OF THE CALIFORNIA DENTAL ASSOCIATION

Journal

JULY 2013

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~ JAMES D. STEPHENS, DDS

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Journal

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CDA JOURNAL, VOL 41, Nº7

Happy Birthday, JCDA

KERRY K. CARNEY, DDS, CDE

For 40 years, it has been the monthly publication that we rely on for information about the science and art of dentistry.

Volume 1, Number 1, July 1973, that was the beginning of the *Journal of the California Dental Association*. Leafing through that issue transports one back 40 years.

The *Journal* was the tangible evidence of the successful merger of California's two dental associations.

The California Dental Association (CDA) represented dentists in Northern California (it was known as California State Dental Association until Jan. 1, 1961). The Southern California Dental Association (SCDA) represented dentists in the southern part of the state.

After their unification in May, the very first issue of the *Journal* of the new California Dental Association was published in July. For 40 years, it has been the monthly publication that we rely on for information about the science and art of dentistry, as well as the issues that affect oral health care today and the challenges that face organized dentistry tomorrow.

That first issue provides a snap shot of what was important to dentistry and dentists of the time. The cover photo is of Burton H. Press, DDS, the first president of the new state association.

According to the editor, Stephen S. Yuen, DDS, the new *Journal* was "… to combine the best features of the former *CDA Composite*; *Journal, California Dental Association; SCDA Newsletter* and *Journal, Southern California Dental Association*." Dr. Yuen described the organization and the goals of the *Journal*.

"*CDA is comprised of people; people are diverse in activities and opinions; we want to reflect all your concerns … We hope that the reading of this and future issues will help you gain a greater measure of what your new California Dental Association is all about. Read us for awhile; let us know what you think. The real responsibility to your profession rests with you. We look forward to the future … with you.*" Dr. Yuen's message foreshadowed our motto: Moving Forward, Together.

Page 6 shows the "New Mod Styling" for a dental chair that incorporated electric yellow or neon orange with a selection of mod plaids. (Some fashions are simply painful to look at.)

In the "Feedback" section, a letter from Jay W. Friedman, DDS, and John I. Ingle, DDS, takes issue with a report by the CDA/SCDA Study Committee on the "Delivery of Dental Services in New Zealand and California."

In the "Composite News and Views," R. Earl Robinson, DMD, writes about "The Loss Leader" and concludes they should be "thrown out. The public should learn that in the long run, good dentistry is probably the best health care bargain today."

There is a critical appraisal of "Health Care, Human Rights and Government Intervention," which warns against the trend toward socialized medicine.

An opinion piece entitled "Triple Threat to High Quality Dental Care" concludes that "dentistry must take a strong and aggressive position of leadership on a national and state level in the formation of health care programs, to see to it that the patient gets quality care and the dentist's position is properly presented to the lawmakers."

The "Council on Dental Care Newsletter" suggests how to navigate the paper claim maze. It reviewed Closed Panel guidelines and related that California Dental Society (CDS, Delta's precursor) had established a Dental Policy Committee to advise on the acceptance of new treatment, techniques and materials. The chair, Sidney R. Francis, DDS, and the associate director of dental care, Gary Radine, sign it.

In "A Goliath Emerges," G. Robert Rogers, DDS, describes the first House of Delegates of the new CDA. It was held in San Mateo on May 12, 1973. (The CDA office at that time was located in the Tishman Airport Center in Los Angeles.) Photos of the event captured the excitement of the first meeting. The men's hairstyles included sideburns reminiscent of Elvis and at least one mullet was visible. The few women in the photos were identified as family or staff.

Among the resolutions approved by the first House were the following:

- Directs the Board of Trustees to appoint a task force to define the standards of quality of dental care.
- Makes continuing education (28 hours every two years) a requirement for maintenance of membership, beginning Jan. 1, 1974.
- Supports registration of dental laboratory technicians.
- Adopts the Code of Ethics of the "old" California Dental Association as that of the new CDA.
- Directs the Council on Legislation to study the feasibility of amending the Dental Practice Act to prohibit advertising by dentists.
- Approves a $1.76 million budget for the fiscal year 1973-74.
- Discourages formation of any new separate organizations, specifically unions,

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Dr. Press charged the new officers and delegates to "prove that the California Dental Association is indeed a unified organization with the interests of the patients (the public) at heart."

In his president's message, Dr. Press discussed "Why should dentistry have an association? Why should you belong to it?" He underscored the most important and immediate issue for dentists, "The burning problem for our association today is the survival of private practice in some recognizable form!"

The fashions and hairstyles are different. The advertisements are different (many ads for dentures and partials). However, the commitment of those engaged in leadership then is the same now. The dedication to communicate with membership and the call for members to engage is unchanged.

The *Journal of the California Dental Association* is your tangible connection to your association. Every month you receive an award-winning, high-quality, peer-reviewed scientific journal.

From the very first issue of the *Journal*, we have continued to seek better ways to communicate, engage and connect with our members. CDA launched a digital version of the *Journal* in May 2013. It is available for download through the iTunes Store, Google Play and the Amazon App Store.

Subscribe for free and the latest issue will show up on your mobile device every month. This is not a simple, lifeless shadow of the print version of the *Journal*. We have parlayed the features that make the *Journal* great through the functionalities of the medium into an enhanced member experience.

It is not just more portable, it provides depth and connection. Easily click through to resources and references. Watch embedded video. Learn and engage. It makes me wonder what the *Journal* experience will be like in another 40 years. ■■■■

CDA JOURNAL, VOL 41, Nº7

Digital Radiography During Implant Osteotomy

This letter is in regard to the article "The Effect of Angulation Sensors on Implant Placement" authored by Goodacre et al., in the January 2013 issue of the *Journal of the California Dental Association*.

Implant placement for a beginner can be a daunting task and errors may occur in initial efforts. One possible error is the placement of the implant at the wrong angulation. Although this may not hamper the osseointegration process, it may compromise the safety of adjacent teeth and structures. In addition, once the "angled" implant is loaded, forces which otherwise would have been compressive may become detrimental in nature. Even the accuracy of impressions can be adversely affected when improperly aligned implants are present.[1] Checking with paralleling pins after every subsequent drill, and the use of guided surgical templates, are options available to prevent misplacement of the implant.[2] Paralleling pins are useful instruments to know the angulation; however, if the angulation of the drill is deviated at the apical portions, it would not be clearly visible. Guided surgical templates increase the chance that implants are placed at the correct angulation. However, the templates used to guide the surgical placement require substantial planning and training. They also increase the cost of the procedure.[2] A recently published study explored the use of an angulation sensor for implant placement in correct angulation.[3]

The use of radiovisiography after every subsequent drill with the drill placed in the osteotomy site is also a valid option to prevent implant misplacement. Digital radiography or radiovisiography results in minimal radiation exposure to the patient and eliminates the need for processing and developing of X-ray films. For a beginner who is placing dental implants, digital radiography with the drill placed in the osteotomy site after every subsequent drill provides the beginner with the option of correcting the angulations of the osteotomy.

Even if minor errors in angulation are seen in the digital radiograph, they can be corrected during further osteotomy. This will result in implants placed in the optimal direction and angulations, thus improving the overall success rate of dental implants.

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RITU RANA, POST-GRADUATE STUDENT
JITHENDRA KD, MDS
Mathura, Uttar Pradesh, India

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The *Journal of the California Dental Association* welcomes letters.

We reserve the right to edit all communications and require that all letters be signed. Letters should discuss an item published in the Journal *within the past two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters may be submitted at editorialmanager.com/jcaldentassoc. By sending the letter to the* Journal, *the author certifies that neither the letter nor one with substantially similar content under the writer's authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights of the author with regard to the letter become the property of the California Dental Association.*

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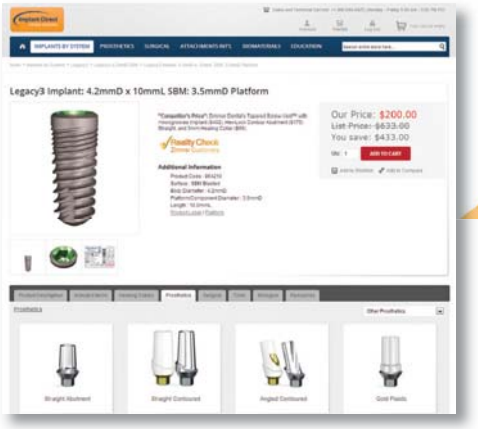

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Writing About the Other Guy

BY DAVID W. CHAMBERS, PHD

I have come to expect that editorials will be about other people doing something they should not have done or failing to do those things that would make our lives easier. A staple in the genre is the ethics editorial. A little preaching to the choir never lost any preacher his or her job.

Scholars say the oldest writings (not the oldest events) covered in the Old Testament are in the Book of Amos. Actually, they are transcriptions of the chants the prophet sang in the gates of the cities of Israel. They are among the most powerful poetry I know. "Thus saith the Lord: For three transgressions of Damascus, and for four, I will not turn away the punishment thereof." This follows

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Correction

In the June 2013 issue of the *Journal*, part of the introduction and several references in the article "Salt Fluoridation: A Review" by Howard F. Pollick, BDS, MPH, were inadvertently omitted or misnumbered. A full, corrected version of the article is available online at cda.org/journal. We apologize for the error.

Law Incorporates Dentists in Emergency Response Plans

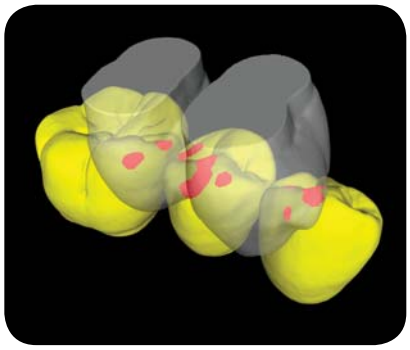
President Obama recently signed into law language incorporating dentists into emergency response plans. The president's action brings to a close a two-year effort by the American Dental Association to include the language in the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPA), according to a news release from the ADA.

The law clarifies that dentists may be considered disaster response public health responders to disasters or other public health emergencies, and states that dental schools are eligible to receive federal funds to train public health and medical response workers.

The reauthorization will ensure that programs created almost 10 years ago to help the government manage medical responses to natural disasters and other emergencies will remain in place. The reauthorizing law contains language that includes dentistry in the response framework, taking advantage of dentists' extensive education, training and professionalism, according to the ADA.

A statement from the White House press secretary said the law "revises authorities for activities to improve public health and bioterrorism emergency planning, preparedness and response; streamlines authorities within the Department of Health and Human Services to improve coordination and eliminate inefficiencies; and strengthens the role of the Food and Drug Administration to bring prevention treatment products, known as 'countermeasures,' to market for emergency use."

For more information, see the ADA news story at ada.org/news/8365.aspx.



Dental tissue and supporting structures of the second premolar of the right mandible after segmentation.

Researchers Digitally Analyze Modern Human Teeth Using Finite Element Analysis

Scientists from the Max Planck Institute and the Senckenberg Research Institute digitally analyzed modern human teeth using a finite element method to evaluate the biomechanical behavior of teeth under realistic loading, according to a news release. The study showed very widespread loss of dental material at the base of the crown could be linked to the reduction of tooth wear in our industrialized societies.

"Over the last century, humans from industrialized societies have witnessed a radical increase in some dental diseases. A severe problem concerns the loss of dental materials (enamel and dentine) at the buccal cervical region of the tooth," authors wrote.

"Based on the results of our simulations of chewing loads, we assume that much of the enamel failure we find today frequently in tooth crowns is probably caused by cyclic tensile stresses during chewing," Ottmar Kullmer of the Senckenberg Research Institute said in the news release.

"The computer simulation of chewing forces creates high tensile stresses exactly in the cervical areas where we frequently find tooth lesions in our teeth," said Stefano Benazzi of the Max Planck Institute. To investigate changes in stress pattern in the same tooth crowns with varying tooth wear ages, two premolars were artificially abraded in the laboratory, based on their individual data of occlusal movement — making it possible to calculate changes in stress pattern, depending on wear stage.

Stress in the teeth with advanced wear shows far better distribution of the loads over the whole tooth crown, reducing tensile stresses. The extension of the lifespan and the quick changes in our lifestyle with a remarkable reduction in tooth wear present a major challenge for modern dentistry, the researchers concluded.

For more information, see the study in the journal *PLoS ONE*, 8(4): e62263 or see the news release at senckenberg.de/root/index.php?page_id=5210&kid=28&id=2711.

Researchers Develop Implant Coating for People With Bone Deficit

Spanish researchers have developed an implant coating with a novel biodegradable material that is targeted at patients with bone deficits. According to the researchers, the new implant material will also increase the overall success rate of implants through an enhanced biocompatibility and reduced time of osseointegration or bone integration.

Elderly people or those with osteoporosis, smokers, diabetics or people who have had cancer are sometimes not eligible to receive dental implants as their bones are unable to correctly integrate the new prostheses, according to a news release from the Asociación RUVID, via ScienceDaily.com.

The recent development "consists of covering the implant with a biodegradable coating that, upon contact with the bone, dissolves and during this degradation process is able to release silicon compounds and other bioactive molecules which induce bone generation," said Julio José Suay, coordinator of the research group of Polymers and Advanced Materials, in the news release.

Called Soldent, researchers say this research line is "totally innovative," as the systems used thus far have consisted of increasing the roughness of implants to allow for integration into the bone.

After in vitro testing with cell cultures of the different biomaterials, they proceeded to the live animal evaluation, until achieving the prototype with the best results. For more information, see the news release at sciencedaily.com/releases/2013/04/130429094941.htm.

FDA Says There's No Guarantee of "Latex Free"

The U.S. Food and Drug Administration recently issued new draft guidance for the labeling of medical products recommending manufacturers of FDA-regulated medical products stop using statements on labels such as "latex-free" or "does not contain latex."

According to FDA.gov, the organization issued this guidance in order to avoid giving a false sense of security to people who are allergic to natural rubber latex, saying, "The problem with that language is that FDA is aware of no tests that can show a medical product is completely without the natural rubber latex proteins that can cause allergic reactions."

The FDA said it wants to promote scientifically accurate labeling and suggests manufacturers who want to indicate that natural rubber latex was not used as a material instead use the more accurate language "not made with natural rubber latex." While this recommended language communicates that natural rubber latex was not used as a material in the finished product or as a material in the container, it also does not make the unsupportable claim that the medical product is "free" of or "does not contain" natural rubber latex.

Natural rubber latex made from plant sources is used in numerous medical products, including medical gloves, adhesive bandages and blood-pressure monitoring cuffs, among others. Repeated exposure can result in sensitivity to natural rubber latex proteins, with symptoms ranging from skin redness, rash, hives or itching to difficulty breathing and wheezing and, rarely, shock and death.

For more, visit www.fda.gov/ForConsumers/ConsumerUpdates/ucm342641.htm.

THE OTHER GUY, CONTINUED FROM 471

with some specifics about these other guys' poor behavior and the punishment they will endure. The same formula is repeated for Gaza, Tyrus, Edom, Ammon, Moab and other local bad actors. That is good stuff if you are into schadenfreude.

Several years ago, I was asked to speak on ethics at a conference where evidence-based methodology was being used to develop guidelines for dentists in a treatment area. If you Google "practice guidelines" you will find about 10,000 such position papers from various organizations telling practitioners in various health professions how they should do their jobs. This was to be another. The little research that has been done on such guidelines shows that somewhat less than half of practitioners in any area are aware of the guidelines that exist, and a small proportion of those who know follow them.

I talked about the ethical responsibilities of advising one's colleagues how to practice. The conference organizers thanked me politely but suggested they had had something else in mind. They wanted me to make a case that it would be unethical for dentists not to follow their guidelines. My personal view is that if they had wanted to engage practitioners they would have invited them to the meeting. Only the people in the room get to say what counts; we cannot do it on behalf of others.

I find four types of written pieces about ethics in dentistry. "Others are doing something wrong" and "our problems would be relieved if others did what they should" are the two most common. Scholarly work designed to explain how people behave ethically is scarce. Of the 18 journals of professional ethics, there are about eight in medicine, several each in nursing, law, business and other fields; but none in dentistry. The writing I am in awe of is where people stand up and say, "This is what I am prepared to do to make the profession better."

Amos cautions against pointing the moral finger. But you will have to look at verse 6 of his passage to find out why.

The nub:

1. Stop talking about what others should do.
2. Search for deep understanding of how people actually behave morally.
3. Declare what you are willing to do for dentistry.

David W. Chambers, PhD, is professor of dental education, Arthur A. Dugoni School of Dentistry, San Francisco, and editor of the Journal of the American College of Dentists.

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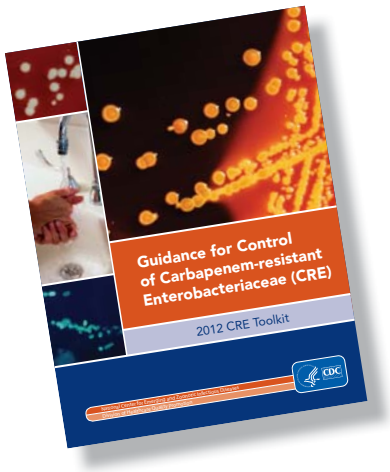


Study Shows Alarming Rise in CRE Infections in Past Decade

According to a recent *Vital Signs* report, antibiotics are being overpowered by lethal germs called carbapenem-resistant Enterobacteriaceae (CRE). In their usual forms, germs from the Enterobacteriaceae family (e.g., E. coli) are a normal part of the human digestive system. However, some of these germs have developed defenses to fight off all or almost all antibiotics available today, according to CDC.

CDC has warned about CRE for more than a decade but says new information shows that these germs are now becoming more common, noting on its website that there has been a seven-fold increase in the spread of the most common type of CRE during the past 10 years.

CDC stated that although these infections are not common, "their rise is alarming because they kill up to half of people who get severe infections from them." Additionally, CRE are known to pass on their antibiotic-fighting abilities to other kinds of germs, which means in the near future more bacteria will become immune to treatment.

"Stopping CRE will take a rapid, coordinated, and aggressive 'Detect and Protect' action that includes intense infection prevention work and antibiotic prescribing changes," according to CDC's website. CDC released a CRE prevention toolkit in 2012 reiterating practical CRE prevention and control steps and recommends leadership and medical staff in hospitals, long-term acute care hospitals, nursing homes, health departments and even outpatient practices work together to implement these recommendations to protect patients from CRE.

For more information, see the report at cdc.gov/features/vitalsigns/hai/cre/index.html.

Fluoride Found to Lower Adhesion Force of Bacteria

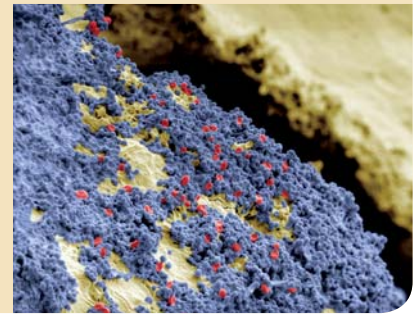
Researchers recently discovered new evidence that fluoride affects the adhesion force of the cavity-causing bacteria that stick to teeth.

Despite more than 50 years of scientific research, controversy still exists over exactly how fluoride compounds reduce the risk of tooth decay, according to a news release from the American Chemical Society. Research established long ago that fluoride helps to harden the enamel coating that protects teeth from the acid produced by decay-causing bacteria, and newer studies have found that fluoride penetrates into and hardens a much thinner layer of enamel than previously believed, lending credibility to other theories about how fluoride works.

For the new study, published in the ACS journal *Langmuir*, in order to characterize adhesion on fluoridated samples on a single bacterial level, researchers used force spectroscopy with bacterial probes to measure adhesion forces directly. The researchers "tested the adhesion of *Streptococcus mutans*, *Streptococcus oralis*, and *Staphylococcus carnosus* on smooth, high-density hydroxyapatite surfaces, pristine and after treatment with fluoride solution." Authors reported finding that all bacteria species exhibited lower adhesion forces after fluoride treatment of the surfaces.

These findings suggest that the decrease of adhesion properties is a further key factor for the cariostatic effect of fluoride besides the decrease of demineralization, authors concluded.

For more information, see the study in *Langmuir*, 2013, 29 (18), pp. 5528–5533.



Mona Lisa Production / Science Source

Throwing Out a Toothbrush After Strep May Be Unnecessary

A recent study has found that it may not be necessary to replace children's toothbrushes after having strep throat as the strep bacteria typically don't survive.

In the study, researchers investigated whether the strep bacteria would grow on new toothbrushes used by 14 children who had strep throat, having them brush their teeth for one minute before placing the toothbrushes in a sterile cover and taking them to a lab for testing. The authors then compared those toothbrushes to those used by 13 patients with sore throats that weren't strep and 27 well children ages 2 to 20, according to the study.

The step bug was recovered from only one toothbrush, which had been used by a patient without strep throat. The other study toothbrushes failed to grow the group A Streptococcus but did grow other bacteria that are common in the mouth.

"This study supports that it is probably unnecessary to throw away your toothbrush after a diagnosis of strep throat," said co-author Judith Rowen, MD, in a news release from the American Academy of Pediatrics, while study co-author Lauren Shepard, DO, noted that the study was small and larger studies with more subjects would be needed to confirm their findings.

The researchers presented their findings at the Pediatric Academic Societies Annual Meeting in Washington, D.C., on May 4, 2013. For more information, see the news release at eurekalert.org/pub_releases/2013-05/aaop-dbq042613.php.

Patients in ICU Rooms With Copper Surfaces See Lower Rate of Health Care-acquired Infections

Placement of copper objects in intensive care unit (ICU) hospital rooms showed to reduced the number of health care-acquired infections (HAIs) in patients by more than half, according to a new study in the Society for Healthcare Epidemiology of America's journal, *Infection Control and Hospital Epidemiology*.

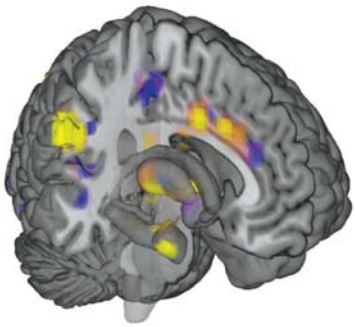
These infections often contaminate items within hospital rooms and allow bacteria to transfer from patient to patient. In this study, patients who were admitted to the ICU of these hospitals were randomly assigned to receive care in a traditional patient room or in a room where items such as bed rails, tables, IV poles, and nurse's call buttons were made solely from copper-based metals. Both traditional patient rooms and rooms with copper surfaces at each institution were cleaned using the same practices.

According to the study, the proportion of patients who developed HAI and/or colonization with methicillin-resistant *Staphylococcus aureus* or vancomycin-resistant *Enterococcus* was significantly lower among patients in rooms with copper surfaces (7.1 percent) compared with patients in traditional rooms (12.3 percent). The proportion of patients who developed HAI was significantly lower among those assigned to copper rooms (3.4 percent) compared with those in traditional rooms (8.1 percent).

"Our study demonstrated that placing a copper alloy surface onto six common, highly touched objects in ICU rooms reduced the risk of HAI by more than half at all study sites," authors wrote, noting that "additional studies are needed to determine the clinical effect of copper alloy surfaces in additional patient populations and settings."

For more information, see the study in *Infection Control and Hospital Epidemiology*, vol. 34, no. 5, pp. 479-486.

"Our study demonstrated that placing a copper alloy surface onto six common, highly touched objects in ICU rooms reduced the risk of HAI by more than half at all study sites."



The neurologic signature for physical pain identified in a new study in the *New England Journal of Medicine*. Credit: Tor Wager.

Brain Scan Patterns Discovered to Objectively Measure Pain

Scientists recently discovered the ability to predict pain levels in people by looking at images of their brains, according to a new study led by the University of Colorado Boulder.

The findings, published in the *New England Journal of Medicine*, may lead to the development of reliable methods doctors can use to objectively quantify a patient's pain, according to a news release from the university.

Current measures of pain intensity depend on a patient's own description, which typically utilizes a one-to-10 scale, but objectively measuring pain could confirm patient reports and provide new clues into how the brain generates various forms of pain. Authors of the study also believe the new research could open the door for using brain scans to objectively measure anxiety, depression, anger or other emotional states.

"Right now, there's no clinically acceptable way to measure pain and other emotions other than to ask a person how they feel," said lead author Tor Wager, associate professor of psychology and neuroscience at CU-Boulder, in the news release.

The researchers used computer data-mining techniques to comb through images of 114 brains that were taken when the subjects were exposed to multiple levels of heat, ranging from benignly warm to painfully hot and found, with the help of the computer, a distinct neurologic signature for the pain.

"We found a pattern across multiple systems in the brain that is diagnostic of how much pain people feel in response to painful heat," Wager said.

