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THE ETHICS OF PROFESSION IN DENTAL MEDICINE

DAVID A. NASH, ED.D., D.M.D., M.S.

Abstract Changes in technology, public policy, and the multi-dimensional relationships of professionals have resulted in renewed interest in the ethics of health care practitioners. This article considers the obligation of dentists to a life of morality in common with all humanity. Additional responsibilities are incurred by a practitioner of dental medicine in keeping the moral rule to "do your duty." These duties are explicated utilizing three classical characteristics of a professional. The Principles of Ethics and Code of Professional Conduct of the American Dental Association are the dental profession's guide to ethical conduct. The Principles and Code are traced in their development, reviewed in their content, and critiqued in comparison to the ethical obligations of the dentist as previously delineated. The use of the Principles and Code as a basis for professional self-government is evaluated.

Too much is taken for granted about the way physicians (dentists) conduct themselves. There is a need to re-examine the sources of the normative principles which govern their behavior in the ordinary medical encounter; the situation where one human in distress seeks out another who professes to have the knowledge to help or heal.

EDMUND D. PELLEGRINO
Humanism and the Physician

INTRODUCTION

Recent interest in ethics of the health professions is related to several factors. These include technological advances that have expanded treatment options; increased concern for self-determined action: growing numbers of franchised and entrepreneurial practice settings; ownership and management of health care facilities by private, for-profit corporations; and changes in the relationships of professionals among themselves, with society and with government.

The U.S. Supreme Court decision (Goldfarb v. Virginia State Bar), declaring that learned professions were not exempt from antitrust legislation, led subsequently to the Federal Trade Commission's ruling in 1979 for the American Medical Association (and in a derivative decision, the American Dental Association) to "cease and desist from restricting, regulating, impeding, declaring unethical, interfering with or advising against advertising... of physicians' services." Coincident, has been the amelioration of the shortage of health professionals, particularly in dentistry, with resulting efforts to promote the professional's services through "marketing." Fein has suggested, "a new language is infecting the culture of American medicine. It is the language of the marketplace, of the tradesman, and of the cost accountant." The consequences of these matters are demands from within and without the professions to seriously examine the relationship of health practitioners to one another, to their patients and to society.

Confusion frequently exists among the concepts of morals, ethics, and law. For the present purpose, ethics and morality will be considered synonymous; with ethics having its origin in Greek and morality deriving from Latin. An argument can be made for drawing a distinction between the two; however, this distinction will not be employed in this article. Ethics or morality can be conceived as that domain of understanding and action that relates individuals' responsibility to others. Ethical behaviors are those actions which can be evaluated as being right or wrong using reasoned, objective criteria. Law, in distinction, is the societal institution of binding rules of conduct or action by a formally recognized authority, with enforcement by that authority. Law is to be understood as public consensus, and not infrequently, a temporary one. Law is to be criticized and questioned: is it just or fair: that is, is it moral?

Part of the focus of this paper will be the Principles of Ethics and Code of Professional Conduct (hereafter referred to as Principles and Code), of the American Dental Association. As the comments will, in part, be a critique of the Principles and Code, it is necessary to systematically review an ethic for dental medicine prior to that discussion. An initial consideration will be the practitioner of dental medicine as a moral agent, in common with all humanity. Additional obligations incurred in the role of health professional will then be addressed. Finally, attention will be focused on the Principles and Code, particularly as they relate to the systematic treatment of professional ethics.

DENTISTS AS HUMANS

Before considering the unique obligations assumed by dentists in the professional role, it is necessary to examine the moral responsibilities they incur as members of society. Only then can the extraordinary ethic be distinguished from the or-
dinary. Stated differently, determining what is not professional ethics for the dentist, but only normal everyday morality is an important initial step in delineating the unique obligations of the practitioner.

Moral rules, to which humans regularly appeal, constitute a point of departure for thinking about ethics. The moral rules are the prohibitions inherent in the structure of the universe, the so-called natural moral law. These rules have universal appeal: rules that all rational humans would agree are necessary for living in an ordered society. Various moral philosophers have attempted to state these rules, to explicate them, and to search for their justification. Many ethicists have held that God and revelation are the source of natural law. Natural law theories are also advanced which do not have their origins in theological positions. Some philosophers have adopted natural law positions parallel to, but apart from, their theological commitments.

