. Morton Rivo: Dr. Peltier spoke about the difference between altruism and treatment aspects versus the commercial aspects of dental decision-making. One of the concerns of dental educators in particular is the high cost of dental education. Dental and medical students leave academia saddled with enormous debts. This can sometimes lead practitioners into performing unnecessary services. Is this a real experience or is it apocryphal? Is this an ethical issue, or is it a commercial issue?

Dr. Peter G. Meyerhof: Well, I am sure it does occur. I have seen it occur among dentists. It is unfortunate that there are pressures to pay the bills. Nevertheless, that does not allow the dentist to violate the principles of meeting the needs of the patient. Obviously, there are pressures on a graduating dentist.

Dr. Edwin J. Zinman: I am like the undertaker—I do not see all the successes, but I do see the wrongful deaths and other wrongdoings. The largest dental care provider in California, with multiple dental offices, is probably the number one defendant in terms of the volume of dental malpractice cases. I have sued them successfully about 50 times. They were fined by the State of California $1.1 million for fraudulent, unnecessary or negligent treatment. They were placed on probation for five years. Unfortunately, all too often, the profit motive is prevalent and prominent in dental negligence cases. When I discussed this briefly with Dr. Christen, he was concerned about the amount of overtreatment with veners and cosmetic dentistry. Therefore, we have to be mindful that even if it is the patient’s choice, it might not be the right choice unless the patient is adequately informed of all the options including minimally invasive procedures.

Dr. Albert R. Jonsen: Well, certainly in medicine, it is obvious in the way in which students choose specialties. Moreover, we see that those figures change every few years. You see them going up and down. There has been a really serious drop-off in family medicine in recent years. In addition, there has been a serious decline in primary care specialties. This situation is really causing a lot of concern. I think it is because of the income potential, which is significant between that and the other specialties like neurosurgery or almost all of the surgical specialties. We do not need any more surgeons.

Dr. Sheldon Baumrind: Well, of course, not all that drives us is unethical. A lot of decision-making cannot but help favor our own interests. Years ago, a study was conducted in the Philippine Islands among populations of workers who sometimes worked in sugar and/or pineapple plantations. They had two kinds of health contracts, one fee-for-service and the other a capitation. There were clear differences in the way the physicians made decisions about what might have been elective procedures. That is human and inevitable. There is a strong difference between elective treatment and cosmetic dentistry. In my own field, orthodontics, there is a real issue about whether certain kinds of malocclusions should be treated in the mixed dentition, or should treatment begin later. It simply is a fact that younger orthodontists tend to treat earlier; and as their practices get busier, they wait and treat later on. When I went into practice, I asked some senior people if I was treating unnecessarily or excessively. Currently, we have a big—as close to a double-blind research project as we can get—at University of the Pacific. We are finding out that some of the decisions about early treatment are unavoidable, but some of it is downright beyond the pale.

Dr. Edwin J. Zinman: There is an expression in the law: it is that “reasonable minds can differ.” There may
be more than one reasonable option. Certain cases go beyond the idea of reasonable care. For example, we just had an orthodontic case. The patient presented to the dentist complaining of that her lateral incisors were in labioversion. The dentist’s treatment plan for this 40-year old woman was to extract all her teeth. They got as far as extracting all of the maxillary teeth, and then, because she had ill-fitting dentures, she went to another dentist to extract the lower teeth. This dentist performed periodontal treatment preserving all of the lower teeth. Her radiographs indicated that virtually none of her teeth needed extractions. When the same office finally produced the records after several months, we found that that she had been a patient in another office of the same group for several years. Her previous visit, 11 months prior, revealed the periodontal diagnosis of gingivitis! Her extractions were unnecessary. I would just add that it is all there in the ethical code: Report faulty dentists to the appropriate reviewing agency. The fact is this requirement is honored in the breach more than in the observance. Therefore, if peer review committees turn these complaints over to ethics committees—and the ethics committees turns it over to the State Dental Board—then there is an enforcement of the ethical code, particularly for unnecessary treatment. Should this happen, the message would be out there; there is a price to pay. Lawsuits have a salutary effect. If the message were out there, just as at the military academy, “You cheat, you’re gone,” then by the next day you will have taken care of the problem. But what happens is that most patients are not going to sue. If these ethical violations were duly reported—and the ethics committees did their job as they are obligated, dentists would get a loud and clear message: There is a price to pay. It is also a moral issue. You are harming people. Primum non nocere. First, do no harm. Look at the big picture. In terms of the ethics, rather than saying it is a good thing to do, a nice thing to do, or it is our ethical obligation—you have to live with yourself. It goes back to that value, that principle of, “DO NO HARM!” If we do that, I think we really understand the foundations of our ethical principles.