The results of the study do not yet allow physicians to quantify physical pain, the news release noted, but they lay the foundation for future work that could produce the first objective tests of pain by doctors and hospitals.

For more information, see the news release at colorado.edu/news/releases/2013/04/10/first-objective-measure-pain-discovered-brain-scan-patterns-cu-boulder or see the study in the *New England Journal of Medicine*, 2013; 368:1388-1397.

UPCOMING MEETINGS

2013

July 18–20	ADA 27th New Dentist Conference, Denver, 312-440-3524 or ada.org/newdentistconf.aspx
Aug. 15–17	*CDA Presents The Art and Science of Dentistry*, San Francisco, 800-CDA-SMILE (232-7645) or cdapresents.com
Sept. 13–15	Fifth Annual Dental Motorcycle Ride, Windsor, sites.google.com/site/dentistrides
Oct. 31–Nov. 5	154th ADA Annual Session, New Orleans, ada.org/session
Nov. 3–9	U.S. Dental Tennis Association, Big Island, Hawaii, 800-445-2524 or dentaltennis.org
Nov. 10–13	National Primary Oral Health Conference, Denver, nnoha.org/conference/npohc.html

To have an event included on this list of nonprofit association continuing education meetings, please email Courtney Grant at courtney.grant@cda.org.

Explore the new Exploratorium

Image by Amy Snyder © Exploratorium

Image courtesy of ZUM, zumllc.com

The beautiful new Exploratorium on the San Francisco Bay, a fun and creative space to explore and play, serves as the setting for this year's CDA Party. Join us for mouth-watering delicacies, fascinating exhibits and live music.

CDA's Party at the Exploratorium

Friday, August 16, 7-10 p.m.

Event # 050

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San Francisco, California
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August 15-17, 2013

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- Beat the crowd with reserved seating for popular lectures.

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CDA Presents Schedule-at-a-Glance

Thursday, August 15, 2013

Moscone South
InterContinental
Dugoni School

* Repeated Course
> Continued Course

Thursday Exhibit Hall Hours
9:30 a.m.—5:30 p.m.

Required Courses — Ticket Required

- **California Dental Practice Act** — *Oromchian, MS 103*
- **Infection Control** — *Molinari, MS 103*

The Spot — Debuting the Smart Dentist Series, Free Lectures in the Educational Theater

- **Office Policies & Procedures** — *Thomason*
- **Handling Insurance Refund Requests** — *Cheesebrough*
- **Characteristics of Ethical Dental Professionals** — *Kozak*
- **Employment Law: How to Stay Compliant in 2013** — *Oromchian*
- **Dealing With Patients Who Won't Pay Their Bill?** — *Fornelli*
- **Health Reform for Small Businesses** — *Catalano*

Workshops — Ticket Required

- **Surgical Crown Lengthening >** — *Kohner, MS 232/234*
- **Implant Esthetics Workshop *** — *Higginbottom, MS 228/230*
- **Suturing for the General Practitioner** — *Silverstein, MS 220/222*
- **Pitfalls to Avoid When Starting or Purchasing a New Practice** — *Hoover, et al., IC Grand Ballroom C*
- **TDIC Risk Management *** — *Jansen, Weiss, IC Grand Ballroom A*
- **Site Preservation for Implant Placement *** — *Ehsan, MS 236*
- **Implants & Attachments *** — *Bambara, MS 224/226*
- **Are Your Pictures Perfect? *** — *Parks, Williamson, MS Exhibit Hall, Booth 302*
- **> Surgical Crown Lengthening** — *Kohner, MS 232/234*
- **Implant Esthetics Workshop *** — *Higginbottom, MS 228/230*
- **Atraumatic Extraction & Socket Grafting for the General Practitioner** — *Silverstein, MS 220/222*
- **TDIC Risk Management *** — *Jansen, Weiss, IC Grand Ballroom A*
- **Site Preservation for Implant Placement *** — *Ehsan, MS 236*
- **Implants & Attachments *** — *Bambara, MS 224/226*
- **Are Your Pictures Perfect? *** — *Parks, Williamson, MS Exhibit Hall, Booth 302*
- **Review of the Medical Emergency Kit** — *Lenhart, MS 270/272*

New International Symposia of Dental Learning

- **Multidisciplinary Treatment Approaches** — *Watanabe, MS 301*
- **Clinical Applications of Orthodontic Treatment in the Esthetic Zone** — *Watanabe, MS 301*

Express Lectures — Speakers New to the Podium

- **The Medical Management of Caries** — *Duffin, MS 309*
- **Management of Dental Trauma** — *Horst, MS 309*
- **Dentalveolar Surgery Tips & Tricks** — *Nattestad, MS 309*
- **Update in Endodontics** — *Peters, MS 309*

Lectures

- **Medical Emergencies in the Dental Office** — *Lenhart, MS 303*
- **Occlusion in Everyday Dentistry** — *Murphy, MS 200-212*
- **Leadership, Vision & Communication for Dental Teams** — *Murphy, MS 200-212*

7 AM · 8 AM · 9 AM · 10 AM · 11 AM · Noon · 1 PM · 2 PM · 3 PM · 4 PM · 5 PM · 6 PM

CDA Presents Schedule-at-a-Glance

Lectures (continued)

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

Fixed Prosthodontics & Esthetics
Nathanson, MS 102

Restorative Materials Update 2013 >
Brucia, MS 104

Direct Resin Bonding >
Mopper, MS 307

Treatment Planning for Success >
Perry, MS 305

Rock Your Communication
Turchetta, MS 308

Transition From Practice to Retirement
van Dyk, MS 302

The Plaque Monologues >
Novy, MS 306

Drugs, Bugs & Dental Products: Prescription Drugs
Jacobsen, MS 103

Technology in Your Practice >
Feuerstein, Flucke, Jablow, MS 101

Cone Beam CT: Acquisition, Reconstruction, Artifacts
Khademi, MS 105

Early Interceptive Orthodontic Treatment
Mahony, MS 304

Dental Sleep Medicine Essentials
Simmons, MS 310

Demystifying Root Resorption
Tittle, MS 100

SM4D – Social Media for Dentists *
Newman, MS 303

New Materials & Technologies
Nathanson, MS 102

> Restorative Materials Update 2013
Brucia, MS 104

> Direct Resin Bonding
Mopper, MS 307

> Treatment Planning for Success
Perry, MS 305

Take My Breath Away
Turchetta, MS 308

The Right Associateship
van Dyk, MS 302

> The Plaque Monologues
Novy, MS 306

Drugs, Bugs & Over-the-Counter Dental Products
Jacobsen, MS 103

> Technology in Your Practice
Feuerstein, Flucke, Jablow, MS 101

Cone Beam CT: Perception, Cognition, Interpretations
Khademi, MS 105

Diagnosis & Treatment of TMD
Mahony, MS 304

Dental Sleep Medicine — Contemporary & Advanced
Simmons, MS 310

Minimizing the Heartbreak of Root Fractures
Tittle, MS 100

SM4D – Social Media for Dentists *
Newman, MS 303

Maximize the Value of Your Most Powerful Asset
Brubaker, MS 200-212

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

CDA Presents Schedule-at-a-Glance

Friday, August 16, 2013

- Moscone South
- InterContinental
- Dugoni School

* Repeated Course
> Continued Course

Friday Exhibit Hall Hours
9:30 a.m.—5:30 p.m.

Required Courses — Ticket Required

- **Infection Control** *Molinari, MS 103*
- **California Dental Practice Act** *Canham, MS 103*

The Spot — Debuting the Smart Dentist Series, Free Lectures in the Educational Theater

- **Paycheck Protection** *Nelle*
- **Addressing Negative Online Reviews** *Corum*
- **Managing Patient Conflicts** *Alvi*
- **CBCT in Private Practice** *Khademi*
- **Wine FUN-damentals** (Ticket Required) *Langer*

Workshops — Ticket Required

- **Clinical Excellence With Esthetic Posterior Restorations >** *Brucia, MS 228/230*
- **The Art of Endodontics *** *Buchanan, MS 236*
- **Don't Let Your Provisionals Look Temporary *** *Henson, MS 220/222*
- **Art & Science = Creativity *** *Mopper, MS 232/234*
- **TDIC Risk Management *** *Jansen, Weiss,* IC Grand Ballroom A
- **Instrument Sharpening** *Andrews, MS 224/226*
- **Radiographs Aren't Just X-rays Anymore** *Feuerstein, Flucke, Jablow,* MS Exhibit Hall, Booth 302
- **Employee Embezzlement & Fraud *** *Lewis, MS 270/272*
- **> Clinical Excellence With Esthetic Posterior Restorations** *Brucia, MS 228/230*
- **The Art of Endodontics *** *Buchanan, MS 236*
- **Don't Let Your Provisionals Look Temporary *** *Henson, MS 220/222*
- **Art & Science = Creativity *** *Mopper, MS 232/234*
- **TDIC Risk Management *** *Jansen, Weiss,* IC Grand Ballroom A
- **In-office Digital Impressions & Laboratory CAD/CAM** *Feuerstein, Flucke, Jablow,* MS Exhibit Hall, Booth 302
- **Employee Embezzlement & Fraud *** *Lewis, MS 270/272*

Lectures

- **Occlusion in Everyday Dentistry** *Murphy, MS 307*
- **Radiology Boot Camp** *Parks, Williamson, MS 301*
- **Treating Trauma Without Drama >** *Tittle, MS 100*
- **Digital Implant Dentistry** *Higginbottom, MS 200-212*
- **Women's Health & Periodontal Concerns** *Plemons, MS 105*
- **Adult & Pediatric Oral Sedation Review >** *Lenhart, MS 303*
- **Improving Case Acceptance** *Murphy, MS 307*
- **Panoramic Radiography** *Parks, Williamson, MS 301*
- **> Treating Trauma Without Drama** *Tittle, MS 100*
- **Current Concepts in Implant Dentistry** *Higginbottom, MS 200-212*
- **>Adult & Pediatric Oral Sedation Review** *Lenhart, MS 303*
- **Common Oral Lesions** *Plemons, MS 100*

7 AM · 8 AM · 9 AM · 10 AM · 11 AM · Noon · 1 PM · 2 PM · 3 PM · 4 PM · 5 PM · 6 PM

CDA Presents Schedule-at-a-Glance

Lectures (continued)

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

What Good Is a Dead Patient With Perfect Teeth?
Meinz, MS 104

Clinical Treatment Planning
Lowe, MS 306

The Impact Dental Insurance Has on Your Practice
Perry, IC Grand Ballroom B

Peer Review
Hansen, MS 274-276

The Agony of the Code
Duncan, MS 304

Direct Restoration Tips for RDAs
Howell, Troendle, MS 308

How Crown Lengthening Will Enhance Your Restorative Results, *Kohner, MS 101*

Principle-based Periodontal Therapy & Treatment Planning >
Miller, MS 305

101 Ways to Improve Your Practice >
Schwab, MS 310

Precision & Semi-precision Attachments
Bambara, MS 302

Prescription Drugs & Herbal Therapies
Spolarich, MS 103

Oral Cancer: A Patient's & Clinician's Perspective *
Carpenter, Grayzel, MS 309

Dental Implant Complications & Failure
Ehsan, MS 105

The Epidemic of Cracked Teeth
Clark, MS 102

Paid vs. Denied
Cheesebrough, Milar, IC Grand Ballroom B

Early Caries, Diagnosis, Prevention & Intervention >
Donly, MS 306

32 Teeth & 100 Birthdays
Meinz, MS 104

Successful Systems for A/R & Insurance Management
Duncan, MS 304

Indirect Restoration Placement for RDAs
Howell, Troendle, MS 308

Improving Esthetic & Restorative Results/Grafting
Kohner, MS 101

> Principle-based Periodontal Therapy & Treatment Planning
Miller, MS 305

> 101 Ways to Improve Your Practice
Schwab, MS 310

Treatment Planning Attachments & Implants
Bambara, MS 302

Natural Product Preparations in Dentistry
Spolarich, MS 103

Oral Cancer: A Patient's & Clinician's Perspective *
Carpenter, Grayzel, MS 309

Anterior Implants & Temporaries
Ehsan, MS 105

Direct Composite Restorations
Clark, MS 102

> Early Caries, Diagnosis, Prevention & Intervention
Donly, MS 306

Dental Benefits
Perry, Weber MS 301

Perio-restorative Interface
Lowe, MS 303

Ergonomics
Andrews, MS 307

National Health Care Reform
Short, MS 104

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

CDA Presents Schedule-at-a-Glance

Saturday, August 17, 2013

Moscone South
InterContinental
Dugoni School

* Repeated Course
> Continued Course

Saturday Exhibit Hall Hours
9:30 a.m.—4:30 p.m.

Required Courses — Ticket Required

7AM | 8AM | 9AM | 10AM | 11AM | Noon | 1PM | 2PM | 3PM | 4PM | 5PM | 6PM

- **California Dental Practice Act** *Canham*, MS 103
- **Infection Control** *Andrews*, MS 103

The Spot — Debuting the Smart Dentist Series, Free Lectures in the Educational Theater

- **Office Policies & Procedures** *Thomason*
- **Handling Insurance Refund Requests** *Cheesebrough*
- **Patient Records/ Access & Rules** *Pichay*
- **HPV & the Mouth Relationship** *Plemons*
- **PPO Mastery** *Straine*

Workshops — Ticket Required

- **Invisalign Clear Essentials II >** *Brandt*, IC Grand Ballroom A
- **Mini Dental Implants/GP *** *Choi*, MS 228/230
- **Better, Faster, Prettier Composite Dentistry** *Clark*, MS 220/222
- **Live Patient Denture Treatment >** *LaBarre*, Dugoni School
- **Oral Lesions: Detection & Diagnosis,*** *Asadi, Carpenter*, Dugoni School
- **Hands-on Participation with Implant Components & Chairside Techniques *** *Sadowsky, Hoover*, MS 232/234
- **Functional & Esthetic Crown Lengthening *** *Lundergan, Bruce, Martinez*, Dugoni School
- **Digital Exam & Treatment Planning** *Feuerstein, Flucke, Jablow*, MS Exhibit Hall, Booth 302
- **Employee Embezzlement & Fraud *** *Lewis*, MS 270/272
- **"I Can Hear the Odontoblasts Screaming!" *** *Novy*, MS 224/226

- **> Invisalign Clear Essentials II** *Brandt*, IC Grand Ballroom A
- **Mini Dental Implants/GP *** *Choi*, MS 228/230
- **Minimally Invasive Anterior Composite Dentistry** *Clark*, MS 220/222
- **> Live Patient Denture Treatment** *LaBarre*, Dugoni School
- **Oral Lesions: Detection & Diagnosis,*** *Asadi, Carpenter*, Dugoni School
- **Hands-on Participation with Implant Components & Chairside Techniques *** *Sadowsky, Hoover*, MS 232/234
- **Functional & Esthetic Crown Lengthening *** *Lundergan, Bruce, Martinez*, Dugoni School
- **What's New & What's Coming** *Feuerstein, Flucke, Jablow* MS Exhibit Hall, Booth 302
- **Employee Embezzlement & Fraud *** *Lewis*, MS 270/272
- **"I Can Hear the Odontoblasts Screaming!" *** *Novy*, MS 224/226

New International Symposia of Dental Learning

- **Considerations for Natural Teeth & Anterior Implant Esthetic Restoration** *Minami*, MS 301
- **Treating Cases of Occlusal Destruction With Full Mouth Reconstruction** *Minami*, MS 301

Lectures

- **Foundations of Dental Office Management** *Duncan*, MS 302

7AM | 8AM | 9AM | 10AM | 11AM | Noon | 1PM | 2PM | 3PM | 4PM | 5PM | 6PM

CDA Presents Schedule-at-a-Glance

Lectures (continued)

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

Managing Geriatric Patients
Plemons, MS 306

Perry–O–Cclusion >
Perry, MS 303

> Perry–O–Cclusion
Perry, MS 303

Contemporary Pediatric Restorative Dentistry >
Donly, MS 200-212

> Contemporary Pediatric Restorative Dentistry
Donly, MS 200-212

Update in Esthetic Restorative Materials
Donovan, MS 102

Restoration of the Worn Dentition
Donovan, MS 102

Challenging the Current Paradigms in Fixed Pros
Felton, MS 101

Diagnosis & Treatment Planning in Fixed Pros
Felton, MS 101

Prescription Drug Abuse
Sammon, IC Grand Ballroom B

The New Face of Drug Abuse
Sammon, IC Grand Ballroom B

Autoimmune Diseases
Spolarich, MS 307

Pharmacologic Treatment
Spolarich, MS 307

The Art of the Smile
Mahony, MS 309

Snoring & Sleep Apnea
Mahony, MS 309

What Good Is a Dead Patient With Perfect Teeth?
Meinz, MS 105

32 Teeth & 100 Birthdays
Meinz, MS 105

Maximizing Social Media — Minimize Risks >
Kirk, Brubaker, Mostofi, McNulty,
IC Grand Ballroom C

> Maximizing Social Media — Minimize Risks
Kirk, Brubaker, Mostofi, McNulty,
IC Grand Ballroom C

The Art of Endodontics >
Buchanan, MS 104

> The Art of Endodontics
Buchanan, MS 104

Dental Etiquette: Patients With Special Needs
Henson, MS 305

Infection Control/Glow Free
Henson, MS 305

S.M.A.R.T. Dentistry
Lambert, MS 308

Sports Dentistry
Lambert, MS 308

Periodontal & Implant Procedures >
Pasquinelli, MS 100

> Periodontal & Implant Procedures
Pasquinelli, MS 100

Advances in Composite Restorative Dentistry
Lowe, MS 304

Prosthetic Tooth Repositioning
Lowe, MS 304

Buying a Laser
Roshkind, MS 302

What Kind of Laser?
Roshkind, MS 302

Culture of Accountability >
Schwab, MS 310

> Culture of Accountability
Schwab, MS 310

Product, Technology Integration for the RDH
Miller, MS 306

Confronting Epidemics & Evolving Pathogens
Andrews, MS 306

Ethics in Dentistry Panel
Kiger, et al., MS 303

7 AM | 8 AM | 9 AM | 10 AM | 11 AM | Noon | 1 PM | 2 PM | 3 PM | 4 PM | 5 PM | 6 PM

cda PRESENTS The Art and Science of Dentistry

Exhibitor Listing

Exhibitor Listing

CDA JOURNAL, VOL 41, Nº7

Dental Ethics:

Professional Challenges in a Changing World

JAMES D. STEPHENS, DDS

GUEST EDITOR

James D. Stephens, DDS, is president-elect of the California Dental Association and a fellow of the American College of Dentists, the International College of Dentists and the Pierre Fauchard Academy. He practices general dentistry in Palo Alto, Calif.

Conflict of Interest Disclosure: None reported.

It seems everywhere I go these days I hear a conversation about "ethics." The subject comes up in relation to business, politics, sports, education, health care and more. Nearly all human interaction requires the use of ethical decision-making. All of this talk is a fine thing, but when you ask people what ethics means and how you make ethical decisions, you are likely to get a blank stare or a vague answer. We talk about it a lot but do not really have a working knowledge of the subject.

Ethics in dentistry is a hot topic. There are courses offered at major meetings and letters to the editor bemoaning the need for improved ethical standards throughout our profession. Much of the chatter focuses on marketing, consultants and corporate investment in dentistry. There is certainly nothing inherently unethical about any of these; however, there can be a certain dissonance between the business of dentistry and the provision of health care to our patients.

The challenge to dental professionals is to balance business and oral health care in an ethical way. In order to be ethical, we must first understand what that means and how one makes ethical decisions. We will need to look at the challenges that confront the profession and consider ways to evaluate the situations before arriving at an ethical decision.

This collection of articles will provide ideas and a common language to facilitate a conversation about some of the pressing challenges facing the dental profession today.

In his essay, "Would Someone Please Explain What It Means to Be Ethical?" David Chambers, PhD, provides a foundation for our conversation on ethics. He discusses the philosophical and principles-based theories of ethics and the confusion that afflicts many of us regarding what it means to be ethical. Of particular significance, he defines how ethics differs from morality and how ethical reasoning can result in the common good we seek as professionals.

Of great interest to the profession of dentistry in the digital age is the

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convergence of social media and dental practice. Bruce Peltier, PhD, MBA along with colleague Arthur Curley, JD, examines the potential advantages and pitfalls of social media and dental practice marketing in "The Ethics of Social Media in Dental Practice: Challenges." There is unease within the profession rooted in rapidly changing expectations of patients and practitioners regarding appropriate use of social media in the promotion of a dental practice. How we meet this challenge may well define our profession in the future. In a second offering, "The Ethics of Social Media in Dental Practice: Ethical Tools and Professional Responses," the authors present tools to guide ethical decision-making and discuss ethical challenges in the current practice environment. To assist the practitioner in balancing marketing and professional obligations, a checklist on making ethical marketing decisions is included at the end of this essay.

In the day-to-day management of their practice, dentists face many of the same stresses, as does the proprietor of any other business. Yet as professionals, our obligation to our patients requires a more beneficent posture than the profit motive of a retail shop. Phyllis L. Beemsterboer, MS, EdD, FACD, and co-author Gary T. Chiodo, DMD, FACD, contrast the dental professional's obligation to the patient with the business of dentistry in "Care Versus Commerce: A Challenge to Professional Integrity?" They argue that maintaining dentistry's long-standing integrity must be the responsibility of each dentist, as well as the profession.

As the result of lapses in judgment in professional schools and out of concern for their newly chosen profession, dental students throughout the country have founded an organization for nurturing professionalism, Student Professional Ethics Association (SPEA). Alvin Rosenblum, DDS, considers the genesis and progress of this movement as students seek to define what it means to be ethical and professional in school, as well as, in future practice in "Our Next Generation: Dental Student Ethics and Its Potential Influence on the Profession."

The CDA Code of Ethics is often cited, but not well understood. In "CDA Judicial Council: Blending Idealism and Practicality," Robert D. Kiger, DDS, demystifies the "Council" and the application of the "Code." From process to intent, there is much to know about how and why we list Peer Review and the Code as member benefits. Enhanced understanding of this aspect of CDA will help keep our members and profession among the most trusted in the country.

Finally, in Perspective, we present the message delivered to first-year dental students by Arthur A. Dugoni, DDS, MSD. In "Road Signs on the Road of Life" you will find, taken from his detailed notes, his thoughts on what it means to be a dentist and a professional. It is also a reminder of how our predecessors, committed to ethics, science and service, moved dentistry from trade to profession. ■■■■

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Would Someone Please Explain What It Means to Be Ethical?

DAVID W. CHAMBERS, PHD

ABSTRACT Definitions are offered to distinguish among behavior that is legal, charitable, professional and moral. Moral acts are especially important because that is what people do to bring about the right and the good that is mutually sought by dentists, patients and the community. Ethics is an academic discipline that teaches about appropriate behavior in an indirect fashion — what we say to justify what we do.

AUTHOR

David W. Chambers, PHD, is professor of Dental Education at the University of the Pacific, Arthur A. Dugoni School of Dentistry in San Francisco and editor of the *Journal of the American College of Dentists.*

Conflict of Interest Disclosure: None reported.

It is not obvious that dentistry faces more or fewer moral challenges today than in prior generations, but there is so much more chatter now. Among the efforts to convert discussions into decisions, 18 years ago the Commission on Dental Accreditation added Standards 2-20 and 2-21 mandating that all dental schools teach ethics and provide evidence that students have skills in the area of ethical reflection. This should make recent graduates the most ethical cohort of practitioners. But still we hear rumblings. There seems to be a felt need for practical ethics.

There are about 18 journals of ethics for the professions.[1] Most are in the general subject of biomedical ethics, but there are four in medicine. Nursing, law and business have multiple journals. There is even a journal of ethics for the uniformed military services. But there is no journal of ethics in dentistry. The *Journal of the American College of Dentists* has a regular feature on ethics. Sometimes there are one or two, but there are usually no ethics C.E. courses at the large state and regional dental conventions. If one were serious about mastering all the dental ethics literature each year, it would not be especially difficult. Ethics editorials have now almost become a substitute for doing something to improve the way dentistry is practiced.

Confusions remain over the meaning of terms such as ethics and legality, charity, professionalism and morality. The purpose of this paper is to present a summary of what has been learned about the various parts of the dental ethics elephant that some of us get our hands on from time to time. That should help us decide where it is best to push and where we should be pulling.

Legal

Illegal behavior is usually unethical as well — but not always. Driving faster than the posted speed limit in perfectly safe conditions may not be troubling to one's conscience, especially if trying to get an injured person to the emergency room. But it is still subject to penalty. And it could go the other direction. Some law enforcement officers have difficulty with strict interpretations of immigration regulations, and priests and lawyers are protected from prosecution if they choose not to reveal information they receive about illegal activity if learned in confidence.