Gert offers a contemporary approach to outlining natural law or moral rules. In *The Moral Rules* he specifies ten rules of morality that can be philosophically justified as basic to human morality.* These moral rules are: don’t kill, don’t cause pain, don’t disable, don’t deprive of freedom or opportunity, don’t deprive of pleasure, don’t deceive, keep your promises, don’t cheat, obey the law, and do your duty. The justifications offered for each of these rules is beyond the scope of the present effort, but it can be readily noted that most of these rules intuitively appeal to our human reasoning. We would have an aversion to having a rule violated with regard to ourselves or anyone for whom we care. The moral rules can be summarized as “don’t cause evil.” Possibly additional rules could be defined and justified. Various communities of individuals would describe additional rules based on a religious tradition. However, all could not accept the unique tradition of the religious community. Although valuable for some, rules derived from the religious perspective could not justly be held as binding on those outside these communities.

In spite of a group of moral rules deriving from a natural order, ethics is a “fairly blunt instrument: it does not cut finely.” Although ethics can be precise and rigorous, it does not always enable one to determine that one, and only one, action is moral. Certain alternatives may be ruled out, but a range of possible actions may remain that are morally acceptable. Not infrequently, all possible actions in a given circumstance could infringe on one moral rule or another. It then becomes a matter of deciding which is the lesser of the evils. Equally moral people may disagree. This introduces the idea that although the moral rules are universally applicable, they are not always absolute. They provide the basis for morality, from which departures must be justified. Justification might be perceived by some as simply appealing to personal preferences and therefore only a method of circumventing the rule in a specific instance. However, Gert further argues for the moral attitude; that is, the rule is to be obeyed except when the individual can publically advocate violating it. Without a willingness to publically advocate its violation, such a violation is immoral and may be punished by society.

It can be argued that human morality is more than just “not causing evil,” by obeying the prohibitions of the moral rules. There must be a positive component to human morality. This component is what Gert calls the moral ideals. These ideals may be abridged to the expression “prevent evil,” or do those things that will or are likely to reduce the amount of evil suffered by someone. The moral ideals can be understood by being paired with the ten moral rules: prevent killing, prevent the causing of pain, prevent deceit, etc. There is an important distinction to be made between the moral rules and the moral ideals in the life of morality. Rational people would require all to keep the moral rules, but would only encourage individuals to follow the moral ideals. Society, as it reflects rational humanity, would not necessarily punish someone for failing to rescue a drowning swimmer, but would punish someone for drowning another: the distinction between “do not kill” and “prevent killing.”

The notion of what it means to be moral is further complicated with the suggestion by some contemporary ethicists, that an approach to morality, such as that of the moral rules and ideals as described, focuses on behavior or actions, not on motivation or character. A case can be made for a virtue theory of ethics with an emphasis on the agent rather than the act. Here the fundamental question is in the classical tradition of Aristotle, “who should I be?” The emphasis can be stated as the difference between acting good and being good. Camus expressed this virtue orientation in literature when he said “Integrity has no need for rules.”

The Preface of the *Principles* and *Code* of the American Dental Association appeals in part to a virtue-based theory of ethics when it summarizes the obligation of dentists as being the “Golden Rule,” which states “whosoever ye would that men do to you, do ye even so to them.” This statement of Jesus is actually a derivative of the commandment of love which He advocated: “love your neighbor as yourself.” Here then the virtue of love is explained.

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pressed as the criterion of morality. St. Augustine asserted it in his aphorism of the Christian ethic, “love, and do as you will.” Propriety defined and explicated as has been attempted, love may provide a basis for the moral life. Other virtues such as justice, kindness, fidelity, integrity, discernment, temperance, trust, prudence, humility, and the like could also be justified as important in a virtue theory of ethics. Action-oriented theorists would not deny that virtues such as those described are important to the moral life, but would reject the idea that they could be primary. The argument is that these virtues or character traits are derived from an agreement on previously understood and subscribed to rules of behavior. Ultimately, these philosophers would suggest, the judge of one’s virtues is how one behaves.

Although this review of normal or everyday morality has been somewhat involved, it is essential to understand dentists’ basic obligation to a morality stemming from their participation in the human enterprise. It is unfortunate that some have assumed that morality was an option for those who desired to be “virtuous” or “religious.” Having chosen to be neither, some individuals have incorrectly assumed license. This is not and cannot be true, as the keeping of the moral rules is essential to cooperation among people so that all may have the most good and the least evil.