Dr. Sheldon Baumrind: Let me raise the question of informed consent. Associated with that idea, the concept of informed consent is the idea that the patient has the right—and the dentist has the requirement—to provide him/her with information on all the possible treatment alternatives. Fully understanding the concept of informed consent is meaningless without a course of training in dental school, even though the explication of all the possible alternatives is clearly unrealistic in most cases.

Dr. Albert R. Jonsen: Dr. Zinman probably had the best answer. The law speaks of information—that is, material that means information relevant to decisions, which patients are likely to make on their behalf. You tailor your information about alternatives based on what you think might make a difference to the patient’s decision, rather than giving him the long list.

Dr. Edwin J. Zinman: California and other states have a “doctrine of informed refusal.” If the patient refuses recommended treatment, then the patient has to be advised of the consequences of that refusal. If you say to the patient, “I think you need a biopsy,” and the patient says, “Well, I don’t want to be cut.” You reply, “Well, the reason I recommend a biopsy is that I don’t know if there’s a malignancy. It might be your life which is at stake.” Often, the patient says, “Well, if it’s that important, I’ll reconsider and permit the biopsy.”

Colloquium Delegate: During the past five years, the term “evidence-based dentistry,” has filtered prominently into the educational system. I have concerns with this structured thought process. Your opinions on its affect with regards to ethics and treatment options?

Dr. Sheldon Baumrind: This raises the question of randomized clinical trials; that levels of evidence below randomized clinical trials are not sustainable. There is an article by a couple of OB-GYN researchers in England who set up a proposed clinical trial on the effect or uselessness of parachutes, a randomized clinical trial on what have been called “Vertically Challenged People.” The researchers point out that some people survive without parachutes, and some people are killed with parachutes, and they set up a mock-randomized clinical trial with an evidence-based consequence. Like many of these things, it can be carried much too far.

Dr. Albert R. Jonsen: I think it’s an enormous step forward to begin to think in those terms, but evidence-based medicine has a really serious implication for the practitioner who thinks in those terms because there is no evidence that is entirely relevant to this patient. Young people do not really recognize that evidence-based medicine—particularly if you are talking about randomized, controlled trials—gives you statistical data, not data about the patient in front of you. The movement of the doctor’s mind, between that data and this patient has to be facilitated. They have to learn how to do that. I think we are getting better at teaching evidence-based medicine.

Dr. Donald Patthoff: I think that Dr. Jonsen is pointing out that we are moving toward what we call “practice-based” skills, which in turn are based on evidence that practitioners acquire. How does the practitioner gain expertise? Practical wisdom comes with age, scholarship, and experience. How do they get that expertise and scholarship with age and wisdom? It is a lot of
experience, and many cases, you do use that evidence. However, one of the greatest teachers is error—learning from mistakes, learning to admit them again, and learning from those processes. The thing that bothers me a lot about turning the legal decision over to the component of solving ethical problems is, it kind of errors. It hides errors from the public, and from the systems, and everything else. Yes, we have inspirational goals of ethics, we have sanctioning goals of ethics, and then we have the educational goals. The educational ones are probably the most important ones, when we are dealing with history and education. Good people sometimes do bad things, and sometimes planned outcomes just go wrong. But when you see unusual and repeated patterns of questionable behaviors, that becomes another story. Therefore, we need sanctions. However, we cannot rely totally on the law to solve ethical problems. Relying on the law alone can create other problems. However, relying on that as the only outcome, I think, one of our problems. We talked a little bit about the Daubert decisions, a little bit about law in there. That process is relatively new. The purpose of it is to have a gatekeeper to junk science into court cases, and to junk evidence and stuff. However, we now have a system where one judge has to decide what counts as evidence, who counts as an expert in this particular case. We allow it for that particular case, but we are no longer allowing in another.