I define legal acts as those mandated by civil authority so that acting inappropriately is expected to result in sanctions. They are ways we must behave, regardless of our conscience, and we are not even rewarded for doing the right thing. Who ever heard of having one's name published in the paper for not cheating on his or her income taxes? "Legal" means others decide what should be done and the only outcome of interest is avoiding a penalty for transgressions.

A classic example of the tension between what is legal and what is ethical in health care involves insurance claims. A patient cannot afford needed treatment without some deception on the dentist's part regarding insurance eligibility, or the patient could receive better care if the reporting rules were bent just a little. Legally, this is usually insurance fraud. Ethically, it is a shame the patient does not receive the best care available. Most dentists say they come down on the side of honoring their contracts. It is otherwise for physicians. A 2000 *Journal of the American Medical Association* paper by Wynia and colleagues[2] is typical of the literature in reporting that about half of physicians alter records or insurance claims to benefit patients.

Such blurring of the lines between what is legal and what is ethical is called a Robin Hood case in honor of the fictitious hero of medieval England. He robbed from the rich and gave to the poor. Ethicists actually make a living debating these cases. The minority view is that it is questionably ethical to get social credit for advancing your own causes by using other people's resources. Working with insurance companies to get around the technicalities is a hassle, but it is sometimes effective. And there is always the pro bono option for those with strong ethical urges.

A CLASSIC EXAMPLE of the tension between what is legal and what is ethical in health care involves insurance claims.

Charity

Charity has some of the opposite characteristics from legal behavior. What we do out of the goodness of our hearts and for the benefit of mankind is of our own choosing and we are rewarded for our goodness and not penalized if we take a pass.

Charity dental care is substantial. The ADA places the value of pro bono and reduced fee treatment at about 5 percent of the total dental expenditures. Perhaps there is some bad-debt write off in there; certainly some of the care was offshore. In one recent study, participation in charity dental care was found to be unevenly distributed, with about half of dentists saying they do none.[3]

Without wanting to diminish the good impact of charity, it is pretty clear that it is different from ethics and cannot be substituted for it. Charity is defined by the giver and may, on occasion, degrade the recipient. We have recently heard reports of tension between American medical personnel who donate services in underserved portions of the world where they do wonderful and life-changing care for small segments of the population but cause disruptions to the local health care system and may leave served populations with unrealistic expectations and no access to follow-up care. Dental students sometimes practice without licenses on mission trips.[4] There are exemplary organizations such as Thousand Smiles that work to mitigate these disruptions. But the best charity typically begins at home.

Professionalism

Professionalism is the private ethics of groups that are recognized, by virtue of their trust and advanced training, to provide exclusive services to the public. Professional codes focus on the relationships among colleagues and secondarily on how professionals have agreed among themselves to serve the public. Such understandings were known historically as codes of professional etiquette.

The ADA statement is actually two documents. One is the Principles of Ethics and the second is the Code of Professional Conduct. They are tied together by a set of five principles, but it is clear from inspection that the largest part of the Code is about how dentists are expected to relate to each other. As far as I know, no patients were involved in the development of the Principles or the Code.

Professional codes come in two flavors. Some are regulatory. The

professional codes in the United States House and Senate are of this type, and members can be sanctioned for violations. The more common type is the aspirational code. Members are urged to guide their behavior by ideal standards in exchange for the expectation that their colleagues are doing the same. Typically, aspirational codes do not have specific criteria for identifying lapses and there is no intention of enforcing the code.

There is a very real possibility that dentists could act in a manner that satisfies their patients but annoys their colleagues. Botox treatment by dentists comes to mind. But it could go the other way as well. My men's book club recently ganged up on some of our local dentists. There were stories about my buddies being brow beaten over declining radiographs and treatments where the high-end work was scheduled first. One friend said he was denied a prophy because he did not want other care and, according to the "voice on the phone," his request for only an exam and prophy was "illegal." My friends seemed to think there was a conspiracy among the dentists.

The very first sentence of the ADA Principles of Ethics certainly seeks to avoid such impressions: "The American Dental Association calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal." Of course, that is not meant in any literal sense. Otherwise dental care would be less expensive and hours more convenient. The medical community has attempted to thread this needle by interpreting "patient first" in the Hippocratic sense that no third parties should stand between the doctor and the patient. The risk, of course, is a slip into paternalism. The patients' interests come first, but the doctor is the interpreter of what is in the patients' best interests.[5]

Ethics

Ethics is the formal theory of right and wrong, the good and the bad. It is about reasoning our way to a justification for our behavior. If this seems a bit academic, that is because ethics is a discipline of philosophy. If it appears that there may sometimes be a disconnect between behavior and ethical reasoning, that is because they are two kinds of activity.

Recently health care ethics has tried to pull itself away from the philosophical tradition. In medicine, nursing and biomedical research, the accepted school of thought is called the principles approach. It is so particular to medicine that it does not even appear in standard anthologies of ethical theories among academics. The principles approach works like this: One considers a behavior that appears attractive to follow. If the act can be classified as an example of an accepted ethical principle, the action is justified. There are literally dozens of these principles, such as self-fulfillment, confidentiality, consistency and dignity. Medicine follows the classic book by Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (now in its sixth edition),[5] in focusing on four principles: respect for autonomy (each decides what is in his or her best interests), nonmaleficence (avoiding harm), beneficence (helping others) and justice (fair distribution of burdens and benefits). The ADA Code of Ethics is built around these principles, plus one other. Veracity means not letting others hold false beliefs to their disadvantage. The largest portion of the items in the ADA Code fall under this fifth category and have to do primarily with dentists representing themselves to the public and interacting with other dentists.

THERE IS A VERY REAL possibility that dentists could act in a manner that satisfies their patients but annoys their colleagues.

The principles approach is a rational one. Ethics training in dental schools includes a large dose of reflecting or reasoning from individual concrete cases to general principles. Sometimes — perhaps almost always — more than one principle might be applicable. In this situation, we say that there is an ethical dilemma. Beauchamp and Childress advise that dilemmas should be resolved by balancing considerations. This means that one should resolve the conflict between principles by using some other higher principle or a personal preference.

For years, I have watched students and practitioners in small groups work through dilemmas. This is the preferred method of teaching ethics in the schools. It seems to be an easy enough task to find the right names for the principles. It is more difficult to get consensus on what should be done. Participants take positions and then defend them with one or another principle. This happens because most teaching cases in ethics are short narratives, open to multiple interpretations. This is probably realistic of the world of dental practice where some different ways of framing the matter are defensible. The disagreements are not the result of ethical disputes over principles. They are legitimate differences of opinion about what the facts on the ground really are. We all bring considerable background to our choices.

One case in particular seems to defeat theory every time. The ADA Code addresses justifiable criticism. Section 4C states, "Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services." I have never witnessed any philosophical discussions about the phrasing of this principle. Neither have I heard any question whether this should be a matter of avoiding harm rather than one of justice as the ADA classifies it. The debate is always about whether the particulars of the case really constitute "gross or continual faulty treatment" and whether there might be extenuating circumstances, not mentioned in the case, but easily imagined.

Human nature is masterful at maintaining lofty principles and avoiding having to act upon them by supplying imagined additional circumstances. Technically, this is known as "situational ethics." A general view is endorsed as a cover position and its application is tailored to particular circumstances. Situational ethics generally has a low reputation among professional ethicists.

Morality

The way dentists actually treat patients and each other, as opposed to what they say about it, is called morality. The distinction is often missed. Many people believe (or hope) that once others see what is right they will automatically do what is right. There is also a cherished notion that we can trust others to have our best interests at heart because they say they do. Research in business shows that the Sarbanes-Oxley laws have been a waste of time and that there is no relationship between a company's having a code of ethics or an ethics officer or ethics training programs and its reputation or the number of lawsuits it endures.[6] The only two factors that matter are the personal behavior of the leadership groups and whether complaints from employees and customers are acted upon. I use the term morality to describe doing what is right and good. I use the term ethics to mean what we say about our actions.

The first year I taught ethics in dental school I had this distinction forced on me. I presented a traditional ethical program grounded in the understanding of principles that students could use to talk about what they did. The final paper was a written case supported by reading material that I placed on reserve in the library. There was grumbling in the class about this assignment being remote from real concerns such as clinical requirements. I was nervous when the student body president and several officers asked to meet with me about the course a few days before the assignment was due. They were upset that someone had stolen the reserved reading material from the library. I quickly replaced it. But to this day, I secretly wish I had just waited to see who turned in a paper rich in theory so I could have separated the ethical students from the moral ones.

Morality operates on practical rather than theoretical criteria. The basic rule is that we should choose those behaviors that bring about the kind of world we would prefer to live in given the circumstances we find ourselves in and given that others involved in the situation are equal moral agents. Gone is the theoretical justification. Gone, too, is the false altruism in putting the patients' interests first. Finally, we must also give up the notion that we are the individual final arbitrator of what is right and good. Morality is a joint decision about futures that satisfy common needs. It is what happens when the dentist takes off his or her white coat and works with the patient.

The classical expression of morality in dentistry is informed consent. *Patients*, by law, in full charity, based on the ethical principle of respect for autonomy and grounded in morality, should participate in decisions that affect their personal values, their financial condition and their self-image. In the natural condition, they are not capable of doing that very well. They lack the technical knowledge to understand the expected progression of their condition and to evaluate the most likely costs and benefits of available interventions. By law, and other right and good considerations, that understanding must be given to patients or their guardians in order that they can participate as full moral agents in the decisions that affect them.

I would add that dentists are moral agents as well, and they need full patient information to make the correct choice from their own perspectives. Patients who mislead dentists about their health history, ability to pay or intentions to cooperate in their therapy are immoral. Dentists and patients, as well as the entire dental office team, are moral agents. Dentists cannot be the dictators of ethics. Nor should patients be. There is probably no subdiscipline of ethics deserving of the name "dental" morality. There is only morality, generally.

Traditional approaches to ethics face three problems: First, theory does not automatically translate into action. Second, debates over whose theory to use are often intractable. Third, enforcement is messy. We cannot always count on the other guy's conscience being in as fine a working order as ours. Legal and social sanctions are costly and may consume all

the benefit they promise. The advantage of morality, as opposed to ethics, is that it is self-enforcing. If a joint agreement has been reached such that neither party has any reason to prefer any other course of action based on their own dreams, the circumstances and other's intentions then we know we have found the right thing to do. We also know that neither agent has any reason to act otherwise. Legal action and ethical rationalization are often signs that original actions were based on morally inadequate grounds.

The logic of morality can be applied equally to the relationships among dentists in the profession. Finding the mutual best way forward based on input from all concerned is exactly what organized dentistry is about. Those who sit on the sidelines in order to preserve their private image of how things should be get exactly what they deserve. The conversation will move past them and they will be left with no option but to pass judgment on past opportunities. If dentistry as a profession prefers to address concerns that involve the profession, patients and the public at large based on only their own interests or standards, it will maintain a costly gap. ■■■■

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Additional Resources

The American College of Dentists has a tradition of engagement in ethics. Actually, this is better seen as a concern for morality in the profession, with primary emphasis on practicing dentists rather than students. For the past 15 years, the College has reached out to partner with other organizations in the profession, conduct workshops to train dentists in ethics and provide programs in dental schools and scholarships for dentists seeking formal, advanced training in ethics.

The College has also developed a range of resources online. These are free to any who are interested and can be found at www.dentalethics.org.

General Material: The aspirational *Code of Conduct of the College*, an ethics handbook and a set of cases exploring sound treatment decisions are found here. This set of material also contains descriptions of ethics programs sponsored by the College, including scholarships for dentists interested in training in ethics.

Courses Online in Dental Ethics (CODE): Set of 28 "courses" that can be attended on the Web. These are predominantly articles from the *Journal of the American College of Dentists*, covering practical topics. Because they come with computerized tests that are machine scored to produce a certificate of participation, CODE is accepted for ADA CERP credit. To date, there have been more than 28,000 courses taken.

Practice Ethics Assessment and Development (PEAD): This package is intended for practicing dentists and their entire office teams. It is a collection of self-tests, surveys, chart audit guidelines, patient satisfaction instruments and other "assessment" approaches, as well as "development" exercises, group discussions and suggestions for reworking office procedures and documentation to promote a moral practice. Offices, rather than dentists, participate for this program, which requires about 50 hours of work, with activities scored anonymously online. This program is also ADA CERP approved.

Interactive Dental Ethics Application (IDEA): This is a downloadable, interactive dental ethics textbook. It comes in searchable PDF format and resides on the user's computer, like a Kindle. There are eight sections. There are only two "chapters" in the traditional textbook sense: one on the basics of ethics and another on how to analyses a moral situation. General ethics resources such as codes are also available. There is a glossary of several dozen key concepts, each explained in about 500 words. Twelve cases are included, some in video format. Those using the cases are invited to indicate how likely they are to engage in any of several alternative behaviors and to give reasons for their actions. These can be compared with norms for how a sample of 75 dentists responded and also how 50 patients reacted to the same material. There are also some self-assessment instruments and exercises.

Predental Ethics Survey (PES): The College is experimenting with a set of open-ended ethics questions for dental students. An example would be to invite responses on questions such as whether it is worse to cheat on a written exam or to alter a patient's record. These questions will be available online to predental students, with their answers being sent electronically to become part of their admissions portfolio at participating schools.

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The Ethics of Social Media in Dental Practice: Challenges

BRUCE PELTIER, PHD, MBA, AND ARTHUR CURLEY, JD

ABSTRACT This is the first of two essays written to consider several important trends in dental practice that result from innovations in digital and social media. This essay reviews ethical and legal implications of the use of websites, Facebook, review sites, email and other digital innovations in dental practice. The second essay provides ethical tools for analysis, illuminates areas of ethical concern in today's practice environment and offers recommendations for future practice.

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Dentists, like so many practice owners and marketers from every industry, are standing at the crossroads of old and new marketing media and trying to decide which path to take.[1]
— American Academy of Cosmetic Dentistry website

There is a paradigm shift underway in dentistry, and the very nature and culture of the profession may be at stake.

The virtual explosion of technology, digital communication and social media has not bypassed dental practice. At first glance, the impact seems huge and wonderful — or threatening and horrible — depending on how you look at it and how much gray is in your hair. Dentists are confronted with Facebook, Twitter, Groupon, LivingSocial, FourSquare, Instagram, LinkedIn, Angie's List, Pinterest, Google+, Yelp, the need for a practice website and a Facebook page, email, blogs and YouTube, with more channels and gadgets emerging every day. The influence of the Internet on dental marketing has been called *"word-of-mouth on steroids."* There is plenty of advice on the Internet about how to use the new media, and scores of eager digital marketers to help you get started.

The question is what should dentists do about the new digital and social media and what are the ethical and practical implications? What's good and bad; what's right and wrong?

This essay explores the impact of digital technology on the practice of dentistry from an ethical perspective. It includes a review of relevant legal issues (not legal advice), and its main purpose is to provide a roadmap to help the reader decide what's the profession to do about the current and future uses of digital communication. Simple discomfort with a new technology is not a moral argument. An accompanying essay provides ethical tools and recommendations for practitioners and dental educators.

The Situation

There is great potential for doctors and patients to benefit from fast, inexpensive, powerful networks of communication and documentation, and many patients expect to find their dentist on the Internet. There is also potential for significant harm to the doctor-patient relationship, loss of confidentiality and a degradation of the professional culture of dentistry. One dental website consultant offers the following advice: *"Don't let privacy be a deterrent. It is only a speed bump."* A long-standing threat — the influence of marketers who are not dentists — suddenly seems more dangerous to the profession. One marketing expert notes on the Internet that:

This is the future of the Web, like it or not. Years ago, just having a website was a major accomplishment, now it is a necessity. Soon a Facebook or YouTube account will turn from a novelty to a necessity.
— Social Media for Dentists
Jason Lipscomb, Sidekickmag.com

While it is possible that much of the current conflict in professional circles is generational, differences are probably more complicated than the usual grousing about how the younger generation of dentists is ruining the profession, or conversely, how the old folks don't get it. Those squabbles have been around longer than any reader of this essay has and are unlikely to dissipate soon. Younger generations of dentists have always transformed their professions over the years, and that's certain to happen again. Younger people do seem more comfortable with the latest gadgets, and reports of infants who develop touchscreen skills before they can walk are now commonplace. But there are plenty of savvy tech types with gray hair, too, and older practitioners often possess the economic wherewithal to hire geeks to bring their practice up to speed, even if they don't really understand how the bits work themselves.

Challenges

The influence of marketers. While this has always been an issue in American health care, the explosion of digital outlets makes it likely that the influence of marketing consultants will grow. Marketers and health care professionals are driven by a different mentality and different set of ethics. Their goals are significantly different, as are acceptable methods of communication. The marketer's principle goal is to increase profitable business using a wide variety of techniques. This influence is already ubiquitous, and there is real danger that a marketing culture could overwhelm the profession. One online marketer suggests that "YouTube is a great way for you to appear in your dental patients' living rooms." Digital mechanisms exist that will remind people of your services whenever they go online. This tactic skates perilously close to the *soliciting* that is illegal in dental practice, and presumes that patients would actually welcome their uninvited dentist into their homes or computers. All one has to do is spend a few minutes on the Internet to get a feel for the power of this marketing. It is harder and harder to differentiate content from advertisement. Often a single message is both at once. It could be very easy for a doctor who does not use the latest sophisticated digital methods to feel left behind by the trend. Younger dentists — the future of the profession — may be especially vulnerable to questionable trends, given their lifelong comfort with technology and the financial challenges they face in the current economy. This situation mandates that dental schools provide powerful educational, ethical and technical experiences so that students enter the real world with tools adequate for the task. If young dentists enter their profession naïvely assuming that dentistry is "just another business," the profession is in peril.

IF YOUNG DENTISTS enter their profession naïvely assuming that dentistry is "just another business," the profession is in peril.

Dental plans are "third-party payers," whose influence on the dentist-patient relationship is complex, but digital media bring a "fourth party" into the mix. A host of others — many of whom are "outsiders" to the dental profession — are in the process of influencing dental care, perhaps unwittingly. These include web designers, coupon brokers and social networks such as Facebook. These players are not obligated to adhere to the CDA Code of Ethics. They don't even know or care about such a thing. Are they selling names, clicks, usage patterns or contact information? Their marketing behavior is not especially transparent to patients or doctors, and most people have no idea what is going on behind the scenes and screens.

Online reviews. Sites such as Yelp, Angie's List, YP and ZocDoc (there are many more) are a seriously mixed bag and unlikely to go away. They create a mechanism for customers and patients to level the playing field of "caveat emptor," offering people an anonymous channel for feedback to doctors who rarely get or even welcome direct feedback from patients. Such feedback can hurt, and most people hate getting it, but it can help shape a practice for the better. That

said, there are serious problems with review and rating sites, especially in the health care arena. Distressed and angry people are much more likely to post a review than happy ones, so the feedback tends to have a negative bias. Sometimes reviews are negative because patients and dentists do not share the same value structure. A practice could receive a hostile review because a cleaning felt uncomfortable or took a long time, even though it was difficult, thorough and well done. On the other hand, some of the most positive reviews are phony, written by shills or ghosts paid to make the proprietor look good. One never really knows if an online review is "real." Here's a notice recently spotted on the door of a San Francisco restaurant:

"Stop the Bully. Boycott Yelp"

Our customers repeatedly tell us that they have submitted very good reviews on our food and service. Yet, they never show on our reviews. We asked Yelp, we were told, "Perhaps if you paid to do Yelp ads we could help you with this."

Online critiques are especially interesting when viewed from a legal perspective. Social media has caused a sea change in the law, as well. In contrast to the one-directional quality of television — where a small number of elite people communicate to a captive audience — the law tends to view social media as if it were the public forum envisioned by our founding fathers, where ideas and opinions are exchanged and therefore subject to constraints such as free speech, defamation and rights of privacy. The law in California protects free speech in social media as *opinion* unless it is an unquestionably false statement of fact that defames or threatens grave bodily harm. Commonly called a SLAPP (Strategic Litigation Against Public Participation) motion, California Code of Civil Procedure (Sections 425.16-18) provides that:

> *A cause of action against a person arising from any act of that person in furtherance of the person's right of petition or free speech under the United States Constitution or the California Constitution in connection with a public issue shall be subject to a special motion to strike, unless the court determines that the plaintiff has established that there is a probability that the plaintiff will prevail on the claim.*

This means that when a person is sued for defamation for publishing a statement in a social medium such as Yelp, the person who made the statement can file to dismiss the complaint. If granted, the defamation suit is dismissed and the person who sued may then collect attorney's fees. This law was designed to provide protection against meritless lawsuits and has spawned numerous law firms that specialize in these motions (casp.net/california-anti-slapp-first-amendment-law-resources/statutes/).[2] As an example, if a patient were to report on Yelp that they were unhappy with a dentist and felt that the treatment was rough and the fees were too high, the law would see such comments as mere opinions, not defamatory statements of fact. Any suit against such statements is risky, as it would be subject to a SLAPP motion and possible attorneys' fees, typically in the thousands of dollars.

STAFF AND CONSULTANTS must be instructed that names of patients and information about treatment of patients should not be discussed in any social media.

The law continues to hold health care providers to a high level of confidentiality when it comes to patient data and protected information. HIPAA and the California Confidentiality of Medical Information Act (CMIA in Cal. Civ. Code §§ 56-56.37) regulate the privacy of medical information. A dentist can be responsible for failing to employ reasonable efforts to maintain patient privacy, unless and until it is waived by the patient. This applies to postings by doctors on Yelp. Staff and consultants must be instructed that names of patients and information about treatment of patients should not be discussed in any social media. That limitation includes references to unnamed patients if the identity of the patient could be established by the information posted. Because a dentist is responsible for all employees, such discussions by staff, even after hours, could result in liability for the dentist who did not have or enforce reasonable efforts at confidentiality.

So, online review sites are not an even playing field for doctors. Patients can express their "opinion" of the treatment they received, but doctors are constrained in their capacity to respond. Aside from the illegality, it seems generally unethical to respond to a negative patient review in public, given the important role that confidentiality plays in trusting the doctor-patient relationship. Would you truthfully reveal details of your medical history if you thought that your doctor might post information about you online? As mentioned, some negative reviews result from misunderstandings that are, to an extent, out of the doctor's control, yet dentists must still be extremely careful when responding. They run the serious

risk of breaking the law, appearing hostile, defensive or obsequious, and information posted on the Internet tends to last forever. A response to a negative review can trigger subsequent retaliation by the original rater. Bear in mind that thoughtful responses, if posted at all, take serious time and effort.

Finally, as the sheer volume of reviews increase, the overall or average validity of ratings is liable to improve, but dentists' offices typically have a small number of reviews, and those can be dominated by the most outrageous of the lot.

That said, reputation management firms are readily available to write responses to negative reviews on behalf of doctors whose reputations are wounded on Yelp. These companies may or may not be aware of confidentiality constraints in the health care arena, and they may use methods that are shady or even dishonest.[3] They may promise to remove negative reviews when this is not possible, and they might attempt to bury a bad review with glowing ones written by paid reviewers. Some try to help by "emailing, calling or faxing their sales pitch to people within minutes of a complaint being posted about them online."[3]. Some will use legitimate methods such as alerting you when your practice has received a negative review, or publish proactive positive information about your practice. Some will coach you to encourage satisfied patients to post reviews. Such coaching seems quite undoctor-like, but remember: marketers do not possess the same professional views as doctors.

Websites. It is hard to imagine a dental practice in the future without a website, and websites are of obvious value to dentists and patients as well. They can be used to provide information about oral health and about the practice, they can help establish and maintain a relationship, they can be used for scheduling and routine administrative communication, they can carry out transactions and they function 24/7. There are, however, ethical pitfalls to be avoided.

The website name itself can be problematic, so it should be chosen carefully.[4] Names such as "bestdds.com" or "superiororthdontics.com" or even "cheapestdentistry.com" are examples of names to be avoided. These obviously run afoul of injunctions against claims of superiority or lowest prices. They may also fail the test of tackiness, diminishing the esteem of the profession.

WHEN CREATING OR modifying a website, dentists are obligated to be sure that all photos are not subject to copyright.

Website developers must be closely supervised, even though they may chafe at the constraint. It is the dentist, not the designer, who is responsible for all that the website communicates, and good web design includes the use of persuasive messaging, including effective use of search engine optimization (SEO). Designers ensure that keywords make their way onto websites to drive their site up the hierarchy of links on search pages. A higher spot translates into more hits and more business and more money. Such keywords might include terms that are unethical in dental communication, such as "best, cheapest, painless or guarantee."[5] SEO technology is evolving and it is difficult, if not impossible, for dentists to keep track of the changes.