**DENTISTS AS PROFESSIONALS**

**Covenant of the Dentist** The ethics of professionalism derive from the role assumed by the dentist in agreeing to enter into a relationship with another human to “do good” for that individual with regard to his or her oral health. All of the moral rules apply to the relationship, but additional moral responsibilities are assumed. These additional obligations are incurred in keeping the moral rules to “do your duty.” Before seeking to develop these professional moral duties, an understanding of the nature of the relationship is helpful.

The metaphor of a covenant has been employed by May in conceptualizing the relationship entered into by professional and patient, and, as significantly, between the profession and society. He suggests that the concept of a covenant is more appropriate in elucidating the nature of the relationship than the priest or parent metaphor which has been previously utilized, or the legal concept of contract.

In its ancient and most influential form, a covenant between individuals or groups included: an exchange of gifts or services, a pledge or promise

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based on this exchange, and finally, but significantly, a change of “being” of the covenanted. May argues that the granting by society the status of “professional” to a group of individuals is indeed the establishment of a covenant. Society gives the gifts of education and the privilege of self-governance in return for the profession's inherent talents and abilities. Society promises the health profession that it will grant a virtual monopoly to the profession with the opportunity for significant personal gain. The profession promises to serve society fairly and faithfully. In this covenantal relationship the nature of being is changed. Professionals become physicians/dentists and individuals of society, patients.

Health science professions proclaim consistently their dedication to the service of humankind. This notion of service is elaborated frequently in the various codes of the professions. But, May suggests, this ideal of service succumbs to what might be called the conceit of philanthropy when the professional's relationship to his or her fellow humans is assumed gratuitous, rather than responsive or reciprocal flowing from an altered state of being based in covenant. Statements that obscure the practitioner's prior indebtedness to the community are tainted with condescension.

The covenant is reaffirmed on an individual basis each time two individuals enter into a relationship where one agrees to be healer and the other patient. The duty of a dentist to the patient is more than just obligations incurred by a contractual agreement between two parties, with the exchange of money for services and the potential legal enforcement of the terms should either party violate the agreement. The duty of service, “doing good,” is rooted in the prior covenant of the professional with society. The dentist realizes there is full reciprocity in the relationship. The patient gives of self to the dentist and the dentist gives of self to the patient. Without the dentist giving to the patient, the patient could not benefit from oral care, and without the patient giving to the dentist, the dentist could not be a dentist. This understanding of mutual benefit and reciprocity is essential to a reasonable professional ethic and an appropriate humility.

One further idea must be elaborated before leaving the concept of a professional relationship based in covenant. May in another instance draws the distinction made by Austin between two types of utterances: descriptive and performative. Descriptive statements report an item: “it is raining.” Performative utterances do not merely describe, but alter the world. The promises of the covenant relationship are such performative utterances. In the case of marriage, “I, David, take you, Phyllis” is a performative utterance. The marriage ceremony is a performative occasion; it changes the world for two people as they enter into a covenant. The
professional relationship is similarly promissory and therefore performative. Accepting a patient activates the promise to help faithfully to the limit of one’s professional resources. The moral rule of “keeps your promise” is activated by entering into the covenant relationship of healer-patient. The virtue of fidelity enables one to keep the moral rule of promise. In the provision of complex care that requires a favorable but uncertain biological response by the human organism, it is wise never to promise anything to the patient, save fidelity. “No matter what, I will not abandon you. Should the therapy fail to achieve its goals, I will be here for you, to try again, or to suggest a different therapy.”

Having said that the nature of the relationship between dental medicine and society, and the dentist and patient is one based on a convenantal obligation, it is possible to proceed to a determination of the specific duties of the dentist as a professional. It would be appropriate to also consider the duties of the patient and society based on the notion of covenant. Such a deliberation, while offering a needed balance, is beyond the scope of this paper.

**Characteristics and Duties of the Profession(s)** In the early part of the twentieth century, Abraham Flexner, a reformer of medical education, delineated the duties of a profession. In a speech before the National Conference of Charities and Corrections entitled “Is Social Work a Profession?” Flexner elaborated what have come to be viewed as the six cardinal characteristics of a profession. These traits can be summarized, as is done in the Preface of ADA’s Principles of Ethics, into three: service to humanity, education beyond the usual level; and self-improvement/self-regulation; they can be designated, respectively, as the moral, intellectual, and organizational components of profession. Characteristically, health professionals possess a technical competence in medicine based on a tradition of advanced learning and for which they will be morally accountable, in placing this expertise at the service of humanity. What follows from this understanding of profession for the practice of dentistry?