Dr. Morton Rivo: Let me thank you all. I want to commend the members of our audience for raising such thoughtful and germane questions, and to commend the members of our panel for their probity, for their help in allowing us the opportunity to study the current state of ethics in dentistry within the context of our historical development as a profession—separate from the physicians and the barber-surgeons. I would like to add a comment. Most clinical dentists still work alone in their own offices, without another practitioner looking over their shoulder—someone who can provide advice or a second opinion for the many ethical decisions made in the course of daily work. So the responsibility for ethical decision making by the dentist is his office can be lonely indeed. And that single fact about the nature of dental practice makes us dentists different from other healthcare practitioners who traditionally work in groups and function in the collegial atmosphere of the hospital where peers more easily identify lapses in ethical behaviors. Absent the group environment, the ethically deficient dentists among us can continue to practice unobserved for many years. To my mind, it is essential that we dentists teach and monitor and enforce ethical behaviors; that we make sure that the student and the researcher and the practitioner are well aware of our established codes of ethics as we return to our individual spaces—unsupervised—to serve the public. Finally, a word about the medical-legal conundrum. Because most of our ethical lapses occur in isolation, they are often noted only after repeated episodes by a single errant dentist or perhaps after a particularly egregious miscue. Professional misconduct among dentists is usually discovered late, and by the time they are noted, patients look at errors that might be considered ethical violations early in discovery as malpractice. They eventually find their way—almost by default—into the legal system, which remains one of the very few avenues where today’s dental patient can find relief. I hope you have enjoyed these two days of intense study, exchange, and reflection devoted to “Ethics in Dentistry: Its Evolution and Its Future.” It is our hope that you will carry back what you have learned to your institutions, to your own offices, and to your colleagues. I want to remind you that each session of this program has been recorded and will be transcribed and edited for publication in the 2007 Winter Edition of the Journal of the History of Dentistry which will be widely distributed to our members, to dental educators, and to the leaders of organized dentistry. Thank you again for coming to San Francisco for the 56th Annual Meeting of the American Academy of the History of Dentistry. It has been our pleasure to be your hosts at this special conference.
The Fifty-Sixth Annual AAHD Meeting

September 30-October 2, 2007
Ethics in Dentistry: Its Evolution and Its Future

Marines Memorial Club & Hotel
San Francisco, California

Presenter Dr. Arden G. Christen
Presenter Dr. Sheldon Baumrind
Presenter Dr. Edwin J. Zinman
Presenter Dr. Bruce Peltier
Morning Q&A Panelists, Day Two
Drs. Christen, Zinman, and Baumriud

Afternoon Q&A Panelists, Day One
Drs. Zinman, Newbrun, and Dolan

Dr. Charles B. Millstein
directs a question to the speaker panel

President-Elect Mary Kreinbring
directs a question to the speaker panel

Dr. Kay D. Curtis
directs a question to the speaker panel

President Dr. David A. Chernin and
Program Chair Dr. Morton G. Rivo share a microphone
Dr. Arden A. Christen presents the 2007 Hayden-Harris Award to Dr. Peter H. Jacobsohn

Dr. Eric K. Curtis presents Dr. Arthur A. Dugoni with the 2007 Orland Lecture Certificate

Banquet guests Mrs. Jenny and Dr. Robert L. Meador, Jr. share a glass of wine with Presenter Dr. Ernest Newbrun

Dr. Arthur A. Dugoni delivers the 2007 Orland Lecture

Dr. G. Rex Holland chats with delegate Presenter Dr. Edwin J. Zinman during a refreshment break.

President-Elect Mary Kreinbring confers with President Dr. David A. Chernin
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