Information and photos should be placed with great care. One must be sure to have proper permissions in both cases. When creating or modifying a website, dentists are obligated to be sure that all photos are not subject to copyright. This can be a problem when the dentist retains a web designer who has technical skills (sometimes a family member) but no understanding of legal issues involved in the use of photos they discovered on the Internet. Posting a copyrighted photo on a Web page without a release is held to strict liability under the law, and ignorance of the copyright is not a defense. The careful practitioner will ensure that the Web page content is either original imaging or ones for which a release (sometimes requiring a small fee) has been obtained. The typical claim for unauthorized use of a copyrighted photo is several thousand dollars. The use of patient photos is especially problematic, as it is a tempting and powerful way to influence other patients, but HIPAA requires a specific written release to use patient photos in any form of medical marketing. Facebook sites routinely show the faces of dental patients, probably with the tacit (but not explicit) permission of the patient. The matter is complicated because some patients may be reluctant to allow their facial photo to be posted, but intimidated by the doctor and disinclined to say "no" even though they are uncomfortable. Other patients may feel great about posting their photo immediately after treatment but might change their mind later. Care must also be taken when posting personal information about patients or using them for testimonials. Some patients may think that they (more or less) *have to* post their own face on the website at some point, in response to group or peer pressure. The posting of patient photos is complicated

because they tend to show results that are especially good, triggering the need for a legal disclaimer such as *"Results atypical."* Before-and-after photos should be taken in comparable poses, angles and lighting conditions so that they are not misleading. According to the Dental Practice Act,[6] photos of models who are not patients must be accompanied by a message revealing that fact. Dentists would be wise to consult an expert other than the webmaster before posting photos on a Facebook page or website.

Special offers on websites can be problematic. They can attract patients, understandably, who seek only the treatment in the offer and nothing else. This treatment may not be something that they actually need, or they may truly need other treatments that are not part of the offer. According to ethics codes,[7] dentists are obligated to inform patients of their current oral health status. An exam and radiographs may well be clinically indicated by the standard of care, but might feel like "upselling" to the patient when their newfound dentist recommends them. It's as if the special offer was a loss leader used to physically bring the patient into the office for other, more costly treatments. Disclaimers are necessary and doable. Here's an example from bestnaturalsmileblog.com/2012/01/promotion:

Note for New Patients: To keep you safe, new patients are required to have a thorough exam and any necessary dental X-rays, which are not a part of this offer. Dental hygiene health is determined at your first visit and any additional recommended therapy would be advised at that time.

Patients who arrive for a discounted "whitening" may be disappointed to discover that they are not "good candidates" for that treatment. These scenarios have a way of altering the doctor-patient relationship forever. One might also wonder how regular, long-standing patients of the practice might feel about these special offers and the new patients who get them.[5] Such offers may cause patients to move around from practice to practice, depending on who's offering the best special this month. That can't be good for dental patients or practices in the long run.

Special offers can result in unequal treatment of patients, a justice issue to be sure. It is likely to be difficult, if not impossible, to treat "bargain" patients or discount patients in the same careful way as "full-fare" or long-standing patients in the practice. In the worst-case scenario, patients who are taking advantage of an especially good deal may even experience conscious or unconscious hostility on the part of practitioners and their staffs.

ACCORDING TO THE Dental Practice Act, photos of models who are not patients must be accompanied by a message revealing that fact.

The phrase "be careful what you wish for" applies here. Special offers, along with social couponing, may also attract patients who are not a good fit for one's practice. The marketing literature refers to this phenomenon as "adverse selection."[8]

In many businesses, the customers most likely to sign on are precisely the worst customers you could possibly find.[9]

Finally, dentists must ensure that their website "maintains or elevates the esteem of the profession.[6] Offers of gas cards or iPads seem inconsistent with health care ethics or etiquette, at least in the traditional sense. Readers are urged to take a look at current offerings on the Web to see how common commercial or distasteful dental websites really are. The senior author conducted such a search while writing this paragraph and the first site to pop up showed a photo of a happy young patient shaking the rubber-gloved hand of a smiling dentist (hopefully a model and not a "real" dentist). The second site offered a "$99 New Patient Special" and "Implants Starting at Just $1,499." Phrases about fees that are vague or invite a bait-and-switch (e.g., *"as low as"*) are actually prohibited by law in California (B & P Codes; B, 3c).

Facebook. Launched in 2004, this powerful and popular social network now claims more than a billion users. It has exploded into a marketing goldmine, is becoming ubiquitous and has morphed from a relationship-builder to a transaction medium. The use of Facebook (if you do it yourself) is free of cost. One marketer wonders, *"How can dentists overlook a way to market to 50 percent of the population?"* Users click quickly and seamlessly between actual, real-life friends and commercial ones. The American College of Dentists' Position Paper on Digital Communication[10] makes this observation:

Those who are struck by the banality of Facebook postings have missed the point. The message is subordinate to the relationship.

A Facebook page is actually easier to update than a practice website and may serve all the same purposes, albeit accompanied by advertisements that the practice did not choose (such as ads for War Commander video games, entries about "dental implant horror stories," or "drill bit found in woman's lung"). One must wonder whether dentists have any responsibility for the content of the advertisements that appear on their

Facebook pages or websites. Do patients assume that the doctor endorses these dental products? The ADA Code of Ethics (5.D.2)[11] says:

> *In the case of a health-related product, it is not enough for the dentist to rely on the manufacturer's or distributor's representations about the product's safety and efficacy. The dentist has an independent obligation to inquire into the truth and accuracy of such claims and verify that they are founded on accepted scientific knowledge or research.*

Facebook is now a portal to a vast array of integrated marketing tools for dentists, including blogs, videos, Twitter accounts and a Facebook page for the practice. The options are dizzying. The opportunities for patient education are very significant, but the distinction between content and promotion is blurred. Any measure of doctor-patient confidentiality seems gone. Marketers are at the ready to help you create and enhance your Facebook presence.

Facebook pages are currently used by dentists to show before-and-after photos, advertise new techniques that are offered, inform patients of recent training taken by the dentist, promote new products, offer tips for patients (including ways to "make the most of dental insurance"), ask for patient endorsements, promote contests, conduct patient surveys about the practice, banter with patients about their weekend activities and show that the practice is a fun, happy place to be. The possibilities for good and bad on Facebook are vast enough to cause vertigo. It's overwhelming.

*Coupon brokers.** There are several large coupon brokerages, such as Groupon and LivingSocial, available online. Dental services (alongside offers for miniature golf, eyebrow waxes, Botox treatments, Brazilian waxing, couples massages and firearms classes) are offered at a discounted rate at local practices. Here's a real-life couponing example: A dentist typically charges $5,000 for Invisalign treatment. The coupon broker posts an online offer to provide that treatment for a discounted price of $3,400. The coupon company collects that fee from the patient, takes a share (say 35 percent of the fee, or $1,200), and sends the remaining $2,200 to the dentist who provides the treatment. The dentist then pays $1,600 to Invisalign for their retainers and services. This leaves a gross profit of only $600 to the dentist, before deducting normal overhead costs. In this example, the dentist provides services for about 20 percent of his or her normal fee. The dentist can make up some of the difference by doing a high volume of these treatments and thereby securing a reduced fee from the lab. This situation is not abstract, extreme or fantastic, as Internet coupon arrangements have the capacity to produce breathtakingly large numbers of new referrals in short periods. Obviously, the dentist hopes to retain some of these patients, but that's an iffy proposition under the circumstances, especially when you consider this passage from the CDA Code of Ethics (Section 9.1-2):

> *A dentist has the obligation to make a reasonable inquiry to determine whether a prospective patient is currently under the care of another dentist. In the interest of preserving the continuity of care, a specialist or consulting dentist has the obligation to inform the patient of the need to continue care with the referring dentist, unless the patient expressly reveals a different preference.*

Obviously, patients themselves get to decide where to seek dental care, but the use of coupons seems likely to encourage "patient poaching."

THE POWER OF social couponing to produce large numbers of new patient referrals can be a double-edged sword.

The power of social couponing to produce large numbers of new patient referrals can be a double-edged sword. When you sign on with a coupon company to make a special offer to the public you may, in fact, be obligated to accept that discounted fee for hundreds (or even thousands) of patients who contact you to use the coupon. Prior to the offer's expiration date, it's unlikely that you can just draw a line when you've had enough. This puts a dentist in a horrible position leading to some very unattractive choices, such as telling new patients that you are no longer willing to honor the coupon that they purchased in good faith — or worse: devising deceptive responses that delay or put such patients off indefinitely.

It turns out that Groupon users tend to review businesses more negatively and provide lower ratings than other customers, and further, that their reviews carry more weight with readers. This is called the "Groupon Effect" and it has been examined extensively in the marketing

* Editor's note: This article discusses the ethics involved with using online coupon brokers to offer dental services. The Legal Division of the California State Department of Consumer Affairs (DCA) has recently released a legal opinion concluding that a contractual arrangement between a health care professional and an Internet marketing service offering online discounts for medical services violates state law.

literature.[12] Explanations include the possibility that businesses using social couponing tend to be weaker or "bad" businesses that are already in trouble, that Groupon users are experimenting when they use a coupon or that businesses are sometimes caught off guard or swamped by large numbers of referrals and unprepared to provide adequate service.

While Internet coupon arrangements appear to constitute fee splitting (discussed below), one might also wonder about the winners and losers. Who benefits from such an arrangement, and what are the trade-offs? These sites create most of the same negative consequences that website offers do, including patient drifting, doctor shopping and suboptimal treatment selection by patients (where patients request treatments that doctors don't think they need while rejecting clinically necessary ones). There are also potential billing problems associated with the integration of dental plans with coupons. What is the "real" fee for the treatment? If you bill a patient's dental plan, are you representing your fees accurately? How do you include payment of a deductible? There is real danger of fraud, even unintentional fraud carried out by a well-meaning practitioner. A recent item in the ADA News[13] notes that:

Dentists who utilize Groupon-like services should ensure that they are not violating their contracts with third-party payers. These contracts sometimes contain provisions requiring that fees submitted to the insurer reflect any rebates or reductions in the fees (or co-pays).

Brokers such as Groupon and LivingSocial are especially tricky for dental practices because they are so large and legitimate.[14] The things they do in the commercial marketplace are quite legal and appropriate in that business context. But those same behaviors and opportunities may well be illegal and inappropriate in the health care arena. The fact that a large, well-accepted commercial entity does something online does not make it OK for dental practices, but the size of the business lends a certain mob credibility ("everybody's doing it"). Doctors are still responsible for upholding the legal and ethical standards of their profession. The ACD's White Paper[10] puts it succinctly:

The overarching theme of this position paper is that dentists should live their professional values uncompromised, regardless of their involvement in digital communication.

PERSONAL INFORMATION about patients must be kept confidential, and digital messaging represents a clear threat to this requirement.

Email (or texts) with patients. This is another technology with great potential value and corresponding dangers. The convenience of electronic messaging is extremely attractive, and its use in dental practice is important. Routine administrative tasks and transactions can be made convenient, and records and radiographs can be transmitted quickly and inexpensively. That same convenience can be risky as well, as email and text messages are anything but confidential. One must assume that everything sent over email could someday be public. That potential always exists, and nearly everyone on the planet has experienced the embarrassment associated with an email message gone rogue. Emails have a nasty habit of ending up in the worst inbox imaginable. Personal information about patients must be kept confidential, and digital messaging represents a clear threat to this requirement. Email is also a notoriously "cold" medium, and a poor way to communicate negative or emotionally laden messages. Short text messages can be downright perplexing. Plus, email messages linger longer than the half-life of plutonium.

It may sometimes be tempting to provide medical or dental advice over email, which could be a good or bad idea, depending on how things work out. Email responses to patients' questions are convenient and quite efficient. Consider, from a patient's point of view, the difference between getting a question answered via email versus trying to get an answer from the dentist over the phone or by going to the practice in person. But clinical advice given through email may be ill-advised without a physical examination. Long boilerplate disclaimers at the end of emails aren't likely to indemnify a practice that makes a serious clinical error in a digital message, either.

State dental boards will be inadequate. The scope of influence of the Internet and social media will swamp the power of government agencies to control or manage the situation. This trend is actually not much different from that of the past. The Dental Board of California, like all components of the Department of Consumer Affairs, is required by law to be self-sufficient and has limited resources. Its operations are funded exclusively by license fees.[15] Dental boards have never really been able to contend with the volume of ads found in phone books, on buildings, signage or on billboards in a state with 37 million people. But, the increase in ad presence is now exponential. While some might prefer it this way, neither the profession

nor the public can expect state boards to protect patients from dishonest practices or predatory commercialism. Will professional organizations such as the CDA and ADA be willing and able to ensure that professional standards are maintained and sustained? Professional dental organizations have little authority over nonmembers.

Recent developments in electronic and social media offer exciting possibilities for the enhancement of dental practice, both for patients and practitioners. But there are very real challenges involved, and they pose credible threats to the profession. Private practice dentists necessarily have one foot in each of the two worlds of health care and commerce,[16] and it is their professional responsibility to manage the inevitable conflicts. Dentists cannot simply employ commercial or marketing ethics to guide their practices. Furthermore, it would be a serious mistake to hope that governmental agencies will effectively manage the evolution from older forms of publicity and marketing, and it is in the best interest of the dental profession to proactively take charge of these changes. The second essay in this series offers biomedical ethical tools for this purpose. ■■■■

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The Ethics of Social Media in Dental Practice: Ethical Tools and Professional Responses

BRUCE PELTIER, PHD, MBA, AND ARTHUR CURLEY, JD

ABSTRACT This article considers several important trends in dental practice that result from innovations in digital and social media. It provides ethical tools for analysis, illuminates areas of ethical concern in the current practice environment and offers recommendations for future practice. A summary in the form of a checklist is posted at the end of this essay for dentists considering the use of social media in their practice.

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Social media is a billion dollar business. Facebook alone has a user base that would rank third in population if it were a country. Twitter sees 340 million tweets posted every day. — Kristie Nation, Dental Economics, 2012[1]

Important sea-change developments in technology and social media have begun to make serious inroads into the practice of dentistry. As health care professions evolve, ethics codes, decision methods and key ideas are available to help in an examination of the inevitable issues that arise.

Standard Bioethical Tools

Normative principles. The most common tool for ethical decision-making in dentistry is a set of principles and a deontological method.[2] The relevant principles include veracity, beneficence, nonmaleficence and often justice. Confidentiality is certainly at stake. The method requires that these principles be honored and never violated. It is a relatively simple method that breaks down in cases where the principles themselves conflict with each other.

Utilitarian, value-maximizing approach. This decision method weighs interests — patient interests, dentist interests, the interests of dental plans or third party payers and perhaps the profession as a whole. This ethical vehicle is essential to the present discussion, as the Internet offers potential for great good as well as significant harm. The trick is to do more good than harm and to limit damage to patients and the profession. It's a balancing act, to be sure.

The central values of dental practice. Ozar and Sokol created a useful method for ethical decision-making in their 1994/2002

text.[3] It established a set of "central values" for the profession and ranked them in a hierarchy. Higher values trump lower ones in the decision-making process. The central values, in rank order are:

1. The patient's life and general health.
2. The patient's oral health.
3. The patient's autonomy.
4. The dentist's preferred patterns of practice.
5. Esthetic values.
6. Efficiency in use of resources.

This view implies that a dentist can choose his or her "preferred pattern of practice (No. 4)," including the use of Internet technology and social media as long as such practices do not violate the values ranked higher on the list, such as the patient's life and general health (No. 1), patient oral health (No. 2), or patient autonomy (No. 3). The same can be said about the efficiencies offered by Internet technology, although "efficiency in use of resources" sits at the bottom of the list of values. It's still on the list, though, and it is an important value.

Professional identity and the fiduciary nature of dental practice. Perhaps the most compelling concept is that of *professionalism*. Professionals, by definition, perform an important service for people who are in a vulnerable position and unable to evaluate that service for themselves. Patients must be able to trust dentists, what they say and what they do. Because the public cannot effectively evaluate dental treatments, it is best if dentists manage their own collective behavior — as a profession. That way, patients can trust what dentists say and do for them, and government agencies need not intervene. The CDA Code of Ethics is clear: *"Service to the public is the primary obligation of the dentist as a professional person."*[4] Dentists, therefore, have an obligation to be trustworthy. It is this exchange, and the autonomous obligation to trustworthiness, that defines a profession.

Professionals also have a perceptual obligation to *seem* trustworthy. The CDA's Code of Ethics codifies this obligation by saying, *"While serving the public, a dentist has the obligation to act in a manner that maintains or elevates the esteem of the profession."* A group of dental students from Columbia University[5] recently made the point that "... aside from the conventional complaints that advertisements can be misleading or even deceptive, the very act of marketing in dentistry does influence the public's attitude toward dentists." The culture of the profession and its reputation are of extreme value to both patients and dentists. Despite decades of nervous hand wringing, dentists still rank number five in Gallup's November 2012 poll of public perception of honesty and ethics.[6]

BECAUSE THE PUBLIC cannot effectively evaluate dental treatments, it is best if dentists manage their own collective behavior — as a profession.

Professional considerations must be differentiated from etiquette (good manners), and a gray area clearly exists. Dentists must discriminate between the two when evaluating the use of digital technology in promoting their practices. It might seem questionable to post photos of a dental team wearing green leprechaun outfits on St. Patrick's Day. Such a posting will seem unprofessional to some, but is more likely a matter of sensibility and style. Publicizing that image may not be such a great idea, but that doesn't necessarily make it unprofessional. If, however, green outfits do actually undermine patient trust, then professionalism is at risk, and that's a different story.

Perception and appearance of professionalism are simply not enough. Bebeau and Monson stress the central importance of identity:

Clearly, the outward manifestations of professionalism may help to maintain public trust, just as a customer service orientation may serve as an antidote to crass commercialism. However, such outward manifestations may not sustain the profession or the professional unless they are linked to a moral identity that not only keeps self-interest in check but also guides and promotes a doctor-patient relationship based upon trust.[7]

The question of identity becomes important when an individual dentist is faced with the decision to participate in emerging methods of promotion or marketing. He or she could make a decision that would promote his or her own short- or long-term interests at the expense of the profession. A "profession" is an abstract thing, and if a dentist's identity does not include a sense of group membership, he or she is unlikely to consider the impact of his or her individual decision on the "profession" as a whole. They ask themselves the obvious rational question, *"Why* shouldn't *I participate in a marketing program that will bring 20 new patients into my practice next month?"* Research by Bebeau and colleagues implies a problem deeper than simple choices about use of technology:

(There is a) substantial body of evidence suggesting that many students entering professional education have not achieved key

transitions in identity formation that prepare them for the other-centered role that society and the profession expect of them.[7]

Furthermore, Ozar notes that "it is not only the dentists who advertise who risk being viewed as merely sellers in the market; rather all dentists suffer to the extent that dental advertising is indistinguishable from marketplace marketing."[8]

Business Versus Commerce

"I liked being a dentist and a salesman at the same time."
— Dr. Painless Parker, ca. 1892[9]

Jerrold and Karkhenehchi's 2000 review of the history of dental advertising observes that the learned profession's consistent attempts (more than 150 years) to constrain commercialism have been "acutely unsuccessful."[10] Ozar, who is a key figure in the evolution of dental ethics, argues that "the single most important challenge" facing the profession is the task of providing proper patient care while "trying to maintain a successful business operation."[8]

Dentistry is a business, but it is not an ordinary business, and it is not only a business. There are clear and irreconcilable conflicts between the competitive dynamics of the commercial marketplace and the cooperative ethics of the health care practice. Patients do not understand what dentists do in their mouths and they cannot compete as a buyer does in the commercial marketplace. Customers understand caveat emptor and the competitive relationship with sellers when they buy clothes or cars. They are capable of researching and evaluating the product or service in question. They can more or less see what they are buying. Such a competitive relationship is incompatible with the uneven playing field of the doctor-patient relationship where patients must rely on the explanations and advice of their doctor. Dentists could easily exploit patients. The entire health care enterprise depends upon those who can be trusted, for if patients decide that they cannot trust their doctor they will be forced to compete in the marketplace for care, and must employ the self-protective behaviors of a consumer.

Commercial sellers routinely strive to create "needs" in the minds of consumers. You *need* the latest iGismo or basketball shoe, and you may end up sleeping in line overnight on a sidewalk to get it. When dentists seem commercial, patients make marketplace judgments and the things that dentists recommend are perceived as attempts to make a sale rather than expert clinical advice. The recommendations of the dentist are then viewed as more of the same commercial noise that inundates American life on a daily basis. Such "messages" are distrusted and discounted if they are not simply ignored. Maybe you tune the dentist out just like you tune out the "TV" ads when you fill your car with gas. When patients are treated like customers, they act like customers, shopping around and making decisions based on price, distrusting what they are told, perhaps even behaving dishonestly toward sellers.

PATIENTS DO NOT understand what dentists do in their mouths and they cannot compete as a buyer does in the commercial marketplace.

The American College of Dentists' *White Paper*[11] points out that dental care cannot be converted into a commodity without compromise and loss of trust. The challenge, of course, is to provide patient-centric care within the framework and constraints of a business. Patients must be treated with care and integrity while the practice takes in more money than it pays out in overhead. A more complete discussion of the conflict between commercial and health care ethics can be found in Peltier and Giusti.[12]

Advertising in the professions. Public advertising has been legal since the Bates decision by the United States Supreme Court.[13] The Federal Trade Commission subsequently barred the California Dental Association from prohibiting members from advertising shortly thereafter.[14] It is, however, illegal to assert professional superiority in public announcements, and to offer guarantees or painless dentistry.[15] Law and ethics codes converge on the phrase "false or misleading." Dentists should not communicate anything to the public that is false or misleading in any material respect. The CDA Code goes on to say:

> *A dentist who compensates or gives anything of value to a representative of the press, radio, television or other communication medium in anticipation of, or in return for, professional publicity must make known the fact of such compensation in such publicity.*[4]

California law also requires advertisements about fees to be accurate and complete, including mention of fees for all necessary procedures and services included in the treatment.[16] If discounts are advertised, special groups who qualify for the discount must be described. As an example, when do you inform people that they might not be a good candidate for whitening or an implant? Before or after they arrive for treatment?

Basis for referral to another dentist or specialist. The fundamental reason to refer a patient to a particular dentist is the best interest of the patient. It is unethical to refer to a specific doctor or health care entity for reasons other than the best interest of that patient. Appropriate reasons include variables such as patient and doctor personality, gender, ethnic group, language capacity, physical location of the practice, finances, dental plans and, of course, the skills and experience of the doctor or specialist in question. The fact that the referring dentist receives a benefit is not an acceptable reason.

The law imposes a reasonable duty to refer standard. If a reasonably careful dentist in the same situation would have referred to a specialist, then the patient should be referred. However, if the patient was treated with as much skill and care as a reasonable specialist would have, there was no negligence.[17]

Split fees and rebates. The CDA's Ethics Code specifically prohibits split fees and rebates. While there are many varieties of rebates, it is clear that a dentist cannot "kick back" part of his or her fee for dental services to the person who referred a patient. The Code states in Section 11 that:

> *It is unethical for a dentist to accept or tender "rebates" or "split fees." Other fee arrangements between dentists or other persons or entities of the healing arts, which are not disclosed to the patient, are unethical. A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims and/or provide administrative services.*

The reasoning behind such a provision goes like this: A split fee might cause a dentist to recommend a service or refer to a particular specialist in order to get a rebate instead of referring their patient to a specialist who would be the best match for that patient's needs and situation. Such a referral clearly puts the dentist's interests ahead of the patient's, a situation made worse when the patient is unaware that the rebate took place.

In November 2012 the CDA's House of Delegates clarified its Ethics Code with the following opinion:[18]

> *The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists*

IT IS UNETHICAL TO refer to a specific doctor or health care entity for reasons other than the best interest of that patient.

> *.... The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" (in cases where the coupon company collects a fee from the patient and remits a portion to the dentist).*

Split fees and rebates are against the law, as well. It is illegal and a violation of the California Dental Practice Act to engage in the practice of accepting or receiving any commission or the rebating in any form or manner of fees for professional services, radiograms, prescriptions or other services or articles supplied to patients.[19]

The ADA's Code is explicit regarding marketing services. Advisory Opinion 4.E.1, "Split Fees in Advertising and Marketing Services," addresses this type of payment arrangement:[20]

> *The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected.*

Furthermore, according to the ADA, there are federal laws that address the use of coupons with older or indigent patients:[21]

> *(A) federal anti-kickback statute generally prohibits dentists from offering or paying money to encourage a person to refer a patient that may be eligible for services under a federal health care program, including Medicare or Medicaid ...*

Recommendations

Engagement. The profession cannot stick its collective head in the sand and pretend that nothing is changing and that everything will be OK if things evolve naturally. All dentists are impacted by the digital revolution whether they personally participate or not. We are experiencing a paradigm shift in the way that professions engage

with the public, and the evolution presents opportunity along with danger. As an example of the cultural importance of new gadgets and media, the Chairman of the FCC recently sent a letter to the administrator of the Federal Aviation Administration urging them to allow airline passengers to use electronic devices during take-off and landings. The letter wrote:

This ... comes at a time of tremendous innovation, as mobile devices are increasingly interwoven in our daily lives. They empower people to stay informed and connected with friends and family, and they enable both large and small businesses to be more productive and efficient, helping drive economic growth and boost U.S. competitiveness.[22]

It seems fruitless and backward for the dental profession to tell its members that they should refrain from joining the digital evolution. The trick, of course, is how to engage, how to join in a way that maintains a professionalism that is beneficial to both patients and doctors.