**Moral Component** Primary to the moral component of profession is the concept of “doing good” for the patient. The moral rules of not doing evil become the moral ideals of preventing evil and the moral duty of promoting good for the patient and society in the area of avowed expertise, oral health. The concept of promoting good is generally specified as the moral principle of beneficence. The goal of the relationship in which one assumes the role of health care practitioner, and the other, patient, is the benefiting of the patient. This benefiting of the patient is accomplished specifically by the clinician in dental medicine by providing the highest quality of dental care possible, contingent to clinical circumstances, the professions’ current understanding, and the patient’s desires. The principle of beneficence can be understood as involving a continuum of actions. At one extreme is “do not cause evil or harm” (non-maleficence), extending through the prevention of evil or harm, the removal of evil or harm, and finally, at the other extreme, the highest conception of beneficence, doing or promoting good. The Hippocratic Oath expresses the duty of non-maleficence together with the duty of beneficence: “I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them” (emphasis added).

In providing benefits, clinicians acknowledge there are inherent risks of harm, which will vary in magnitude from one circumstance to another. Professionals not only have a duty to be positively beneficial as well as non-maleficent, but also have a moral obligation to weigh possible benefits against possible harms, in order to maximize benefits and minimize risks of harm.

The dentist sometimes has a conception of benefits and risks which may be different from his patient’s views. Whose conception of the requirements of beneficence and non-maleficence should prevail? This question introduces a companion principle to that of beneficence, the principle of autonomy.

“Autonomy” is derived from the Greek and means “self-rule”. The most general idea of self-rule is self-government, being one’s own person. The autonomous person determines his or her own course of action in accordance with a self-chosen plan. The moral rule stated previously, “do not deprive of liberty or freedom of opportunity” means that it is moral to grant the right of self-governance to others. This basic moral right is not abandoned in the practitioner’s reception area. Moral dentists generally will not constrain the actions and choices of their patients.

By respecting the patient’s autonomy, dentists provide patients full participation in the decision-making process. The patient requires instruction in the problem(s) associated with oral health, the various goals possible, and the risks and benefits of the alternative modes of treatment in achieving the desired goal(s). An additional factor to be considered is the cost of care weighed against the value to be derived. This balancing of the principle of beneficence with the principle of autonomy in concert with the patient has come to be known as informed consent. The patient’s consent to therapy is gained after the opportunity to freely and intelligently consider the options.

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Culver and Gert have specified three ingredients to an informed (or valid) consent. First, the patient must be provided with adequate information. Faden has emphasized that the concept of adequate information can deteriorate into a mechanical rehearsal of data to legally protect the doctor, unless it is tempered with the idea of comprehension. The dentist is obligated to disclose all the information a rational person would desire in arriving at a decision, but to do so in a manner that ensures patient comprehension. This is done by processing the information in a reciprocal manner, i.e., by asking for patient validation of understanding and requesting and responding to questions. It is important to note that informed consent does not require that the patient be told everything there is to know (an impossible goal), but rather that information adequate and reasonable to making an informed decision. The second ingredient of a valid consent is lack of coercion by the practitioner. Certainly education and persuasion are permissible, but manipulation becomes questionable, and disabling physically or therapeutically is obviously coercive and morally inappropriate. Progressing beyond persuasion toward control as the professional perceives what is best for the patient disregards the patient's autonomy and shows "paternalism."

Etymologically, paternalism is rooted in "relating like a father." It is the claim or attempt to supply the needs or regulate the conduct of a person, in an authoritative manner, as a father might his children. The following assumptions are made when paternalism is used to describe the role of health professionals in care: the professional is acting benevolently; she/he is violating a moral rule with regard to the patient; the patient has not given consent, and the patient is competent to give consent. Paternalism poses moral questions as it involves the claim that beneficence should take precedence over autonomy, i.e., literally, doing perceived good to others in spite of their wishes to the contrary. Occasionally, this may be necessary, and it is possible to justify paternalism. The practitioner might seek to justify paternalistic behavior if the harm prevented outweighs the loss of freedom suffered. Some practitioners and philosophers grant greater weight to beneficence in their balancing, whereas others demand a preeminence of autonomy.

For one reason or another, all patients are not always able to act autonomously. The third and last ingredient of Culver and Gert's formula for informed consent—competence—is not present. Their state, which may be temporary or permanent, is specified as one of incompetence or "reduced" autonomy. Patients may be immature (children), incapacitated, psychotic, coerced by others, or in a position where they can be easily exploited by others. As a consequence of the situation or circumstance the patient is incapable of deliberating rationally concerning the risks and benefits of the options available in care. The health professional's duty in this regard is to attempt to gain as much autonomy for the patient as possible by explaining treatment on each patient's level. This approach applies to children as well. Interestingly, this idea is advocated in clinical literature as being an aid to managing the child's behavior. The concept is based on Ginott's principle of offering children choices and options, not as an issue of ethics, specifically, but rather as a strategy in the enhancement of the relationship. Ginott further suggests the principle of treating the child with respect: this is a virtue notion, but a virtue at the core of the principle of autonomy. In the case of the extremely apprehensive adult, reassuring and calming in the process of informing can help restore autonomy and facilitate a rational decision. Sometimes paternalism in the face of reduced autonomy is and must be justified. Parents must make decisions regarding health care for minors, and the family must make decisions regarding adults incompetent to make decisions concerning their well-being.

- Intellectual Component Quality oral health care presumes competence. This competency is initially certified by the institution of higher education from which the dentist graduates; he/she is then validated by state boards of dental examiners. State practice laws do not generally require periodic recertification, although some do have continuing education requirements for annual relicensure. Regardless, it is the ethical duty of the practitioner to be updated in accepted dental therapeutics through a program of formal or informal continuing education. Dramatic advances in all phases of oral health care have improved understanding of oral disease and procedures. The practitioner who is not committed to lifelong learning and change in practice strategies has difficulty practicing ethically.

- Organizational Component The final category of a profession, using the Flexnerian model, is that of organization. Flexner said, "professional groups have tended to view themselves as organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights or the protection of interests and privileges...organization is explicitly meant for the advancement of common social interest through the professional organization" (emphasis added). There are those who would cynically suggest that whereas Flexner's assessment in 1915 of the purpose of professions in organizing was social good, that purpose has become increasingly secondary to self-interest in the latter years of the century. George Bernard Shaw expressed this sentiment when he said "all professions are conspiracies against the public."

Regardless, from the organizational component
is derived the duty of the dentist to fully participate in the appropriate professional community and its decision-making. This obligation exists for two reasons: to promote justice in society for the fair distribution of society's resources in meeting the dental health needs of the population; and to participate in the establishment and maintenance of professional standards in dentistry and self-regulation of the profession.

Justice is seen by Gert as that attribute, virtue in one sense, that characterizes the person who does not, without reason, violate any moral rules. In that sense, it can be understood as a principle to apply to each patient, that is, treating each patient fairly by adhering to the moral rules. Rawls has argued for two facets of a principle of justice. In the first sense, "each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others," i.e., giving to each his or her fair share, or right. In the second sense, "social and economic inequities" are to be arranged so they are both reasonably expected to be to everyone's advantage, and attached to positions and offices open to all, so-called "distributive justice."

The present discussion focuses on the dentist laboring within the professional organization to ensure societal justice; the patient becomes the patient as they are amalgamated into society at large. Implied is the concept that some goods of dental health are societal, not individual considerations. An obvious example is water fluoridation, where the good is not achieved individually, but through community action. The profession then is obliged to work for the fair distribution of benefits and burdens of oral health among the populace. Although society proclaims the value of all people and supports that proclamation with legal guarantees of equal rights and protection, economic disparities among individuals result in an unjust distribution of society's resources. The dentist is all too familiar with the inequity in oral health that exists between the children of families economically able to purchase care and the children of the poor. Working within the profession to assure that all are treated justly is an ethical duty of the dental health profession.

Professional self-government is the second obligation deriving from the organization component. It is an onerous obligation, and difficult to achieve. The duty to colleagues seems, at least superficially, to take precedence over the obligation to patients in the matter of documenting professional incompetency. May articulates well the requirement of self-regulation:

In order to guarantee to the public that certain standards shall be maintained, the state limits the license to practice to those who have completed a course of professional education. Professionals as a group profit from this state created monopoly. They fall short of their responsibilities for the maintenance of standards if they merely practice competently and ethically as individuals. The individual's license to practice depends on the prior license to license, which the state has, to all intents and purposes, bestowed upon the guild. If the license to practice carries with it the obligation to practice well, then the license to license carries with it the obligation to judge and monitor well. Not only the individual, but also the collectivity is accountable for standards.

To the extent that concern for other dentists prevails over concern for clinical mismanagement of patient(s), professional ethics reduces itself to "courtesy within a guild." But a cautionary note is advised. It is a violation of autonomy of colleagues, that is, a limiting of their freedom or opportunity, if comments are made to patients which could be taken to reflect in a disparaging manner, without surety of the complete facts.