The California Dental Association has begun this process in earnest. The House of Delegates passed a resolution at its November meeting encouraging the Dental Board of California to clarify the legal status of social couponing.[18]

Young dentists must be invited to participate in the decision process. It won't be long before a dental student will complete the entire experience of dental school without handling a single piece of paper, so it makes no sense to tell them to take out a listing in the Yellow Pages (paper edition), join the Rotary Club and build a practice using only word-of-mouth. Young patients expect dentists to have an online presence. Even so, it would be an unfortunate mistake for young dentists to abandon community service and presence to rely solely on the Internet for referrals. Personal relationships and word-of-mouth still matter and probably always will. But personal relationships and word-of-mouth referrals do not evolve quickly.

Dental associations should become involved in the development of recommendations that express the profession's view of professionalism and digital communications along with specific recommendations for practices that they view as good and bad. The American College of Dentists has made a first step in that direction with its preparation of a comprehensive white paper.[11] Much more needs to be done — and soon. Clear guidelines, such as the checklist at the end of this article (**FIGURE 1**) and group pressure will help, but they tend to influence those who are members of organized dentistry. What about the others?

IT SEEMS FRUITLESS and backward for the dental profession to tell its members that they should refrain from joining the digital evolution.

Fee splitting. State boards and professional organizations need to continue to deliberate and make decisions about Internet coupon sites. Do they feel that participation in these services constitutes illegal, unethical rebates or not? Perhaps they represent a net benefit to the public, with positives that outweigh the negatives, much like the Supreme Court decided in the Bates case (that the public would benefit when the professions advertised). Furthermore, it is probably possible for coupon brokers to find a way to compensate dentists in a way that meets legal criteria. The profession needs to decide what to think and do about this, and the dental profession will have to impose these limits, as it is unlikely that commercial marketers will.

Dental schools. As always, dental schools must evolve to respond to changing practice patterns. They have a responsibility to prepare young graduates for the modern practice environment awaiting them. They need to know what to expect and how to respond to a culture and practice environment that seems to endorse a commercial view of dental care. Ethics programs and their efforts to develop the professional identity of students need to be expanded to explicitly address digital and social media. Such discussions must be part of the formal curriculum, and older mentors cannot be the exclusive source of wisdom in this arena.

Continuing education. Continuing education mandated by state boards, such as the "California Dental Practice Act" course, should be expanded to provide legal and ethical guidelines about use of social media.[23]

Conclusions

Digital and social media are exploding and cannot be ignored. There can be no reasonable debate about whether or not the Internet will impact dental practice and the culture of the profession. That horse is seriously out of the barn. The question of whether the horse is too wild is an open one. Here's how one younger dentist puts it on his website:

Ethics Checklist for Engagement With Social or Digital Media in Dental Practice

Does the Activity/Is the Activity?

Yes	No		
❑	❑	1.	Basically honest (not false or misleading in any material respect)?
❑	❑	2.	Diminish the esteem of the profession? (Is it too commercial? Tacky? Tasteless? Undignified? Diminish other practitioners?)
❑	❑	3.	Violate the law?
❑	❑	4.	Involve split fees or rebates for referrals?
❑	❑	5.	Use prohibited language such as "painless, as-low-as, lowest prices, and-up, guarantee?"
❑	❑	6.	Use mechanisms that could constitute a "bait-and-switch" tactic? (or be perceived as such?)
❑	❑	7.	Tend to make exaggerated claims or use "puffery?"
❑	❑	8	Intrusive? Does it solicit patients or treatments?
❑	❑	9.	Jeopardize patient confidentiality in any way?
❑	❑	10.	Use patient photos or personal information? Have patients given explicit permission?
❑	❑	11.	Use before-and-after photos that are accurate and comparable?
❑	❑	12.	Pressure patients for testimonials?
❑	❑	13.	Violate agreements with dental plans or other third-party payers?
❑	❑	14.	Do special offers include information about good or bad candidates?
❑	❑	15.	Do special offers include information about full exams and essential X-rays?
❑	❑	16.	Do you check with patients about their current dentist when they respond to your special offer?
❑	❑	17.	Are you prepared to treat all patients in basically the same way, including patients who are paying more or paying less?
❑	❑	18.	If you make special offers, do you have a plan for "regular patients?" (How to discuss the special arrangements, what to do when they request the same treatment.)
❑	❑	19.	Does your entire team understand the ethical implications of social media and the ways your practice intends to use these digital methods?
❑	❑	20.	Are you careful with email traffic with patients?
❑	❑	21.	Does the dentist supervise all aspects of the practice, including marketing and the website?
❑	❑	22.	Does someone monitor social media as they relate to the practice?
❑	❑	23.	Do more good for patients than harm?
❑	❑	24.	Do more good for the profession than harm?

FIGURE 1. Ethics checklist for engagement with social or digital media in dental practice.

Odds are Google Maps has a picture of your house already, so don't lose any sleep over Facebook.
— Jason Lipscomb, DDS, DigitalPlanet.com

Digital and social media offer huge opportunities for dentists and patients. They can be used to educate patients, to develop and enhance certain kinds of relationships and serve as a vehicle for inexpensive, streamlined communication and transactions. While their use in health care is fraught with challenges — even dangers — their increased influence is inevitable. It is important for dental professionals to ensure that their presence does more good than harm. Core values of health care still apply, but may require sophisticated understandings and approaches. All members of the profession have an interest in the outcome. Some are willing and able to see the dangers while others are not. The future of the profession may be at stake. ■■■■

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ASK THE BROKER

How does 'goodwill' affect the value of the practice?

The dictionary says goodwill is:

"An intangible, salable asset arising from the reputation of a business and its relations with its customers, distinct from the value of its stock and other tangible assets."

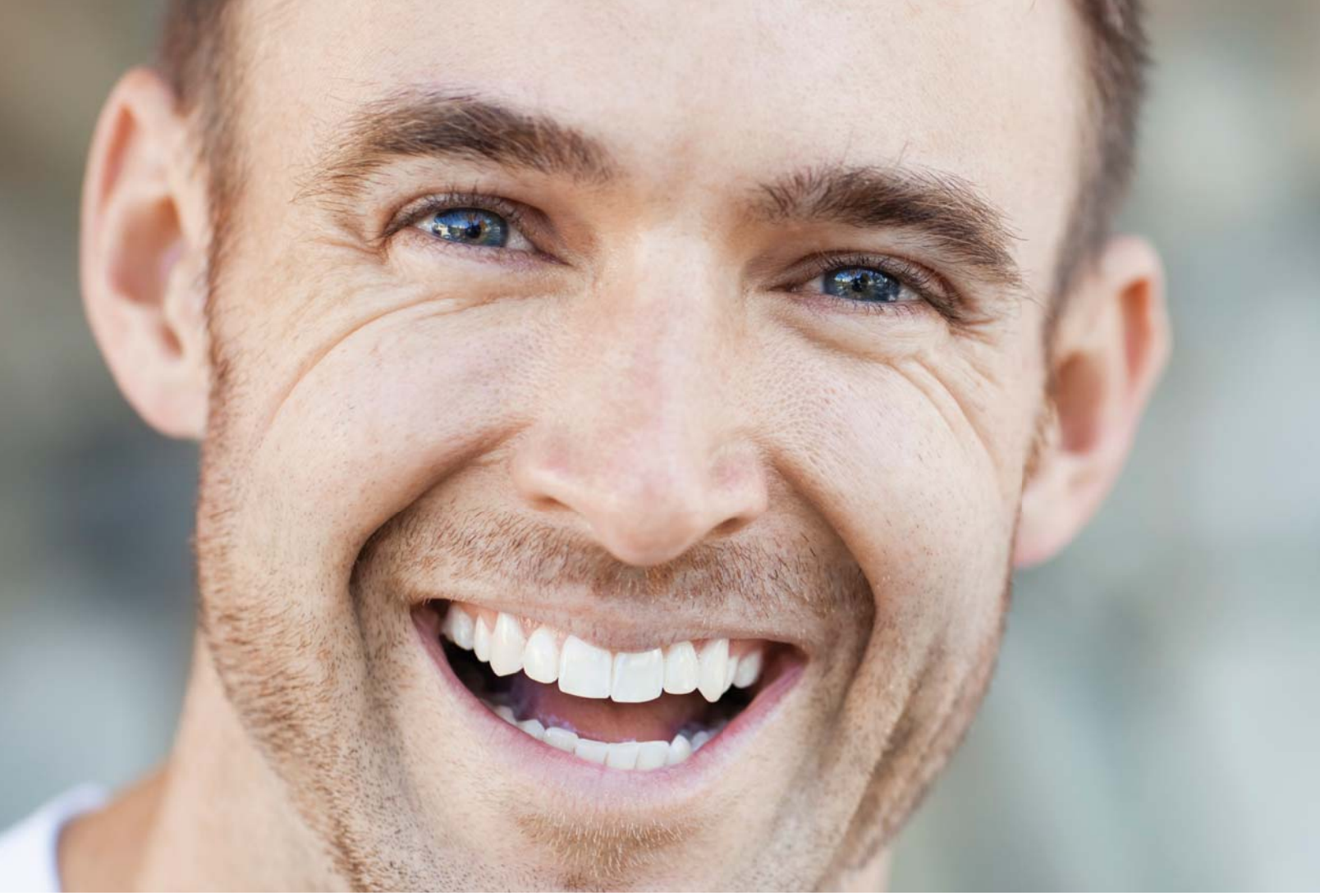
From an accounting standpoint, goodwill in a dental practice is the difference between the value of the hard assets and the price of the practice. Practice transitions generally allocate goodwill around 70-80% of the practice price. The reality is the goodwill may actually be in the 90% range depending on the size of the practice and the equipment. What does this mean to a seller or buyer of a practice?

Tangible goodwill boils down to what puts the patients in the chairs. Putting 'patients in the chairs' may be related to a great web page, marketing efforts, a great location due to foot traffic or terrific demographics. Repeat business from active patients is normally the primary factor that puts patients in the chairs, but it maybe just one component of a developed practice. Many dentists equate goodwill with the length of time the practice has been in business, but I could argue that in some cases after a transition, an older practice based on long-term relationships might suffer more than a newer practice that relies on participation in PPO plans.

The seller has signed a "covenant not to compete" with language that states he will assist with the transfer of the patient base in the practice. Studies have shown that 90-95% of the patients will come back to the office at least one time to try out the new dentist. (they do not want new x-rays!) Keeping the patients in the chairs, or retention of the "goodwill" or patient base then rests on staff relationships and the new doctor establishing trust with the patient.

By definition, many aspects of goodwill are totally intangible. The intangible aspects of how each and every one of us doctors treatment plan and gain patient trust places the burden of determination in the hands of the buyer to assess the intangible aspects of any practice in relation to their own attributes. It is up to each buyer to determine the specific real value of the goodwill on a practice transition to determine if the price of a practice makes sense.

Timothy G. Giroux, DDS is currently the Owner & Broker at **Western Practice Sales (westernpracticesales.com)** and a member of the nationally recognized dental organization, ADS Transitions. You may contact ***Dr Giroux at*: wps@succeed.net or 800.641.4179**



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Care Versus Commerce: A Challenge to Professional Integrity?

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Integrity is never a given, but always a quest that must be renewed and reshaped over time. — William Sullivan

Integrity is an ethical posture that leads an individual to adhere to his or her values. The process that leads to integrity is one of reflecting on and acting in such a way that acknowledges the duty and responsibility of a human being living in a complex society. However, health care professionals have even a more stringent duty than merely following their personal values. The health care provider's pact with society requires that professional values must be followed regardless of personal interests. Professional integrity and a commitment to adhere to the ethical standards of the profession are the foundation of our contract with society and the resulting public trust that dentistry enjoys.[1] Integrity is tested on a consistent basis by the tensions and challenges inherent in the practice of dentistry.

Today, there are many factors that a patient will weigh when seeking and choosing dental care. Fee-for-service, employer-based insurance as well as various public health options are all available to the dental consumer. Massive billboards, shiny flyers in the mail and full-page inserts in local newspapers present options for the dental consumer. The priorities of these consumers will often be confused by a lack of understanding of their dental needs, the vagaries of dealing with complex dental situations and assumptions that dental care can be "shopped" like other goods and services. For the patient with no dental insurance, the need to make critical treatment decisions based upon finances rather than ideal procedures can be the most important factor in consenting to a treatment plan. At the same time, the patient with generous insurance and limitless funds will also have treatment plan options that must be presented in the process of obtaining informed consent. Both of these situations call upon the ethical integrity of the dentist to objectively present treatment options without regard to the potential financial gain to the dentist personally. Absent this ethical integrity, the potential for financial conflicts of interest to enter into the discussion will present itself.

Financial conflicts of interest in medical practice are well described in professional journals and addressed in codes of ethics. Some physicians have generated unfortunate headlines for being on the payroll of drug companies, paid speakers for device makers, referring to

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laboratories they own, being invested in companies that make the drugs they prescribe and similar arrangements where competing interests exist. Some drug manufacturers supposedly even paid doctors to criticize and demean the competitions' products. Dentists have not been free of the taint of such financial relationships. Several recent exposés of commercial dental practices have called into question dentists' motives in their practices and in the doctor-patient relationship. While these newsworthy cases cannot be presumed to reflect the values of an entire profession, they do raise doubt in the minds of dental consumers who may question whether a dentist's recommendation is based upon the patient's best oral health interests or the dentist's financial best interests.

Each day a dentist makes myriad decisions that can influence the type of care patients choose. Is the best restorative choice an amalgam, composite or cast gold restoration? Is it better to fill a space with a fixed bridge or an implant or is it acceptable to simply leave the space? Will a single appointment, CAD/CAM-generated crown work or is a cast crown more appropriate? A part of that decision process is how the patient will pay for or arrange purchase of the dental care. However, the financial considerations in treatment plan selection are the province of the patient, not the dentist. Patients who have more generous insurance coverage may or may not be influenced to make treatment decisions that are different from patients who pay for their care out of pocket. It is not safe to routinely presume that the wealthier patient will opt for the more expensive treatment plan. Similarly, the working poor patient who places a high value on oral health may very well make the financial arrangements needed to complete the treatment plan of first choice. Many dentists will report dentistry is the easy part of practice and that the business aspects provide the greater challenge and one that they did not receive adequate training for in dental school.

Of course, when faced with the presentation of several treatment plan options that range from expensive to relatively low cost, the simple answer is also easy — the care of the patient comes first and the ideal treatment plan is the one that best serves the ethical goal of beneficence. In the first section of the American Dental Association Principles of Ethics and Code of Professional Conduct, the concept of honoring the patient's "needs, desires and abilities" is addressed and dentists are cautioned that the patient must be involved in a "meaningful way."[2] This clearly honors the ethical principle of respect for autonomy. Patient autonomy is an ethical principle that gives the patient very broad discretion in determining what treatments will and will not be done. What is not so easy is the balancing of the business side of dentistry with the professional responsibility to place the needs and autonomy of the patient uppermost. The tension between care and commerce exists and must be acknowledged and dealt with by the dental practitioner. Indeed, in both dentistry and medicine, this tension is increased when the doctor is practicing in a fee-for-service system versus a capitated payment system. Does this challenge the professional integrity of the dentist? Does this challenge the doctor-patient relationship?

THE TENSION BETWEEN care and commerce exists and must be acknowledged and dealt with by the dental practitioner.

The apparent answer to those questions is, probably not. Dentistry as a profession enjoys an enviable level of trust from the public. Patients trust the dentist and dental team to recommend and deliver the best quality treatment. When multiple treatment options are presented to the dental patient, many will ask the dentist, "What would you do if it were your tooth?" or some variation of that hypothetical question. This level of trust is admirable, very impressive and worth protecting. The doctor-patient relationship is special because of the professional knowledge and skill of the doctor. This also is why doctors are afforded a privileged position in society. In dental schools, we spend a good deal of time instilling the foundations and standards of the profession with the developing dentist-learners. We also devote time and energy teaching about ethical reflection and decision-making and the need for the practitioner to be able to manage the conflicts inherent in dentistry as a business and a healing service. The goal of this curricular time is to instill how the future dentist will balance the benefits versus the burdens of a dental professional person. This tension and balancing is introduced in dental school where patient experiences are the commodity for the student as he or she gains competency. There is an inherent conflict between the dental student's need to meet requirements and demonstrate competencies and the patient's ideal treatment options. For the student who needs one more cast crown

to graduate, the patient who needs a large amalgam restoration replaced may very well look like the ideal crown candidate, even though some other, less expensive treatment option might better meet the patient's goals. This tension certainly does not decrease when that student graduates with a large student loan debt burden and begins a practice that must generate large overhead costs before a profit is shown.

Peltier and Giusti in 2008 examined the essential elements of conflict between doctors and patients by comparing selling and caring.[3] Their premise was not limited to dentists but generalized to all doctors and characterized as an "irreconcilable tension." Beginning with the basic measurement of commerce, they described the primary outcome of commerce as monetary profit and the customer as the means by which the profit goal is attained. Whereas for the dentist, the care of the patient is a fiduciary relationship and the money earned is a derivative of the interaction. The dentist is not expected to be unaware of the profits generated in his/her practice; however, he/she is ethically required to not let a profit motive drive treatment plans. Indeed, the tension of commerce is present whether one practices in a fee-for-service system, where more profit is generated for performing more treatment, or a managed care system, where the doctor's pay is greater if fewer services are delivered. Either system connects personal remuneration with procedures delivered. Thus, in practice, this ethical requirement is no different than it is for the dental student described above, who needs just one more crown to move on. While the care versus commerce tension will always be present, we believe that it is better described as unavoidable rather than an "irreconcilable tension." Dentists and physicians reconcile it every day by relying upon their professional ethics and integrity.

Nonetheless, competition and a market-driven economy is the mainstay of American business and are considered to be healthy, functioning aspects of our daily business decisions. Doctors tend not to think in terms of competition. Rather, the culture among professional health care providers is one of cooperation. Assisting each other with advice and counsel is commonplace and collegial and helping each other with difficult cases is a normal part of the landscape. This is all done with the goal of ideal patient care in mind.

AT THE END OF THE DAY, the practice model cannot change the individual dentist's ethical obligations and integrity.

Generally, this professional camaraderie is beneficial for patients and dentists, as patients receive the best possible care and dentists enjoy robust and rewarding practices. In this model, patients benefit from improved health outcomes and the community benefits when financially successful dental practices continue to be available to provide care — a healthy interdependence. Successful practices honor the ethical principle of justice in that they provide access to care for people within the community. The commercially unsuccessful dental practice will cease to exist and that could result in a substantial disadvantage for a community. Presuming the practice employs others, there would be further harms if the practice were not economically viable.

One final note should be mentioned regarding the care versus commerce dilemma in dental practice. Whereas, in the not too distant past, almost all dental care was delivered via the private practice, solo doctor model, new delivery models and large, commercial practices are becoming more common. While the advertising and promotion that go with some of these new models can appear, to the general public at least, to have moved the dental profession into more of a commercial endeavor, it would be incorrect to presume this is always or even generally the case. Large, conglomerate dental practices have certainly changed the options for dentists entering practice and patients seeking care. However, at the end of the day, the practice model cannot change the individual dentist's ethical obligations and integrity. It is in each individual doctor-patient interaction that those ethical obligations are lived. Dentists who maintain this ethical compass will manage the care versus commerce tension regardless of the type of practice they enter.

Thus, the dentist's ethical obligations to respect patient autonomy and strive to benefit patients and minimize harms need not conflict with the commercial interests of the practice. While a potential moral tension will always exist in any system where a service is provided for money, the ethical provider knows how to place the patient's interests first and adhere to the basic ethical principles of the profession. Moreover, in a self-policing profession, such as dentistry, providers enjoy the continual oversight and wisdom of colleagues. While it will always be possible that a few members of a profession will place commercial interests above ethical duties, ethics awareness education and professional codes of ethics help to establish and maintain acceptable standards.

Upton Sinclair once wrote, "it is difficult to get a man to understand something when his salary depends on his not understanding it." Understanding this tension is important and part of what a dentist must do on a daily basis. It does demand self-awareness and discipline — a skill that is practiced along with the knowledge and technical side of dentistry. The bottom line is that the professional person has the responsibility and the duty to safeguard his/her professional integrity assuring that the patients' care always comes before the commerce. ■■■■

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Our Next Generation: Dental Student Ethics and its Potential Influence on the Profession

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The most important human endeavor is striving for morality in actions. Our inner balance and even our very existence depend on it. Only morality in our actions can give beauty and dignity in life. — Albert Einstein

In virtually any gathering of practicing dentists, you are likely to hear about the perceived failures of ethics in the profession. Often it faults the most recent generations of dentists. "They've lost their moral compass." "Look at all the cheating that occurs in dental schools." "They don't have the same commitment to professionalism that has existed in the past." "It's advertising, competition and commercialism that are ruining our profession." So it's said.

In other conversations among our peers, you might hear thoughts about how corporate dentistry is a plague destined to crowd out the solo practitioner and the small, dentist-owned practices. You might hear how the trend to train "mid-level" care providers will further impact what has historically been called "private practice." You also might hear how so-called cosmetic dentistry is being promoted for financial gain and is questionably applied for the benefit of the dentist rather than in the patients' best interests. Again, much of the concern about perceived ethical shortcomings and the accusations are directed to a generation other than the speaker's own. It is always "they" who are creating the problems.

Those concerns and others, coupled with a study reported in the August 2007 issue of the *Journal of Dental Education* by Andrews et al., in which 1,153 dental students were surveyed regarding academic integrity, showed that 74.7 percent of students admitted to some level of cheating. This report, and accounts of students forging faculty signatures, performing unnecessary procedures in order to complete requirements, and of institutions taking monetary contributions to accept students into specialty programs, among other issues, was reported in *White Paper on Ethics and Professionalism in Dental Education*[1] by the American Students Dental Association (ASDA), which stated that "immediate action must be taken." The students were concerned about the same problems and the same issues that their seniors in the profession lament.

The intention of this article is to share with you how today's students, faced with a rapidly changing environment

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FIGURE 1. The founding students and mentor of the Student Professionalism and Ethics Club. Back row: Sunjay Lad, Alvin Rosenblum, Michael Meru, Serge Lokot, Bryan Stimmler. Front row: Ray Klein, Alon Dori, Nicola Malik, Vicki Nguyen, Tracy D'Antonio, Nathan Coughlin. Not pictured: Dawn Jarocki, Anahita Taraporewalla, Joseph Field, Willie Waite.

that impacts the behavior of many in the profession, are responding to the perceived problems in the profession and to the ASDA *White Paper's* call for "immediate action." This article will illustrate how young people in our profession are working to learn about, and help teach, the discipline of ethics and ethical decision-making so that all in dentistry are on the same page and speaking the same language regarding professionalism. Dental students recognize that it is not only their peers but also the more established dentists who have demonstrated their share of violations of the tenets of ethics.

So, whatever our thinking is about the issues, is it the "ethics," the lack of moral character of more individuals in our profession that creates what we perceive as unprofessional behavior? Or, is it perhaps primarily systems and circumstances that create trends that affect individuals who are in fact just like us, basically good people? And, do those trends and circumstances, and the perceived decline in ethics, affect all segments of our profession, and not disproportionately the later generations as some argue?

I believe that most of the people who become dentists are essentially good people. Are there some bad actors? Of course, there always have been. In the opinion of the author, those who enter dental school today are, in character, very much the same as those who entered all during the second half of the 20th century. In my class in the early 1960s, we had a few who were not trustworthy, and just as few who were impeccable with regard to their behavior. For the most part, we were young adults who abided by most, and I emphasize most, of the rules. I believe it is the same today.

The circumstances today, however, are profoundly different. And, it is to a great extent a reaction to those changing circumstances that have contributed to an apparent increase in the frequency of ethics failing in our profession. Dentists with experience and those new to the profession today are facing changes that are in some cases unique and in other cases the result of existent problems that are becoming more profound. The economy of dentistry has changed dramatically. There is an increasing need for capital in practices because of extremely expensive technology and the increased complexity of running a business. There has been a relatively rapid increase in the sale prices of dental practices. Student debt[2] and a dearth of employment opportunities impact many new graduates. Those conditions, along with numerous other elements, are driving the profession in new directions.