Documentation of specific and repeated breaches of professional behavior by colleagues morally demands that the "whistle be blown." The professions' covenant with society requires the community of professionals to act vigorously in maintaining its moral integrity. Evidence that it is failing to do so will result in a breakdown of credibility with society and damage to the covenant. The privilege of self-government is jeopardized.

The extraordinary duties of the dentist deriving from profession can now be summarized as:

- to benefit patients and their oral health by providing quality care, while respecting their human right to autonomy,
- to ensure the care provided is of the highest standard available from the profession by maintaining current knowledge and skill, and
- to participate fully in the professional community to ensure that society's resources are justly allocated and that the covenant of the profession with society is not violated through the unethical behavior of colleagues.

**Principles of Ethics and Code of Professional Conduct**

Having delineated the ordinary (human) and extraordinary (professional) moral duties of the practitioner of dental medicine, it is now possible to review and critique the dental profession's Principles and Code.

**Historical Development of the Principles and Code**

Burns has written a review of the historical development of codes in American dentistry. The first Code was adopted in 1866 at the sixth annual meeting of the American Dental Association. It was
similar to that of the American Medical Association which had been adopted 25 years earlier, and advocated the virtues of firmness, kindness, sympathy and temperance. Dentists should make no false promises and should explain their professional procedures. A dentist should be a gentleman in all respects and never speak disparagingly of a colleague's practices. In 1880 adoption of the Code was made mandatory for membership in the ADA. The Code was revised in 1899 to encourage consultations and to permit the use of cards and newspapers for advertising names and office addresses. In 1922 the Code was substantially modified. Statements about duties to patients were summarized in a single exhortation: the dentist should conduct himself "in accordance with the Golden Rule." In 1928 a new section was added requiring dentists to report "illegal, corrupt or dishonest conduct on the part of any member of the dental profession" to the proper authorities. This Code also urged dentists to be good citizens and conduct themselves as members of a profession "whose prime purpose is service to humanity." The imperative to be good citizens and serve humanity was omitted in 1944 as was the duty to report illegal and unethical conduct. Added to the Code at that time were two important sentences:

There are many obligations assumed by those who choose dentistry as their life's work, in addition to the foregoing statements. To know the answer to most questions not presented in this Code, we need but to be guided by the Christian rule to do unto others as we would have them do unto us.

Burns suggests this permitted liberal interpretations but was an "invitation to oversimplify the ethical conflicts generated by the emerging social and technical complexities of middle-century dental practice." The Judicial Council of the ADA converted sections of the Code into a set of Principles of Ethics which first appeared in 1955. Subsequent minor revisions occurred in 1958 and 1960.

Two of the changes adopted in 1974 were significant. The first precluded discrimination by dentists in providing care on the basis of race, creed, color, or national origin. The duty to report illegal or unethical conduct, which was deleted in 1944, was restated by making it obligatory to report "gross and continual faulty treatment by another dentist." This revision led Waldman to ask the question, "Is peer review informing?" He states that for too long practitioners took refuge in a "conspiracy of silence," reinstallation of the ethical obligation to review the work of one's peers is an essential ethical duty of a profession. He answers his question by concluding that it is informing, not in the sense of "squealing." Slightly revised Principles were published in 1976 and 1977.

The House of Delegates of the American Dental Association adopted a comprehensive revision of the Principles and Code in its 1979 session. In this revision the Principles are set out separately from the Code. The Principles are stated as general goals toward which "dentists should aspire and are not intended as enforceable rules of conduct." The Code sections were stated to be "design for enforcement through appropriate disciplinary actions." This change was possibly the result of an antecedent change made by the legal profession in its Code of Professional Responsibility. The secretary of the Bylaws and Judicial Affairs Council of the ADA is an attorney, and he indicates that sometimes changes are suggested for dentistry's Code as a result of changes in the attorney's Code. This change is an attempt to distinguish between minimum disciplinary rules, which codes tend to emphasize, and maximal ethical considerations: the so-called "ethics of duty" versus the "ethics of aspiration." The most significant change in the document from 1976 to 1979 was the result of the Federal Trade Commission's order to the ADA on September 6, 1979 "not to restrict or declare unethical, truthful advertising by dentists," pending the final outcome of the FTC's case against the AMA involving the same issues. The order became final with the judgement against the AMA. The Principles in 1976 had stated:

Advertising reflects adversely on the dentist who employs it and lowers public esteem of the dental profession. The dentist has the obligation of advancing his reputation for fidelity, judgement, and skill solely through his professional services to his patients and society. The use of advertising in any form to solicit patients is inconsistent with this obligation.

In 1979, as a footnote to the principle of Profession Announcement (Principle—Section 5), the following statement was made:

Advertising, solicitation of patients or business, or other promotional activities by dentists or dental care delivery organizations shall not be considered unethical or improper, except for those promotional activities which are false or misleading in any material respect. Notwithstanding any ADA Principles of Ethics and Code of Professional Conduct or other standards of dentist conduct which may be differently worded, this shall be the sole standard for determining the ethical propriety of such promotional activities. Any provision of an ADA constituent or component society's code of ethics or other standard of dentist conduct relating to dentists' or dental care delivery organizations' advertising, solicitation, or other promotional activities which is worded differently from the above standard shall be deemed to be in conflict with the ADA Principles of Ethics and Code of Professional Conduct.

In addition to the structural change and the major modification regarding advertising, two changes occurred in the Preface. The citing of the "Golden
Rule" as a guide to professional conduct, which had been deleted previously, was reinstated. In addition, the five characteristics of a profession were condensed to three: primary duty of service to the public, education beyond the usual level, and responsibility for self-government. This summarization emphasized organization for self-government rather than for sharing new knowledge as previously; subsumed continuing education into education generally; and eliminated the previously stated "dedication to service, rather than to gain or profit from service." Advisory opinions which had been published with the Principles in previous years were deleted in 1979. Minor changes occurred in revisions of 1981, 1982, 1983. The publication of advisory opinions with the Principles and Code was reinstated in 1982.

The current Principles and Code have evolved over many years and reflect professional and societal changes. The seven dentists who are members of the ADA's Council on Bylaws and Judicial Affairs are charged with maintenance of the document and the advisory opinions. They lead in suggesting revisions. Any member of the Association can advocate revision through communication with the Council, or directly to the House of Delegates of the ADA through their constituent society and duly elected representatives. House action is necessary on all modifications. The current Principles and Code have not had benefit of consultation by an ethicist. The Secretary to the Council is an attorney and participates in discussions and revisions of the document.

STRUCTURE AND CONTENT OF CURRENT PRINCIPLES AND CODE

The current Principles and Code are introduced by a preface which emphasizes the obligation of the practitioner of dentistry to maintain and enrich the profession's status. The obligation is constant but its fulfillment is said to vary as society's needs change. The spirit of the obligation, therefore, must guide professional behavior and is summarized by the Golden Rule "whosoever ye would that men should do to you, do ye even so unto them." The Preface concludes with a reference to the heritage bestowed by previous generations of dentists in acquiring for dentistry the three characteristics of a profession mentioned heretofore.

The Preface is followed by five sections, each section stating an "ethical" principle of aspiration. In each section, codal duties (enforced by discipline) are expressed which are thought to derive from the "ethical" principle. Additionally, the Council on Bylaws and Judicial Affairs offers "Advisory Opinions," when considered appropriate to assist in understanding the codal duty, particularly as related to current legal requirements.

The first principle is stated in Section 1:

SERVICE TO THE PUBLIC AND QUALITY OF CARE

The dentist's primary obligation of service to the public shall include the delivery of quality care, competently and timely, within the bounds of the clinical circumstances presented by the patient. Quality of care shall be a primary consideration of the dental practitioner.

Examples of codal conduct derived from this principle include: prohibition of discrimination in patient selection on the basis of race, creed, color, sex or national origin; obligation to safeguard confidentiality of patient records; obligation to improve the dental health of the public as well as conduct oneself so as to elevate the esteem of the profession; obligation to make arrangements for emergency care for patients of record as well as patients not of record; obligation to seek consultation whenever welfare of patients can be safeguarded or advanced; obligation to assign auxiliary personnel only those duties which can be legally delegated; obligation to report to the professional society instances of gross and continued faulty treatment by other dentists, and to inform patients of their current oral health status without disparaging comments; permission to provide expert testimony in judicial or administrative action; prohibition against rebates or split fees, and obligation not to misrepresent care being rendered or fees being charged.

The second principle is stated in Section 2:

EDUCATION

The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

No codal obligations are stated to derive from the principle.

Section 3 relates to the:

GOVERNMENT OF A PROFESSION

Every profession owes society the responsibility to regulate itself. Such regulation is achieved largely through the influence of the professional societies. All dentists, therefore, have the dual obligation of making themselves a part of a professional society and of observing its rules of ethics.