Dental students graduating over these past few years have been aware of the challenges facing the profession and some have made a commitment to address those difficulties, perhaps in new ways. The following is a brief history of a dental student-driven movement across the country that bodes well for our profession's future and the ability of our profession to adapt to changing times without sacrificing our values and our principles.

The History of Student Professionalism and Ethics Association (SPEA)[3]

In March 2009, a small group of students at the Ostrow School of Dentistry of the University of Southern California approached the author to discuss those ethics issues that were occurring in the profession and in their school environment. Issues like those mentioned in the introduction of this article (**FIGURE 1**). The students were looking for a way to become more proactive in promoting ethics not only in their school setting but also in the profession in general.

Those few students were advised to invite like-minded students to participate in a series of brainstorming sessions during which it was suggested that they start an ethics club. Because those students were being educated in a problem-based learning (PBL) environment, they were encouraged to develop their organization based on PBL principles, namely having it be student initiated, student centered and that they be committed to their long-term independence and lifelong learning about ethics. They started the club and called it the Student Professionalism and Ethics Club or SPEC.

The students met and developed a mission statement in which the stated

purpose of the organization was to increase the overall level of ethics and professionalism at the Ostrow School of Dentistry. The intent was to unite the community of students, faculty and staff in order to promote lifelong thought and action in dental ethics. Their aim was to foster an environment where ethics and professional behavioral issues could be addressed in an open, unbiased forum and further the ethics education of every student in a way that would support and guide students throughout their professional careers.

The students were eager to learn about the discipline of ethics and about ethical decision-making. They decided to hold monthly gatherings to discuss the field of ethics as it relates to dentistry, asking questions and sharing ideas. They invited notable guests, knowledgeable in the discipline of ethics, to speak to and interact with the SPEC students. At their first monthly meeting, there were about 100 attendees.

As time passed and more of the students became knowledgeable in the discipline of ethics and they developed a better understanding of professionalism, they participated in the ethics orientation of each subsequent entering class, providing early exposure to this vital subject for the new students. By 2008, the fledgling organization had gained recognition from the American Society for Dental Ethics[4], the American College of Dentists[5] and the American Dental Association.

In 2009, ASDA passed a resolution and the ADA offered support through its Committee on Ethics, Bylaws and Judicial Affairs and its Joint Subcommittee on Ethics in Education. The students at USC had detailed their developmental process and created a "startup kit" for use by other dental schools and institutions in order for them to begin what was then being called SPEC Chapters. In the December 2009 edition of the *ADA News*, a report told of dental students who had been, and were becoming more of a "driving force" behind a resurgence in ethics and professionalism. That resurgence continues to this day.[6]

National Organizational Development

How did SPEC students come to the conclusion that ethics is a student concern? When asked that question Michael Meru, DDS, a founding member of the Alpha Chapter when he was a student at Ostrow, offered the following:

> "I think the answer to this is twofold. First, upon entering dental school I don't think the founding students completely understood the fine line that we as dentists walk between being health care providers and business people. And as graduation grew closer, there was a desire to have more specific guidance and a forum where our questions and concerns could be addressed because we knew that after graduation we would be faced with decisions where ethics and patient care would come into play. Second, we saw actual ethical breaches happening in dental schools across the country, as well as in our own dental school, and we wanted to do whatever we could to stop these issues."

SPEC at Ostrow formed a national committee, composed of nine students from Indiana University, Midwestern University, University of the Pacific, University of California, Los Angeles, University of Southern California, and Virginia Commonwealth University, who were tasked with paving the way for SPEC to become a national organization. This committee met in 2010 and had several specific goals. They committed to draft a constitution and bylaws for the organization, to brainstorm the leadership structure at the national, regional and local levels, to begin formulating a strategic plan for the organization, to plan the 2011 inaugural annual session in Las Vegas and to identify the best ways to get involvement from as many dental students as possible. Those goals were discussed, modified and ratified by the attendees at the inaugural annual session. After which time, elections took

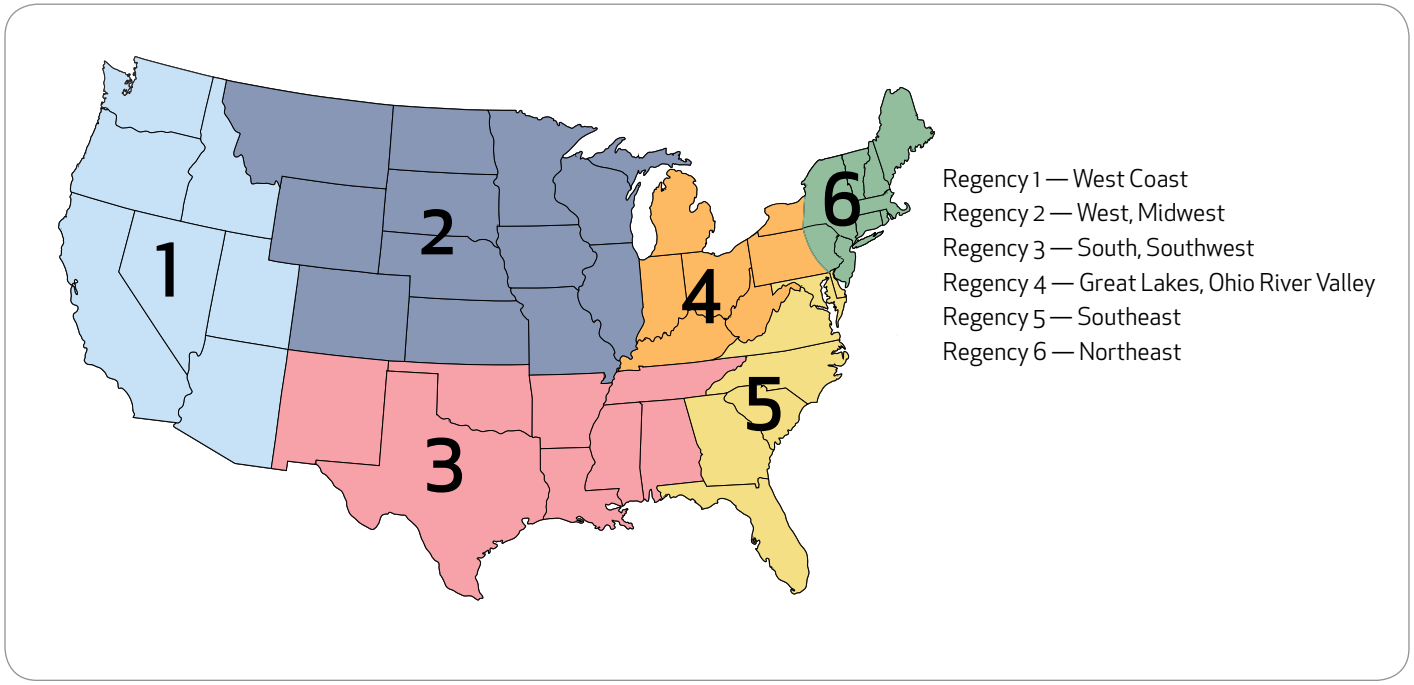

FIGURE 2. Student Professionalism and Ethics Association membership regencies.

place and the leadership ranks were filled with students from around the country.

So in 2011, what was SPEC became SPEA, the Student Professionalism and Ethics Association[7], with chapters in more than half of the U.S. dental schools. This still-growing organization held its second annual national meeting in conjunction with the annual meetings of both the ADA and the American College of Dentists in San Francisco in October 2012. At the convocation of the American College of Dentists, SPEA received the prestigious Ethics and Professionalism Award. What began as a small group of concerned students who were interested in informing their peers about ethics has grown into a recognized national movement that is likely to impact the entire profession.[2]

The students have created a structure modeled after the American College of Dentists. They have grouped the states into six geographic regions based upon the location of the dental schools within the states. Each regency (**FIGURE 2**) has representation in the national leadership and contributes representatives to the national meetings. In the short time since its inception, SPEA has become a national leader in ethics in U.S. dental schools and is making inroads in Canada and Latin America.

SPEA Activities

The SPEA groups at the individual dental schools are discussing and debating the many issues that they see as having ethics components. Their issues parallel those faced by practicing dentists such as health care reform, barriers to care and the development of mid-level providers. As are their elders in the profession, they too are concerned about the use of live patients in licensing exams, inappropriate use of social media and increased commercialization of the profession.

Their concerns that are unique to the dental school setting include interest rates of student loans, high debt incurred during dental school, patient-specific issues such as trading patients, violations of appropriate record protocol and the numbers-based curriculum rather than one based on competency. There is of course concern about any form of cheating or plagiarism. They are also concerned about by what criteria specialty programs will be selecting candidates now that the National Board Examination is assessed on a pass/fail basis.

Each SPEA chapter is different and is allowed to hold activities as it sees fit. Most have regular meetings with presentations by both students and faculty on issues the school is facing. SPEA students are studying the discipline of ethics and are inviting guest speakers to address topics in the context of that discipline. They have had guests from most of the major organizations within dentistry, ethicists, authors, psychologists and practicing dentists and have convened panels to explore varying points of view.

SPEA as a national entity is planning a charitable event to support veterans of military service. That first event will most likely be held summer 2014.

It seems that the pressures felt by both dental students and dentists alike have increased over time. It also seems

that the changing circumstances have a different effect on different segments of our profession. Challenges in our present economy, and the increasing competitiveness and commercialization of dentistry along with ever increasing cost of education and practice startup are contributory to choices about where and how to practice. Over the last decade, rising student debt has had an impact on some young dentists' selection of a practice model. That, along with infusions of venture capital, seems to be fueling the growth of corporate practices.

An unpublished survey of students[8] indicates that they overwhelmingly prefer the private practice model. They rate private practice, military and public health practices highest in 10 categories ranging from ability to provide quality care to providing the most professional satisfaction. In the same survey, corporate practice rated highest only in availability of employment opportunities following graduation from dental school.

Advances in dental education have been many, well meaning and constructive. Nevertheless, there have been historical impediments to accepting the teaching of applied ethics. Many dental school programs that are labeled as "ethics" are little more than case "show-and-tell" by dentists untrained in the discipline of ethics. In many cases, the courses are little more than "risk management" with elements of law. Most ethics teaching in dental schools is by faculty who have other major obligations. Ethics is relegated to catch-as-catch-can by well-meaning teachers who have other primary responsibilities or by part-time faculty with inadequate support.

There has been a serious effort known as the Professional Ethics Initiative, or PEI, led by the American College of Dentists and the American Society for Dental Ethics to create a variety of ethics education programs. The hope is that these programs will improve the quality of ethics educators and ultimately, the effectiveness of ethics courses in our dental schools.

It seems clear that in order to relieve the angst evident within the profession, we must improve the ability of individuals to cope with the pressures and demands that can potentially lead them to violate their own values and the values of the profession. SPEA, a growing movement among students of dentistry, with the support of their elder colleagues, seems poised to take on the challenge of maintaining professionalism while adjusting to whatever challenges face our profession. ■■■■

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CDA Judicial Council: Blending Idealism and Practicality

ROBERT D. KIGER, DDS

ABSTRACT The California Dental Association Judicial Council has the responsibility for interpreting and enforcing the Code of Ethics, for disciplining members and for fostering a climate of education and ethics awareness for CDA members. The Council recognizes the inherent difficulty in rigid enforcement of the Code of Ethics, and chooses to take an approach that educates and encourages members to embrace the highest standards of our profession as outlined in the Code.

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The California Dental Association (CDA) Judicial Council acts on behalf of CDA in the areas of ethics and member discipline. It is one of the many CDA committees and councils that work diligently behind the scenes to carry out the business of CDA. The Judicial Council consists of 11 volunteer members serving three-year terms with members eligible for a maximum of two consecutive terms. If you ask the average CDA member what the Judicial Council does, you would probably find that most would suggest that the Council is responsible for maintaining and updating the Code of Ethics and for reviewing violations of the Code of Ethics to determine if disciplinary action is necessary. While this is essentially true, the Judicial Council also carries out a number of other activities throughout the year that may not be as obvious.

The CDA Judicial Council serves as a support and referral service for our local component ethics committees. Most complaints about possible ethics violations are dealt with at the local component level and generally managed successfully by the component ethics committee. However, there are instances in which issues might not be settled at that level; those cases may then be referred to the Judicial Council. In addition, local ethics committee chairs may be confronted with situations where the necessary action may not be obvious; the Judicial Council may be asked to provide an opinion or to lend advice about how to proceed in handling the given situation. Many of the members of the Judicial Council have had previous experience serving as component ethics chairs, so the working relationship between the local component and the Council is comfortable and efficient.

If we look at the CDA Bylaws, some additional perspective can be gained about the role and function of the Judicial Council. The role of the Council is stated as follows:

- To consider proposals for amending the CDA Code of Ethics and related matters.
- To provide advisory opinions regarding the interpretation of the ADA Principles of Ethics and the CDA Code of Ethics.
- To consider appeals from members.
- To exercise the power of this Association to discipline members, either upon its own initiative or upon the request of any component society. Decisions of the Council shall be final unless a right of appeal is provided in the Constitution and Bylaws of the American Dental Association.
- To act on the recommendations of the Membership Application Review Subcommittee.

Essentially, the Judicial Council deals with complaints that are referred from individual component ethics committees and acts as a final arbiter in determining whether or not ethics violations are serious enough to warrant terminating a dentist as a member of the California Dental Association. The Judicial Council understands the need to help define the professional standards of ethical behavior. It plays an important role in disciplining those members who choose to violate our ethical standards. However, anyone who has served on a component ethics committee or on the Judicial Council soon understands how difficult it is to force people to be ethical. We also have to understand that our sense of what constitutes ethical or unethical behavior also changes with time and with the values of our society as a whole. Challenges that faced us 30 years ago may no longer be relevant.

Many of the issues that we deal with currently were not even anticipated five years ago. As an example, the issue of what constitutes ethical advertising has changed dramatically in recent years. There was a time when Yellow Page advertisements were discouraged as being inappropriate for the professional. Now it would seem that almost all dentists have accepted the need to be listed in the Yellow Pages. Print media is almost becoming irrelevant with the advent of social media interactions and the development of web pages and online advertising services. The questions that are raised today about what types of advertisements are acceptable are totally different from those raised five or 10 years ago.

MANY OF THE ISSUES that we deal with currently were not even anticipated five years ago.

Historical Perspectives

If we look back in time, we can see that various events have influenced how the Judicial Council carries out its functions today. I entered the profession of dentistry as a CDA member in 1973, a time when many felt that the Code of Ethics could be used to compel members to act in a manner that was consistent with their image of the profession. "Enforcement" of the Code was expected as a means of ensuring that member dentists followed the letter and intent of the Code. Strict adherence to guidelines regarding the type of advertisement allowed in the Yellow Pages, the size of lettering on an office door and the type of information that could be included on a business card was common. I can remember setting up a practice a number of years ago and asking my local component exactly what types of things I could and could not do, with the understanding that I needed to conform to the guidelines established in the Code if I wanted to be accepted by my colleagues. That type of attitude, common 30 years ago, has been replaced with new graduates asking how they can most effectively market themselves either in the printed or electronic media to ensure that they can compete for their share of the consumer dollar. The desire for new graduates to conform with their peers and be accepted as colleagues has largely been replaced by a need for new graduates to find a competitive edge to compete with their peers for their share of the patient pool.

Certainly the economic realities of private practice today have influenced this need to be more competitive. With increasing urgency, we realize that while dentistry is still a profession, it is also a business. In our current economic climate, the need for new graduates with considerable student debt to find practice opportunities, coupled with the additional costs added to the practice of dentistry by OSHA guidelines, mercury disposal regulations and clean water requirements, results in an even more urgent need to operate a dental practice with a focus on economic realities. The Federal Trade Commission in recent years has adopted the position that the profession of dentistry needs to be regulated as a business, rather than being regarded solely as a profession. If CDA, through the actions of the Judicial Council, attempts to dictate

the content of print or electronic media advertisements, we can be seen as interfering with the right to free speech. If a professional organization such as CDA attempts to limit advertisement of its members' professional services, it could be considered to be in violation of business practices that allow the consumer opportunity to choose and select their providers. If member dentists attempt to band together to influence reimbursement services for insurance companies, they can be viewed as violating anticompetition or antitrust statutes. More than ever before, the Judicial Council's decisions regarding enforcement of the Code of Ethics must be made with an understanding of the limitations imposed on organized dentistry that are the result of legal battles that have been fought and resolved in recent years. Therefore, CDA and the Judicial Council must now deal with the reality that dentistry is both a business and a profession. While our members might like to see more regulation of the profession of dentistry, and enforcement of its Code of Conduct and Ethics, they must also understand that the business of dentistry is going to be conducted in a manner that includes advertising, competition, self-promotion and other aggressive marketplace practices. It has now become necessary to find a middle ground between enforcing a code of conduct defining professional behavior and allowing for freedom of speech and action in the marketplace.

Many of the issues that develop currently, and many of the complaints that are referred to the Judicial Council for resolution, arise out of the inherent conflict that develops when our members engage in practices that are designed to promote their businesses. In a more authoritarian time, the component ethics committees and/or Judicial Council may have had the opportunity to be more direct and forceful in regulating the activities of member dentists. The possibility that a dentist could lose his/her membership in a dispute over some of these practices may have been a significant deterrent. Ideally, because the Judicial Council is the CDA entity that interprets the Code of Ethics, it should also be able to determine what type of activity and behavior is ethical or unethical. It should be able to hold the membership to the high standard of ethical conduct expected of all dentists. If this were the case, the Judicial Council and component ethics committees would be able to exert leverage, as needed, to ensure that any member engaging in unethical conduct received a clear and urgent message that he or she should either comply with the expected ethical standard or risk loss of membership with its inherent privileges. However, this more coercive model fails us on two counts. First of all, there are very few activities that a dentist might engage in that are subject to discipline. Blatantly false and misleading advertising is a violation of the Code of Ethics and of the Dental Practice Act, and therefore is one area that can be readily monitored. However, even arguments about what is "false" or "misleading" might be subject to interpretation in a court of law. Overbilling or overselling of dental care is even more difficult to monitor because regulation of that would involve infringement on the right of an individual dentist and his/her patient to come to agreement on fees and services. Secondly, the goal of the Judicial Council in enforcing ethical activity is to encourage the dentist to continue as a member of CDA, not to threaten him/her with loss of membership and privileges. Enforcing ethical standards that ultimately result in dentists relinquishing membership rather than embracing compliance will never serve our Association's best interests. So in recent years, the Judicial Council has become more sensitive to the need to be supportive and practical in its approach to enforcement, rather than being idealistic and rigid.

CDA AND THE
Judicial Council must now deal with the reality that dentistry is both a business and a profession.

Finding a Balance

So how does the Judicial Council balance this tension between idealism and practicality? My recent experience on the Council suggests that we have gradually moved toward an enforcement model that encourages members to embrace the ideals and standards of the profession rather than to fear discipline. For example, if a complaint is received about a print advertisement that appears to push the limits of good taste or truthfulness, the member is counseled to correct the ad and advised as to what part of the ad is deemed objectionable. If a complaint is received about a dentist who is making disparaging remarks about a colleague, the member is approached to see if the comments can be stopped and the dispute resolved rather than threatening more severe disciplinary action. If it appears that gift

cards are being used to reward patients for referring friends into the practice, the member dentist is advised that such a practice is a violation of the Code of Ethics and Dental Practice Act, and he/she would be encouraged to seek other ways of thanking patients for their referrals. To summarize, the actions of the local component ethics committees and the Judicial Council are now geared more to education of the membership to outline appropriate ethical behavior, rather than attempting to enforce or coerce acceptable ethical conduct. The fundamental approach to ethical activity is to assume that the member dentist wants to comply with the profession's ethical standards; that given the opportunity to be ethical or unethical, he/she would choose to be compliant and maintain the high standards of the profession as opposed to engaging in practices that push the boundaries of acceptable conduct and thereby diminish the image of the profession. Disciplinary action would not be needed or suggested in general, but would be reserved for those situations where a member is given the opportunity to comply, and foregoes the opportunity to be compliant, choosing instead to continue the unethical behavior.

Examples of Current Activity

You may still be wondering in what type of activity does the Judicial Council actively engage. Perhaps a brief outline of the types of issues that come before the Council and an explanation of how those issues are resolved might be helpful. On a regular basis, the Judicial Council will review the Code of Ethics to ensure that the Code maintains its relevance in a changing practice environment. Most of the principles fundamental to the Code remain unchanged and continue to be useful. However, how those principles are interpreted or applied may change from time to time. As an example, the Council recently recommended inclusion of some additional advisory opinions to the Code of Ethics to aid in resolving questions about patients' right to choose their dentist when practice associates separate, about billing issues when work is billed but not completed and about the use of social media for advertising purposes. An addition to the ADA Principles of Ethics regarding fee splitting was also reviewed, and similar language recommended for the CDA Code of Ethics. As other questions arise and are referred to the Council for review, the Code is continually reviewed for ongoing relevance and for the need for modification.

WE ARE UNDER NO obligation to accept into membership a dentist who has participated in unethical activity either previously or in another jurisdiction.

Another example of Council activity is ongoing review of disciplinary actions taken by the State Board of Dental Examiners. In situations where a member dentist may be convicted of a felony, action may be taken by the Board to place that member on probation. Those actions are forwarded by the Board to the Council for review, and by action of the Council's Investigative Panel, a member may be placed on probation with CDA so that our action is consistent with the Board's action. Conviction for any felony is a violation of the Code of Ethics statement that it is unethical for a dentist to violate any law of the State of California. Violations of the Dental Practice Act or conviction of a crime are therefore interpreted as unethical conduct unbefitting a member of the dental profession. Such violations will be the basis for disciplinary action ranging from probation to loss of membership.

The Council also reviews applications for membership in CDA when dentists who have been disciplined in another state or disciplined in California apply for CDA membership. This review occurs through the activity of the Council's Membership Application Review Subcommittee (MARS). The primary concern is to ensure that a dentist applying for membership is not currently under sanction by another state organization, or that if disciplined in California, to ensure that all the conditions of the previous disciplinary action have been met. This is simply a process to ensure that applicants to our professional organization meet high standards of ethical conduct before they are admitted to the Association. We are under no obligation to accept into membership a dentist who has participated in unethical activity either previously or in another jurisdiction. On average, MARS may review 10-15 cases of this nature per year.

Disciplinary actions may be taken against a member dentist for significant ethical violations. The most common issue resulting in loss of membership is the failure of a dentist to accept the recommendations of a component Peer Review Committee. Failure to comply with recommendations of a Peer Review Committee constitutes a violation of

the section of the CDA Code that says that a member dentist has the obligation to comply with the requests of duly constituted committees, councils or other bodies of the component or CDA. Failure to comply with Peer Review Committee decisions places a member dentist in conflict with the standards of the profession and is also judged to be unethical.

When disciplinary actions are carried out, due process must be respected. Any member facing discipline is offered a chance to appeal that action by appearing before the Judicial Council's Hearing Panel. The opportunity to appear before the Hearing Panel and appeal actions and decisions of the Judicial Council ensures that fairness and oversight are part of the disciplinary process. Scheduling of Hearing Panels and identifying volunteer members to serve on the Hearing Panels are additional activities carried out by the Judicial Council.

Finally, the Judicial Council recognizes the need for ongoing education of member dentists with respect to ethical issues. Our basic assumption is that members who value their membership in CDA and who want to participate in the benefits of membership will take advantage of opportunities to become better informed about current ethical issues and concerns. The Judicial Council conducts a workshop for component ethics chairs and executive directors every two years, using a case-study format to work through examples of typical complaints. In addition, legal counsel is available at these sessions to discuss questions and concerns of ethics chairs in an attempt to bring everyone up to date on the current legal concerns that may influence the counsel that we provide to member dentists at the local level. Recognizing the need for ongoing education, the Judicial Council has also established a subcommittee on ethics in dentistry. This subcommittee is active in developing a list of potential authors and speakers who will be available to provide continuing education courses, presentations at local component meetings and who will author brief articles on ethics as needed for inclusion in component society newsletters. The subcommittee is also working in collaboration with *CDA Presents* to develop an upcoming ethics course for the 2013 *CDA Presents* in San Francisco. Additional information on ethics will also be prepared and communicated through the CDA Compass. Print resources and case studies available from other organizations, such as the American College of Dentists, will be collated and cross-referenced on the Compass website, cdacompass.com. Thus, the Judicial Council continues to meet its commitment to education and communication of ethics throughout CDA in multiple ways.

THE MOST COMMON ISSUE resulting in loss of membership is the failure of a dentist to accept the recommendations of a component Peer Review Committee.

Summary

The CDA Judicial Council is active and highly engaged in ethics education, interpretation of the Code of Ethics, resolution of member concerns and disputes, and effective communication with membership. We recognize that as a result of limitations placed upon us by FTC regulations, recent legal decisions, our current social climate and legal challenges to our ethical code by members of our profession, interpretation and enforcement of ethical standards has become increasingly difficult. Our response as a Council has been to renew our commitment to providing the best possible advisory opinions regarding ethical issues, to be as instructive as possible in educating component officers and membership as to how to meet the ethical challenges of the day and to create an atmosphere conducive to mediation and support for members attempting to find answers to their concerns.

The Judicial Council is motivated by a sincere desire to maintain and promote for CDA and its members the highest standards in the area of professional ethics. All professionals must meet the challenge to maintain their standards and integrity in the world in which we live. Your Judicial Council is committed to the task of assisting CDA membership in maintaining the ethical principles embodied in the CDA Code of Ethics. However, the only way this goal can be achieved is for each individual member dentist to recognize the need to incorporate integrity, service and empathy into every aspect of his/her daily activities. The Judicial Council attempts to serve as a guide and a resource for those CDA members who value ethical standards and who desire to see those standards reflected in their day-to-day activities.

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Road Signs on the Road of Life

Student Professionalism and Ethics Presentation, University of the Pacific, Arthur A. Dugoni School of Dentistry in San Francisco

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Editor's Note

Earlier this year I had the opportunity to attend a study club featuring Dean Emeritus Arthur A. Dugoni, DDS, MSD. His presentation that evening brought back memories from more than 34 years ago when, on my first day in dental school, I sat waiting for the "Welcome to UOP" address from the recently appointed dean, the very same Dr. Dugoni. My dèjá vu was the message, which is based on the lecture he gives to first-year students at the Arthur A. Dugoni School of Dentistry. While the words may have been different, the message was the same: professionalism, integrity, stewardship. This has guided my professional and volunteer career for more than 30 years.

Put yourself back at your first day of dental school, full of expectation mixed with apprehension. The following is an edited transcript of Dr. Dugoni's comments, which still resonate, maybe even louder, today.

Welcome doctors to a profession!

Please realize, however, your life will never be the same. You are committing yourself to service above self — and committing yourself to caring for others. Here, "we build people, and along the way they become doctors." We strive to *build* people who have integrity; who have the commitment, character and dedication to the values that are essential as a doctor. As you go through dental school, one of these important building blocks is to develop a passion for *integrity*. Integrity is one of the greatest of virtues.

Well over 100 years ago, a few super professionals, with dreams, ambition, ideals and aspirations of making dentistry a noble and learned profession, organized and developed our ethical standards — our code of conduct — now our heritage — and molded a profession from a trade. You are aware of the *ADA Principles of Ethics and Code of Professional Conduct* and the Hippocratic Oath of Medicine and Dentistry. However, our forefathers recognized human frailty and morality. They would have agreed with Mahatma Gandhi on those things that will weaken or destroy us as individuals or as a profession:

"Politics without principles, wealth without work, pleasure without conscience, knowledge without character, business without morality, science without humanity."

We in dentistry today inherit positions of respect, given to us by individuals who achieved that respect by

adhering to principles, by going the extra mile, by giving of their time, talent and treasury, to create a profession.

They looked upon their fellow dentists as colleagues and not competitors. They believed we were a profession, not a trade. They believed we were providers of service, not commodities. They believed we have a commitment to serve mankind. That is how we got where we are; but the challenge we face is to *keep us here.*

In the past, professional people were considered to be very special. Parents would say, with pride, *"My son, the doctor," "my daughter, the lawyer,"* etc. Professions were referred to as "callings." These callings were the conscience of America, dedicated to noble things, moral things and helpful, idealistic and unselfish causes generated for the benefit of humanity. This commitment earned dentists and dentistry the stature of a learned profession (from a trade to a profession — it took us more than 50 years!).

We are called "doctor" and are filled with pride when we hear our names called as doctor, or when that patient says to us, *"Thank you, doctor, thank you for stopping my pain," "thank you for my smile,"* etc. What does the calling to be a doctor imply?

In my mind, it implies fairness, integrity, honesty, service above self or self interest, respect for the human dignity of everyone, a passion for quality and a commitment to excellence.

Albert Einstein reminds us to "try not to become a success but rather to try to become a man of value."

Character comes from the Greek words "to mark or engrave." Are adults doing enough to engrave ethical values in young people? Do our leaders set the example? Our parents? A Harvard University study of confidence in leadership found that almost two-thirds of Americans think we are suffering from a leadership crisis.

The Harvard study's respondents showed little confidence in the honesty, integrity and ethics of leaders in sections ranging from business and religion to local, state and federal government.

In my view, one possible answer is that we are ignoring what really constitutes leadership. According to Michael Josephson of the Josephson Institute:

"We are focusing too much on issues of style and ignoring issues of true substance — character and values. I believe that a leader's character *is central to the development of positive relationships with followers.*

IT IS MY STRONG BELIEF that leaders have the ability and the opportunity to influence ethical behavior and, thus, can truly make a difference in the lives of others.

Transformational leaders act in ways that turn followers into leaders. By empowering their followers, they build excitement around an appealing vision that creates performance excellence in challenging times."

It is my strong belief that leaders have the ability and the opportunity to influence ethical behavior and, thus, can truly make a difference in the lives of others. A few such leaders include Dr. Martin Luther King Jr., Rosa Parks, Mother Teresa, Nelson Mandela, Pat Tillman, Maya Angelou and John Wooden.

I believe leaders must grow people. As dean and as a professor, I took every opportunity to do that. I repeated often that our mission as educators and teachers was to grow people and along the way, we made them doctors. If we *only* educated them as doctors, we failed. We needed to grow people, connected to what is right, to what is best for their profession, best for their patients, best for their community and best for their families.

These are difficult times for individuals to lead and demonstrate those qualities of ethical and professional leadership that are essential and important in order to influence change — difficult, but not impossible! I believe everyone, and especially all leaders, must be teachers, and whether you are a dentist, football coach, basketball coach, senator, parent or an educator — all of us must be teachers. Teachers affect all eternity, as those who are taught in turn teach others.

President Teddy Roosevelt told us, "To educate a person in the mind but not in morals is to educate a menace to society."

Michael Josephson of the Josephson Institute, gives us six pillars of character: trustworthiness, responsibility, fairness, respect, caring and citizenship. On these pillars rest these powerful statements that reflect *who* we are, *who* we have become or *who* we will be.

"Please realize someday, ready or not, your life will come to an end. There will be no more sunrises, no more minutes, or hours, or days, and all the things you collected whether treasured or forgotten, will pass on to someone else.

> *Your wealth, fame and temporal powers will shrivel to irrelevance, and it will not matter what you owned or what you were owed. Your grudges, resentments, frustrations and jealousies will finally disappear. So too, your hopes, ambitions, plans and your to-do lists will all expire. The wins and losses that once seemed so important will fade away.*

It will not matter where you came from or what side of the tracks you lived on. It will not matter whether you were beautiful or brilliant. Even your gender and skin color will be irrelevant.

So what will matter? How will the value of your life be measured?

•What will matter is not what you bought, but what you built, not what you got but what you gave.

•What will matter is not your success, but your significance.

•What will matter is not what you learned, but what you taught.

•What will matter is every act of integrity, compassion, courage or sacrifice that enriched, empowered or encouraged others to emulate your example.

•What will matter is not your competence (although it is important), but your character.

•What will matter is not how many people you knew, but how many will feel a lasting loss when you are gone.

•What will matter are not your memories, but the memories that live in those who loved you.

•What will matter is how long you will be remembered, by whom and for what.

•What will matter are the lives you touched along the way."

Living a life that matters does not happen by chance. It is not a matter of circumstances but one of choice. As health care professionals, you have chosen to live a life that matters. And because you have, many individuals will have a better quality of life, go to bed without pain, have a beautiful smile, live longer, healthier lives, walk a little taller — and you will know in your heart that you have made a difference.

Congratulations for choosing to live a life that matters. ■■■■

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"If not us, then who?" Robert Kennedy, circa 1963.

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"Try not to become a success, but rather try to become a man of value," Albert Einstein.

"My best friend is the one who brings out the best in me!" Henry Ford.

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John Knipf & Robert Palumbo

LOS ANGELES COUNTY

BURBANK (Ortho) - 45 yrs gdwll. Consists of 2 chairs in open bay w/ Pano/Ceph in 1,221 sqft ste. Grossed ~$292K in 2012.ID #4047.
COVINA - Leasehold & Equip Only! 3 eq op office located in 1 story med building. Reasonable rent with excellent terms. ID #4355.
CULVER CITY - Leasehold & Equip Only! 10 eq op office in a single story bld. In residential area. Heavy traffic flow. ID #4261.
HUNTINGTON PARK (GP) Established in 2008. In a 2 story free stranding bldg near residential area. Has 4 eq ops. ID#4295.
LONG BEACH (Ortho) - 46 yrs of goodwill. Located in a 3 story medical bldg. 4 chairs in open bay. In residential area. ID # 4255.
LONG BEACH (Ortho) - Three practices as one entity. Have approx. 300 active patients. Has over 50 yrs of goodwill. ID#4285.
MOORPARK - Leasehold & Equip Only! Modern office w/ 4 eq ops, 1 plmbd not eq in a 1,346 sqft ste. Reasonable rent. ID # 4343.
N. HOLLYWOOD (GP/ORTHO) -Over 14 years of goodwill located in Prof. Bldg. Consists of 4 ops. Monthly revenues ~$32K. ID#4265.
TARZANA (GP) - Fee for service practice w/ over 28 yrs of goodwill. Consists of 8 eq ops and 2 plmbd not eq. ID #4313.
VALENCIA - Leasehold Improvements Only! Beautiful office w/ 6 plmbd not eq ops in 2,400 sqft. suite. Busy shopping center. ID#4321.

ORANGE COUNTY

HUNTINGTON BEACH (GP) - Modern designed practice w/ 3 eq ops & 1 plmbd in a 1,280 sqft ste. Grossed $246K in 2012. ID #4317.
HUNTINGTON BEACH (GP) Located in a 2 story prof bldg w/ 3 eq fully eq ops, Dentrix software in a 1,650 sqft ste. ID # 4327.
LAKE FOREST (GP) - Turn key practice w/ 3 spacious eq ops, 1 plmbd not eq in a 1,200 sq ft ste. Busy shopping center. ID #4123.
MISSION VIEGO (GP) - Well designed turn-key practice w/ 3 eq op & 3 plmbd is located in a prestigious shopping center. ID #4303.
NEWPORT BEACH - Leasehold & Equip Only! On a 2 story med/dent bldg w/ 3 eq ops in a 1,000 sq ft suite. Reasonable rent. ID#4325.
TUSTIN - Leasehold & Equip Only! Beautiful state-of-the-art off. Great for GP or Spec. 5 eq ops/3 plmbd not eq for expansion. ID #4225.

RIVERSIDE / SAN BERNARDINO COUNTIES

APPLE VALLEY (GP) - Established in 2007 this modern designed office is in a busy shopping center. Net of $384K. ID #4271.
BARSTOW(GP) - Long established office w/ 4 eq ops in a single story bldg. Easy freeway access. Fee for service. ID #4241
FONTANA (PEDO) - State-of-the-Art office w/ 2fully eq ops & 3 chairs in open Bay. 15% Insurance & 85% Denti-cal. ID #4301.
MURRIETA (GP) - Beautiful office w/ 3 eq ops surrounded by major anchor tenants. Some Capitation. 4 day/wk office. ID #4247.
PALM DESERT (GP) - Well established practice w/ 5 eq ops in 1 story bldg w/ ample parking & excellent signage. Net $119K. ID#4331.
UPLAND - Leasehold & Equip Only! All active pt charts included. Located in 2 story med bldg (ground level) w/ 3 eq ops. ID #4323.

SAN DIEGO COUNTY

ENCINITAS (GP) - Corner location w/ excellent signage and street visibility. Consists of 2 eq ops. Fee for service. ID # 4315.
RAMONA (GP) - Established in 1979 and located in single strip mall. Busy area. Fee for service. Consists of 3 eq op. ID #4305.
SAN DIEGO (GP) - In free standing bldg w/ private prkng. Consists of 5 ops w/ Dentrix software. Monthly revenues of ~$40K. ID #4279.
SAN DIEGO (GP) - Beautiful Turn-Key practice with 8 eq ops in a modern designed shopping center. Absentee owner. ID #4335.

VENTURA & SANTA BARBARA COUNTY

SANTA BARBARA (GP) - Well established practice in busy shopping center w/ 3 eq ops in a 1,220 sq ft suite. ID #4311.

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How to Place a Free Classified Ad

The *Journal* has changed its classified advertising policy for CDA members to place free classified ads online and publish in the *Journal*. Only CDA members can place classified ads. Non-CDA members can place display ads.

All classified ads must submitted through cda.org/classifieds. Fill out the blank fields provided, including whether the ad is to appear online only or online and in the *Journal*. Click "post" to submit your ad in its final form. The ad will post immediately on cda.org and will remain for 90 days. Space permitting, your ad will run one time in the next issue of the Journal following the posting of your online ad. After 90 days, you will need to repost your ad if you wish to continue running it online. Note that CDA reserves the right to modify your classified ad for CDA style and to correct typographical errors.

Classified ads for publication in the Journal must be submitted by the fifth of every month, prior to the month of publication. Example: Jan. 5 at 9 a.m. is the deadline for the February issue of the *Journal*. If the fifth falls on a weekend or holiday, then the deadline will be 9 a.m. the following workday. After the deadline closes, classified ads for the *Journal* will not be accepted, altered or canceled. Deadlines are firm.

Classified advertisements categories are: Equipment for Sale, Offices for Sale, Offices for Rent or Lease, Available Positions, Opportunities Wanted, and Practices for Sale.

How to Place a Display Ad

Nonmembers are welcome to place display ads. For information on display advertising, please contact Corey Gerhard at 916-554-5304 or corey.gerhard@cda.org.

CDA reserves the right to edit copy and does not assume liability for contents of classified advertising.

AVAILABLE POSITIONS

ENDODONTIST — Endodontist for multispecialty dental office in Chino Hills, Calif. Requires Texas license and travel/relocation to unanticipated worksites throughout Texas. To apply, please email Eiman Abedi, DDS, with Job #2947AR in the subject line, at drabedidds@gmail.com.

DENTAL ASSISTANT — Busy and well-organized private dental office looking for energetic and enthusiastic dental assistant with at least two years of experience. Good compensation and flexible working hours. Please fax resume to 818.757.7788.

REGISTERED DENTAL ASSISTANT — Cervantes and Prado Dental Care Inc. will be thrilled to welcome a new Registered Dental Assistant, part- or full-time, to our team of highly qualified, motivated professionals. If you are a driven, goal-oriented and compassionate individual, come join our team. We are seeking a friendly Registered Dental Assistant with at least two years of experience to help provide exceptional dental care in a progressive, growing, family-oriented dental practice. Candidate must be able to fabricate temporary crowns with ease, work some evenings to 7 p.m. and occasionally on Saturdays. Our ideal candidate would possess the following attributes: Ability to communicate effectively with patients;

CONTINUES ON 534

CLASSIFIEDS, CONTINUED FROM 533

positive and enthusiastic team player; professional and self-motivating; Spanish speaking a plus. If you are this person, please send us your resume including cover letter and wage request. Email resume to arizbelcervantes@yahoo.com or call 707.557.5822 for the fax number.

ORTHODONTIST ASSISTANT — High-tech office seeking an Orthodontist Assistant with two to three years of experience. We are located in the Torrance area. Please fax resume to 310.257.1112.

REGISTERED DENTAL HYGIENIST —Busy dental office in South Lake Tahoe is looking for a good Hygienist for a full-time or part-time position with benefits. Experienced preferred. Please include expected salary and some references. Call Paul at 516.603.9071.

ASSOCIATE DENTIST — Associate wanted full- or part-time for busy, state-of-the-art general practice in the Northern California wine region. Must be energetic, collaborative and willing to grow with our practice. Doctor willing to train and develop Associate. Possibility to buy in. High clinical standards, long-term commitment and excellent communication skills a must. Email CV and references to blueridge2920m@gmail.com. Contact Jennifer at 707.448.6882 for more information.

ASSOCIATE GENERAL DENTIST — We are looking for a friendly and motivated General Dentist to see our adult patients in our beautiful, newly remodeled group practice in San Juan Capistrano. Our practice consists of limited PPOs and cash patients. California license and at least two years of private practice experience required. This is a part-time position. If interested, please contact us at achandsa@gmail.com or call 949.661.3380.

ENDODONTIST — We would like to invite a board-certified or eligible Endodontist to come and join our multispecialty group of offices in and around San Jose. Please email bayareadentist2009@gmail.com or call 408.656.4567.

ASSOCIATE DENTIST — State-of-the-art general practice is looking for a good General Dentist with the following requirements: U.S. graduate (three to four years), three years of real-life dentistry or two years real-life dentistry plus one year AEGD or GPR certificate You should understand and able to work with HMO or PPO, have good communication skills and be able to handle most situation by yourself with help from another dentist Team work is a must. Please email your cover letter and CV to richardlqn@gmail with subject: dentist job.

ASSOCIATE DENTIST — Get out of the crowded city, make great money and get excellent additional training working with me in my rapidly growing office. We do all areas of dentistry and pride ourselves on our outstanding gentle care. With more than 100 new patients a month, we are growing too fast to keep up. We are proving that taking excellent care of patients can bring great dividends. Come work in a beautiful part of California, with a great team and great equipment in our new chartless office. Experience is always helpful, however, as long as you are willing to learn, a lot of experience is not necessary. Email CV or letter explaining interest to brent@parrottdds.com. You may also send a fax to 530.533.8204.

ASSOCIATE DENTIST — Multispecialty PPO office is hiring a full-time Associate Dentist. Must have experience working in a PPO multispecialty environment. Three years working experience required and you must do molar and endo. Please email CV to sdpartners346@yahoo.com.

ASSOCIATE — My name is Dr. Charles Cox and I practice in Paso Robles, Calif., a town located on the beautiful Central Coast. It's a great place to live. I'm looking for an Associate to work in our practice. Our practice is thriving and growing and we need help. I'm creating a great opportunity for someone who wants to treat our patients with quality and care. I'll handle the marketing, new patient generating and management hassle. We offer great income potential and a great office to work in. I think we have it all. If you are interested, please email your resume to chuckcoxdds@msn.com.

ASSOCIATE DENTIST — Full- and part-time position available for experienced Associate Dentist. Office is a PPO office, with all specialties in house. Doctor must have three years of experience working in a multispecialty environment, and have molar and endo experience. Please email CV to sdpartners346@yahoo.com.

ASSOCIATE/PARTNER DENTIST — Seeking seasoned Associate/Partner to join our team and to experience what dentistry is all about. Are you highly motivated, committed and passionate about dentistry? If you are, our eager staff will assist you to a successful career. Please email resume and picture to Krisdavejosh@yahoo.com.

PERIODONTIST — HMO multispecialty office hiring an experienced Periodontist. Must have three years of working experience and have experience working in an HMO office. Please email CV to sdpartners346@yahoo.com.

CONTINUES ON 536

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BAY AREA

AC-187 SAN FRANCISCO: Near Union Square in the heart of the City! 950 sf w/4 ops **$225k**

AN-182 SAN FRANCISCO: Outstanding opportunity near Pacific Heights. 800 sf w/3ops **$395k**

B-9851 SAN RAMON Facility: This opportunity will not wait! 1,700 sf w/ 3+ ops **$219k**

BC-162 PLEASANT HILL Facility: Updated office, large windows & views of the outdoors. Open floor plan. 1,852 sf w/6 ops **Reduced! $150k**

BC-174 DOWNTOWN HAYWARD: Large & Stable. Off major thoroughfare in residential area. 1,500 sf w/4 ops **$200k**

BC-175 EAST CONTRA COSTA: Vast employment, shopping & activities! 1,995 sf w/5ops **$300k**

BN-183 HAYWARD: ***Kick it up a notch by increasing the current very relaxed work schedule!*** 1,300 sf w/ 3 ops **$150k**

CC-077 BENICIA: Highly visible. Within walking distance of downtown. 820 sf w/2 ops **$100k**

CC-133 SANTA ROSA: Stable patient base. Well-respected. Location = new patient traffic. 1,291 sf w/3 ops + 1 add'l **$480k**

CC-151 SANTA ROSA: Stable patient base, well-respected, close to Memorial Hospital. 2,262 sf w/ 6 ops **$875k** *Real Estate avail.*

CC-170 SOLANO COUNTY: Minutes from nearby wine country! 950 sf w/3 ops **$225k**

CN-158 PETALUMA: Predominantly Capitation practice. 1,000 sf w/ 4 ops **$450k**

CN-184 SOLANO COUNTY: Well established, premier practice. 2,180 sf w/ 5 ops. State of the art equipment **$775k**

CN-189 ANTIOCH VICINTY: In the heart of the beautiful California Delta! 3 ops **$275k**

D-9091 ATHERTON: Turnkey operation 969 sf & 3 ops ***Call for Details!***

DC-113 MILPITAS: Seller retiring! Great location 1,009 sf w/ 3 ops. Plumbed for 1 add'l **$110k**

DC-164 WATSONVILLE: Shopping complex/main thoroughfare. Modern & Attractive. 2,365 sf w/ 6 ops **$395k**

DG-116 SALINAS AREA: Large, loyal & stable. Popular Retail Center. 1,400 sf w/5 ops. State-of-the-art Equipment **Reduced! $205k**

DG-124 MILPITAS: Highly visible. Desirable area. 960 sf w/ 2 ops + 1 add'l **$130k**

DG-138 MONTEREY: Centrally located in "New Monterey". Charming office. Excellent street exposure! 1,200 sf w/ 4 ops **NOW ONLY $620k**

BAY AREA CONTINUED

DG-147 SANTA CLARA Facility: Popular anchor stores/Rtl Shp Ctr. 1,500 sf w/ 3 ops + 2 **$185k**

DG-156 SAN JOSE: Hardwood Floors & plenty of windows! 1,160 sf w/ 3 ops (+2 add'l) **$145k**

DG-161 FREMONT: Beautiful office generating 40+ new pts/mo. 1,440 sf w/ 4 ops **$215k**

DG-180 APTOS: Beautiful seascape & beaches in Santa Cruz county! **Cash flow an amazing $375k!** 750 sf w/3 ops **$588k**

DN-084 PALO ALTO Facility: Educated, upper middle class community. "Move-in" ready! 700 sf w/3 ops **REDUCED! Now Only $94k**

DN-099 SAN JOSE Facility: Ultra-modern facility. Well-established. Dental Professional Complex. 1,450 sf w/5 ops **$99k**

DN-153 SAN JOSE: Est. 40 yrs. 2,200 sf w/ 5 ops. Includes Cerec **$750k (Real Estate $950k)**

DN-186 SUNNYVALE: Beautiful , state-of-the-art practice. 1,214 sf w/4 ops **$400k**

NORTHERN CALIFORNIA

EG-179 SACRAMENTO: Stunning inside & out! Modern & well-appointed. "**Must See**" Fully computerized, 2,000 sf w/4 ops + 3 **$455k**

EN-145 ROCKLIN Facility: Very desirable community! 1,400 sf w/3 ops +1 add'l **$150k**

EN-167 SACRAMENTO: One of the most desirable, affluent areas. 2,400 sf w/5 ops. **$450k**

FN-181 NORTH COAST: Well respected FFS GP. Stable patient base. 1,000 sf w/3 ops **SELLER MOTIVATED! $150k (25% interest in building also available)**

FN-087 LAKE COUNTY: Quality practice, friendly staff & Cerec 2,400 sf w/3+ ops **$699k**

FN-148 MENDOCINO CO: "Gateway to the Redwoods!" Quality care in 4 ops **$325k**

FN-185 UKIAH: Street-level office/desirable area. 900 sf w/ 3 ops **$275k**

GG-140 CHICO VICINITY: Selling for less than 50% of gross! 1,200 sf w/4ops. **Reduced! $195k**

GN-058 YUBA CITY: Known for quality dental care. 1,704 sf w/ 4 ops Reduced! **$359k**

GN-103 CHICO: Successful, highly esteemed practice! 3,500 sf w/ 8 ops + 2 add'l **$850k**

GN-134 REDDING: Stellar reputation, quality care and location! 2,264 sf w/4 ops. **$500k**

GN-149 YREKA: Quality FFS, Warm & Caring. 900 sf w/ 3 ops **$200k/Real Estate $110k**

GN-166 CHICO: Well Respected Practice, loyal patient base. 1,800 sf w/4 ops. **$495k w/Cerec!**

GN-177 CHICO/OROVILLE: Spacious and spectacular! 2,500 sf w/6 ops **$399k**

CENTRAL VALLEY

HG-159 S. LAKE TAHOE: Retail Center w/ *spectacular* views of the lake from each Op. 2,000 sf w/ 5 ops **REDUCED! NOW ONLY $400k**

HN-059 LASSEN CO: Quality, well-established, family-oriented. 1,600 sf w/3 ops **$120k**

HN-169 SONORA AREA: Nestled in the pines East of Sonora. 1,800 sf w/3 ops + 1 Add'l **$250k**

I-9721 STOCKTON: Prof. complex. 1,450 sf w/ 3 ops & plumbed for 1 add'l **$75k**

IG-067 STOCKTON: Fully computerized, paperless, digitalized. 5,000 sf w/10 ops **Now $425k**

IG-081 TURLOCK Facility: 1,512 sf w/5 ops. **Oppty to Buy Condo Also! Practice: $50k**

IG-165 TURLOCK: Well established Shared/Solo Group Practice. 10 ops (shared) **$428k**

IN-176 TURLOCK: Mother Lode, SF Bay & Sierras nearby! 2,500 sf w/3 ops **$120k**

J-1000 TULARE: Highly visible location! 1,650 sf w/4 ops **$465k /Real Estate: $249k**

JG-136 FRESNO Facility & Property: Highly visible, free-standing Prof. bldg. Major thoroughfare. 5,000 sf w/9 ops **$475k**

JG-137 FRESNO: Own the Building too! 3,500 sf w/ 5 ops **Now Only $425k/ Real Estate $350k**

JG-188 FRESNO: Well loved, respected, established! Net Profit over $350k! 1,452 sf w/4 ops **$390k**

JN-157 FRESNO: Comprehensive care and comfort . 1,470 sf w/3 ops **$200k**

JC-178 SAN JOAQUIN VALLEY: Historical Building in thriving area! 2,206 sf w/6 ops **$495k**

SPECIALTY PRACTICES

AC-119 MILL VALLEY Prostho: State-of-the-art equipment including: digital charting and x-ray. 1,100 sf w/ 3 ops. Plumbed for 4th **$450k**

CG-105 VACAVILLE Ortho: Strong, loyal, widespread referral base. 30+ pats/day. 5-6 new starts/mo. 2,000 sf 4 chairs/bays **$280k**

EG-131 ROSEVILLE/AUBURN Ortho: 2 practices within ½ hour of each other! **$175k**

I-7861 CENTRAL VALLEY Ortho: 2,000 sf, open bay w/ 8 chairs. Fee-for-Service. **$370k**

I-9461 CENTRAL VALLEY Ortho: 1,650 sf w/5 chairs/bays & plumbed for 2 add'l **$180k**

IC-163 CENTRAL VALLEY Perio: Well-respected FFS. 2,300 sf w/5 ops **$175k (Bldg: $250k)**

CLASSIFIEDS, CONTINUED FROM 534

ENDODONTIST — Due to the growing demand for root canals in our office we are looking to bring on a board-eligible or certified Endodontist to join our group on a part-time basis. We will need approximately six to eight days of commitment per month. For the right Endodontist this opportunity may blossom into many more days if the doctor prefers to add more days. Please send your resume or simply send an email indicating your interest in this opportunity. Email to bayareadentist2009@gmail.com is the preferred for initial contact.

GENERAL AND SPECIALTY DENTAL GROUP — If you have at least three years of post-schooling experience, we would like to invite you to send your resume. We are a general and multispecialty dental group. This is a great opportunity to serve the community. Experience with simple extractions and simple anterior root canals preferred. If you reside in San Jose, the Watsonville/Monterey area is only about an hour drive and it's against the traffic. It takes less time to get here than to go from San Jose to Oakland during rush hour. Prefer email to bayareadentist2009@gmail.com contact initially.

ORTHODONTIST — High-tech office seeking energetic, compassionate and experienced Orthodontist in the Torrance area. Please fax resume to 310.257.1112.

ORAL SURGEON — Sacramento Oral Surgery (SOS) in Northern California is a five-practice affiliate of American Dental Partners. Our practices are located in south, north and midtown Sacramento along with facilities in Roseville and Folsom. We offer oral surgery in all of our practices and are

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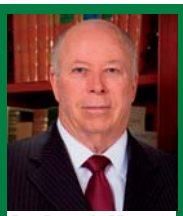

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- **BISHOP:** *For Sale*-General Dentistry Practice & Building. Collections were $1,000,243 in 2011 with $387,000 Adj. Net Income. 5 op., 1,800 sq. ft. building. #14390
- **CENTRAL COAST:** *For Sale*-Specialty Practice. Four operatories. Gross Receipts of over $775,000. #CAM546
- **CENTRAL COAST:** *For Sale*-Prosthodontic Practice. Four operatories, full in-house lab. $1.1M in Gross Receipts in 2011. #CAM535
- **CHICO:** *For Sale*-General Dentistry Practice. 2012 Collections of $1,385,222. Free-standing building with 2,464 sq. ft. Buyer can purchase or lease building. #14392
- **COASTAL ORANGE COUNTY:** *For Sale*-General Dentistry/ Implant Practice. 2011 Gross Receipts were $1.2M 1,800 sq. ft., 4 op office with implant systems in every op. #CA520
- **COASTAL ORANGE COUNTY:** *For Sale*-Perio Practice. 5 Operatories, retiring doctor works 3 days with 4 days of hygiene. 2011 Gross Receipts were $400,000. #CAM533
- **COASTAL ORANGE COUNTY:** *For Sale*-General Dentistry Practice. 4 Operatories with modern, new equipment and high-end finishes. 2012 GR of over $690,000 #CA529
- **FRESNO:** *For Sale*-General Dentistry Practice: $935K in collections in 2011, w/Adj. Net Income of $337K. Office is 2,300 sq. ft. with 6 equipped operatories. #CA502
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. Collections of $491K with an Adj. Net Income of $130K. Office is 1,555 sq. ft., 4 equip. ops, 5 available. #14379
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. 2012 GR of $442,736. 6 Ops in approx. 1,950 sq. ft. office condominium available to purchase. #14372
- **GREATER SACRAMENTO:** *For Sale*-General Dentistry Practice. 2012 Gross Receipts of $879,000 and Adj. Net Income of $446,218. 1,400 sq. ft. office with 5 ops. #CA525
- **HAWAII (MAUI):** *For Sale*-General Dentistry Practice. Gross Receipts of $636K. Office has four equipped operatories in 1,198 sq.ft. #20101
- **HUNTINGTON BEACH:** *For Sale*-General Dentistry Practice. 1,395 sq. ft., all new, high-end office, paperless, digital. 2012 Gross Receipts of $187K. #CAM521
- **INDIAN WELLS:** *For Sale*-General Dentistry/TMJ Practice. 4,000 sq. ft. suite, 6 ops. 2011 Gross Receipts over $350,000 on just one doctor day/week. #CAM530
- **LANCASTER:** *For Sale*-General Dentistry Practice. This 4 operatory office is located in 2,360 sq. ft.. GR were $676,000 with $174K Adj. net income. #14376
- **LINCOLN-ROSEVILLE:** *For Sale*-General Dentistry Practice. 2012 Gross Receipts of $787K with Adj. Net Income of $358K. 4 ops in 1,268 sq. ft. #CA545
- **MERCED:** *For Sale* - General Dentistry Practice. 2011 gross of $878K with Adj. Net Income of $294K. Four treatment rooms in 1,550 sq. ft. office. #CA512
- **MURRIETA:** *For Sale* - General Dentistry Practice. Four operatories in 1,300 sq. ft. 2012 GR were over $530,000 with $213,000 Adj. Net Income. #CAM544
- **NEWPORT BEACH:** *For Sale*-General Dentistry Practice. Three operatories, newer, high-end equipment. 2012 GR of $350,000 on 3 1/2 days per week. #CAM534
- **NORTH OF SACRAMENTO:** *For Sale*-General Dentistry Practice. 2012 Gross Receipt of $521K with low overhead of only 52%. 1,650 sq. ft. with 4 ops. #CA528
- **ORANGE:** *For Sale*-General Dentistry Practice. Five operatories. 2011 Gross Receipts of over $775,000. #CAM543
- **ORANGE COUNTY:** *For Sale*-Periodontal Practice. Six operatories available, five fully equipped. 2012 Gross Receipts $590,000 on a 4 day week. #CAM536
- **PALM SPRINGS:** *For Sale*-General Dentistry Practice. Four operatories. PPO/Fee For Service, no HMO with 2012 Gross Receipts of $348,000 #CAM538
- **RIDGECREST:** *For Sale* – General Dentistry Practice and Dental Building: 4 ops in 1,536 sq. ft. office building. This small practice grossed about $175K in 2012. #CA523
- **SACRAMENTO:** For Sale-General Dentistry Practice. Gross Receipts $546K with adjusted net income of $159K. Office is 2,400 sq ft with 7 operatories. #14374
- **SAN FRANCISCO:** *For Sale*-General Dentistry Practice. Three equipment rooms plumbed with NO2 in 648 sq. ft. 2012 Gross Receipts of $314,000. #CA527
- **SAN GABRIEL VALLEY:** *For Sale*-General Dentistry Practice. Four operatories. 2012 Gross Receipts of $950,000. #CAM537
- **SAN GABRIEL VALLEY:** *For Sale*-General Dentistry Practice. Four operatories. 2011 Gross Receipts of over $590,000 on a 3 1/2 day week. #CAM541
- **SAN JUAN CAPISTRANO:** *For Sale*-General Dentistry Practice. Four fully-equipped operatories. Gross Receipts of $650,000 in 2012. #CAM539
- **SAN RAMON:** *For Sale*-FACILITY SALE. Great location: equipment, leaseholds & furnishings only. 1,400 sq. ft. with 4 equip. treatment rooms (2 additional plumbed) #CA511
- **SAN RAMON:** *For Sale* - General Dentistry Practice. 2012 Gross Receipts of $926K with Adj. Net Income of $340K. 5 ops (6th plumbed) in approx. 2,000 sq. ft. #CA547
- **SAN JOSE:** *For Sale*-FACILITY ONLY:Three fully equipped ops in approx. 1,200 sq. ft. including Digital sensor, Eaglesoft software, and full computer network. #CA515
- **TURLOCK:** *For Sale*-General Dentistry Practice: Doctor's gross receipts in 2012 were over $950,000 with $443,777 Adj. Net Income. #CA506
- **WESTWOOD:** *For Sale*-Alamgam-free General Dentistry Practice. Five operatories, near UCLA. $630,000 in Gross Receipts in 2011. #CAM542
- **WALNUT CREEK:** *For Sale*-Prosthodontic Practice. Three fully-equipped operatories and lab. 2012 Gross Receipts of $530,000. #CAM540
- **YORBA LINDA:** *For Sale*-General Dentistry Practice. Five well-appointed operatories. #CAM531

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ASSOCIATE DENTIST — Private General Practice in beautiful Windsor, Sonoma County, is seeking an Associate Dentist. Long-term, stable employment with possibility of leading into partnership. 2-plus years of experience preferred. Please email resume to Barbara at barbara@windsordentist.com.

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3092 SF FACILITY

1,600 sq. ft. street-level dental facility in Marina/ Cow Hollow neighborhood across from Presidio with excellent visibility and signage for foot traffic plus easy diagonal parking in front of building. Move in ready with 4 ops., 2 labs, kitchenette, reception and 2 desk areas plus 2 pvt. offices, 2 bathrooms, 1/2 basement & backyard with deck.

4003 SAN JOSE ORTHO

Owner passed away. Practice available immediately SOLD contact us for more information. Asking $295K.

3096 NORTH BAY PERIO

Step into quality practice with established referral base. 2,200 sq. ft. office w/6 fully-equipped ops. Modern facility kept updated with recently purchased chairs, lights, Pano & lasers. Seller will grant a fair market lease and would consider selling the office space. 5 year avg. GR $1.2M+

3099 LOS GATOS GP

Well-est. general, restorative & cosmetic practice available in very desirable neighborhood. Gorgeous 1,530 sq. ft. office in single story dental complex w/4 ops. Asking $580K. SOLD

3098 SALINAS GP

Well-known GP specializing in restorative dentistry retiring from 28 year practice located in highly visible downtown office. 4 fully-equipped ops., Panorex, digital x-ray & recent equipment upgrades. 2 year avg. GR $331K+ w/approx. 152 doctor days/yr.

3995 SAN CARLOS

Seller well-known for quality patient care retiring from established practice with loyal patient base, in highly desirable neighborhood. Asking $515K. SOLD

3085 MODESTO GP

State-of-the-art practice in approx. 2,800 sq. ft. facility w/7 fully-equipped ops. This practice is for an established dentist or 2 dentists w/experience & who will appreciate a high quality practice. Asking $745K. SOLD

4002 SANTA CRUZ AREA GP & BLDG

Well-est. practice in modern 1,250 sq. ft. office w/ 4 ops. 5 year avg. GR $630K+ w/ just 4 doctor days. Selling building & practice together. Practice asking price $430K, building to be determined.

4000 SONOMA COUNTY GP

Practice in a relaxing small town community located in the Sonoma wine country. Owner retiring from well-established practice in charming, fully-equipped, 3 op. turn-key facility. Approx. 400 active pts. Asking $110K.

4001 NORTHERN SONOMA COUNTY GP

Approx. 1,059 sq. ft. facility w/3 fully-equipped ops and dedicated parking in downtown area. Practice & building for sale. Great opportunity. Practice Asking $311K, building to be determined.

3094 NORTH BAY PERIO

North Bay Perio now available. Seller retiring from well-est. practice with seasoned staff and active referral base. 1,300 sq. ft. very nice office with 4 fully- equipped operatories. 2012 GR $450K+ with just 3 1/2 doctor days and 5 days of hygiene per week. Great upside potential since owner does few implants. Asking $271K.

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DENTIST — Great part-time opportunity. We are in need of a Dentist for Thursdays and Fridays for our established general practice in Windsor, Calif. May lead to more days and possible partnership. Please send resume/CV for immediate consideration to barbara@windsordentist.com.

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6008 **MENDOCINO COAST – FORT BRAGG** Cultural haven offers attractive lifestyle. 2012 collected $750,000. 4-days of Hygiene. Digital radiography. Computers in ops.

6029 **NORTHEAST CALIFORNIA – ALTURAS** Trade in smog and congestion for soaring mountains and close-knit communities. 2012 collected $514,000 on 3-day week. 3+ days of Hygiene. Strong Recall. Great staff. Beautiful office. 3-ops with Adec delivery systems. Be busy, be happy and take vacations. No worries here.

6034 **SAN LEANDRO AREA** Did $[illegible],000 in 2011. Owner reduced time in 2012. Collected $450,000 3-ops. Nice Hygiene schedule. Great blue collar practice. SOLD

6035 **SAN FRANCISCO'S EAST BAY – ORTHO** Part-time practice collected $425,000 in 2012. Very desirable location. SOLD

6038 **FREMONT** On part-time schedule due to other responsibilities,collects $300,000 per year. 2-days of Hygiene.

6039 **LAKE TAHOE – CALIFORNIA SIDE** Long established. 2012 collected $515,000 with 2-months off. Realized Profits of $230,000+. Attractive 3-op office.

6040 **SANTA ROSA** Sleeping Giant. Beautiful 4-Op office is paperless, digital and employs laser technology. Collected $480,000 in 2012. Should have done more! Prior year did $625,000. Package includes 1,500 sq.ft. condo which shall create a facility cost which shall be cheaper than rent.

6041 **PLEASANT HILL** Collected $365,000 with Profits of $142,000 in 2012. Owner slowing down. Previous 3-years averaged collections of $415,000 and Profits of $180,000.

6042 **BERKELEY** 2012 produced $1.3 Million and collected $1.23 Million. Available Profits totaled $465,000. Owner works just 3-days a week. 6-days of Hygiene per week. Very strong foundation.

6043 **EL SOBRANTE** 3-day practice collected $170,00 in 2012. 3-ops.

6044 **MODESTO** Great location in area with new development occurring nearby. Collected $380,000 last year. Very attractive office.

6045 **TRACY, STOCKTON, MANTECA, MODESTO AREA** Beautiful office with great location. 3 Ops with two more wired/plumbed. Investment 10-years was $180,000. Practice has done more when Owner worked harder. 2012 collected $327,000 on a 3-day work week with 5-weeks off.

6046 **PINOLE** Collected $500,000 in 2012. 4-days of Hygiene produced $178,600. Beautiful office. Refers Endo. Lots of Goodwill here.

6047 **STOCKTON** Best location outside Brookside Country Club on West March Lane. Annualized revenues of $500,000. Attractive 3-Op office. Package sale includes condo.

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3350 **ANAHEIM HILLS** Partner with Lady DDS who will sell all in 3 years. Purchase half now for 50% of Gross. Beautiful Hi Tech office.

3351 **CARLSBAD** 4,000 sq.ft. Freeway Visibility. Grossed Million+, Absentee Seller. 12 Ops. Develop Solo Group. Specialists will pay for your investment. FP RE $1.5 Million and Practice $685,000.

3352 **BAKER/VISTA – LAKE SAN MARCOS** Established 20+ years. Recently moved to prestigious Hi-Traffic location. 4 Ops with 10 plumbed. State of Art. Collections $50K/month. FP $550,000.

3353 **EAST SAN DIEGO** DDS in a pickle will assist Buyer to Gross average $50K/month. FP $300,000. Unusual opportunity. Seller would sell half @ $165,000.

3354 **GRANADA HILLS – BEST PRACTICE – NO PPO's – NO HMO – NO MEDICAL** Cash and Insurance. Established 45 years. Hi identity building. Property could be purchased. Grossing $1.1 Million. 7 Ops. FP $.1.2 Million for Practice. .

3355 **SAN FERNANDO PRACTICE & VALUABLE RE** Hispanic Market. 60-to-70 NPs/month. Store front. $40,000 Digital sign changeable with Dental Ads to 1,000's of passing cars daily in Front of High Traffic intersection. 7 Ops. Practice and RE $3.3 million.

3356 **APPLE VALLEY – VICTORVILLE** Grossed $675,000. Modern Hi Identity shopping center. 8 Ops. With little marketing, will do $800K next year. Great Profits.

3357 **CUCAMONGA** Shopping center on 210 Freeway. 50-to-70 new patients/month. 2013 is projecting $1.2 Million. Beautiful 5 Ops.

3358 **TEMECULA** Seller busy with young family and two thriving practices. Can take in Partner for one with option to buy all once Buyer bonds with patients. Buyer should Gross minimum of $500K.

3359 **ONTARIO** Stater Brothers Center. Hispanic patients. 5 Ops plumbed, 3 equipped. Rent less than $3,500/month. Needs marketing to do $500K+/year.

3360 **PALMDALE – BARGAIN** Shopping center. 4 Ops, grossing $15K-to-$25K part time by Absentee DDS. Full time DDS will do up to $600K like prior Owner. Asking $185,000.

3361 **FONTANA – SUPER HI IDENTITY** Shopping center. 4 Ops. All Hispanic, next to McDonald's. Part time DDS. FP $285,000.

3362 **BALDWIN PARK** Established 20+ years. 3 Ops in 1,000 sq.ft., Lady DDS Retiring. Conservative Seller needs to sell. Eager Buyer will gross in excess of $500K in this hi Identity Dental Building.

3363 **LAMONT/ARVIN – GP/ORTHO** Grossing $30K/month on 2 days. Beautiful 4 Op office. RE For Sale as well. 3,000 sq.ft. includes apt. Full time DDS will do $40K+/month.

3364 **RIALTO** Dental/Medical Building 18,000 sq.ft.. Room to build self-storage center in back. $1,200,000 or make Offer.

3365 **YUCCA VALLEY** Hi Identity. Small practice needs TLC. On major Highway. Full Price $165,000.

3366 **INDIO** First Dental Building in Indio. New campus for 3,000 students being built 2 blocks away. Hi Identity.

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OFFICE FOR SALE — Established, 25-year dental office in Mojave, Calif. This is the only office in town. Office has three fully equipped operatories and has street-front visibility in a busy shopping complex with plenty of parking. This is a direct sale. Please email himale@gmail.com.

EQUIPMENT FOR SALE

EQUIPMENT FOR SALE — Soredex Cranex 2.5 panograph X-ray. Works great, currently in storage. Pick-up only, central California area. Call Dr. Leroux at 805.543.3747 or send email to jldds@hotmail.com.

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Jimmy. Of course, they can always be fixed when he's a little older, you know, before the other kids start making fun of him in nursery school. Remember Cousin Jimmy? They got the top part pinned back all right, but the bottom half still sticks out."

This goes on until the child is well into puberty. Julie's eyes — Charlie's nose before he got it fixed — cries a lot like little Susan did until she was into counseling. Small wonder a lot of kids spend the rest of their lives trying to "find" themselves, wondering who the "real me" is when it seems they are just a conglomeration of relatives' bits and pieces.

I don't see any of this. Great-grandson has a nice round head the shape of a bowling ball and pretty much a standard eye, nose and mouth arrangement although arguably cuter than any other child ever born.

Our conversation is limited to my interpretation of his squeals and gurgles. Again, women are better at this, easily divining the early formation of words like Ma-ma and Da-da in every utterance. I recognize the need for a diaper change, but that's about it. We stare at one another for a while. I blink first; he seems unimpressed. "You know, of course, that if it weren't for my wife and me, you wouldn't be here?" I offer.

"Oh yeah, you're not my real father. And what about my mother?" he squeals.

"Well, sure," I agree, "but your mother is my son's daughter and her father is your grandpa."

"But if your mother hadn't met my great, great grandfather, you wouldn't be here," he counters. "Did your great, great, great grandmother on your mother's side even know my great, great, great, grandfather on my father's side?"

"I don't think so, they traveled in different circles," I reply.

I see where this is going and if I don't get up pretty soon, we'll be opening that ancient question, "When does Life begin?"

"Well, there you go, then," he sighs. "You never get born if people who don't know each other insist on traveling in circles!"

The kid is beginning to annoy me like my second cousin George who argued about everything. I see where this is going and if I don't get up pretty soon, we'll be opening that ancient question, "When does Life begin?"

Cavemen, still pondering the concept of "round" so the wheel could be invented, used to pause and discuss whether Life began at the moment of conception or when birth actually occurred. They never figured out any connection between these two events, a conundrum that puzzles some people today. Consensus among the Flintstones of the time was that life pretty much ended when you got smacked upside the head with the recent invention of the club.

So the argument still goes on today, except at the DMV where your birthday is the only thing accepted and only then after you've spent the better part of the day at Windows One through Eight and had a picture taken of what is obviously not the "real you." The moment of conception side of the argument might argue the date to be nine months sooner, but proving it is iffy and the place where it happened doesn't appear on any of the 25 forms the DMV has you sign and initial.

Personally, I am going with this hypothesis: Start with the United States, leave Europe out of it because that only complicates an already unwieldy scenario. I scroll back in my mind through a couple hundred thousand couples. The first couple in this mob and all those great, great, great, great, etc. grandparents thereafter followed the script. If just one of them opted out — just one — I wouldn't be here. This was my beginning. When sperm met ova I weighed less than a fraction of a milligram. Nine months later I topped 10 pounds and if I had kept going at that rate I would be well over 900 pounds today and a bit over 2,000 feet tall. If there is a flaw in this reasoning, I can't find it.

I tried explaining this to my great-grandson, but he had toppled over, sound asleep, thumb in mouth. He left a message: I need a change, it implied.

I agreed. ■■■■

CDA JOURNAL, VOL 41, Nº7

The Beginning

"You know, of course, that if it weren't for my wife and me, you wouldn't be here?" I offer.

Robert E. Horseman, DDS

ILLUSTRATION BY VAL B. MINA

I was down on the floor playing with my 6-month-old great-grandson. Getting down there was easy, but since there is a 92-year differential in our ages, he tired of this activity sooner than I did and my immediate concern was how to arise without aid from EMTs.

Pending my glacial and uncertain return to an upright position, there were fortunately no women nearby at the moment so I felt free to speak to the infant man-to-boy. "Well, you are the cutest thing I ever saw!" I stroked his stubble-free cheeks with the back of my fingers. "Yes you are! YES. YOU. ARE!" Men can't talk to babies this way in the presence of women. Men have always believed that all newborn children resemble Winston Churchill and usually confine their remarks to something like "Yep, he's gonna be tall all right!" This supposition is based on his present height of 22 inches that will obviously position the kid as an NBA center in a few years.

Female family members are more acutely observant. No sooner is the cord cut than the inventory of resemblances begins:

"He's got his father's chin."

"Those cheek bones — I see Aunt Debbie's high cheek bones, don't you?"

"Will you look at those long fingers? And those feet! That's Ted exactly."

"Notice his ears? Poor Cousin

CONTINUES ON 545

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