Again, no codal duties are specified.

RESEARCH AND DEVELOPMENT is the title of Section 4, containing the fourth principle:

Dentists have the obligation of making the results and benefits of their investigative efforts available to all when they are useful in safeguarding or promoting the health of the public.

From this principle, dentists are obliged to use only those drugs, instruments, techniques, etc.,
whose complete formulae are available to the profession: dentists are given the right to secure patents and copyrights, provided they are not used to restrict research or practice.

The final principle, stated in Section 5, deals with:

**PROFESSIONAL ANNOUNCEMENT**

In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect.

Based on this principle, the dentist is permitted to advertise, although in no false or misleading manner and prohibited from using a trade or assumed name that is false or misleading. (The use of a dentist's name may no longer be associated with the practice after a period of one year.) This principle also encompasses a myriad of specific regulations relative to the announcement of the services of a general practitioner and the specialization or limitation of a practitioner. All these regulations are designed to help the public make an informed selection and to ensure that services are not offered in a false or misleading manner.

**INTERPRETATION AND APPLICATION**

The Principles and Code are followed in their publication by a statement of their purpose, interpretation, and application as understood by the Council on Bylaws and Judicial Affairs.

Their purpose in the postscript is stated “to uphold and strengthen dentistry as a member of the learned professions.” It is further stated that constituent (state) and component (district) societies may adopt additional provisions not in conflict with the Principles and Code which would “enable them to serve more faithfully the traditions, customs, and desires” of their members.

There are provisions for resolving problems of ethics at the local level. If a satisfactory decision cannot be reached, the question should be referred on appeal to the constituent society and the Council on Bylaws and Judicial Affairs of the American Dental Association as provided in Chapter XI of the Bylaws of the ADA. Members found guilty of unethical conduct are subject to the penalties set forth in the Bylaws.

The Constitution and Bylaws provide a systematic process for the hearing and adjudication of charges of unethical conduct. These are written to ensure due process of law to all members. Section 20 of Chapter XI specifies that a member may be disciplined for having been found guilty of a felony, having been found guilty of violating the dental practice act, or violating the Bylaws or the Principles and Code. Disciplinary penalties include censure, suspension, probation or expulsion. Censure is a disciplinary sentence expressing in writing severe criticism or disapproval of a particular type of conduct or act. Suspension means loss of membership privileges for a specified period of time after which full membership privileges are automatically restored. Probation is imposed for a specified period without the loss of rights, in lieu of a suspended disciplinary penalty. Expulsion is an absolute discipline and may not be imposed conditionally.

**A CRITIQUE OF THE PRINCIPLES AND CODE**

The description of the duties of the dentist in reference to ethical theory, and the review of the specific content of the existing Code permits a critique of American Dentistry's guide to ethical behavior and discipline.

An initial difficulty encountered is the failure to acknowledge the indebtedness of the profession to society. The symbiotic relationship of giving and receiving, at work in the professional relationship and discussed in the idea of covenant, needs acknowledgment in order to avoid what in fact occurs in the Code: the expression of a gratuitous service to humanity and an orientation to self-protection.

The opening sentence of the Preface to the Principles is revealing: “The maintenance and enrichment of professional status places on everyone who practices dentistry an obligation which should be willingly accepted and willingly fulfilled.” The initial obligation expressed is self-serving. Although reference is made in the Preface to “the human beings that a profession is dedicated to serve,” the continuing use of the term obligation refers to the initially stated “maintenance and enrichment of professional status,” not to the giving of service to humanity rooted in the gift granted by that humanity. The second and concluding paragraph of the Preface continues this language, lauding the profession for gaining such “stature” through the efforts of previous generations. The same attitude surfaces when stating the obligation of dentists to the community (Section 1-C): “dentists shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.” Again in the statement of principle regarding professional announcement (Section 5) the comment is made, “dentists should represent themselves in a manner that contributes to the esteem of the profession.”

The failure to acknowledge the reciprocity of relationship between profession and society leads naturally to the major failing of the Principles and Code: the failure to acknowledge the principle of autonomy of society and the individual patient. The balancing of the principles of beneficence and autonomy in providing care was stated previously to be a primary ethical duty of a health professional.

The first section of the document addresses the
The concept of beneficence by stating that the primary obligation of the profession is service to the public by providing quality care. This principle of benefiting the patient is advanced subsequently in the Principles and Code: “dentists shall provide any information that will be beneficial for the future treatment of the patient.” (Section 1-B); “obligation to ... improve the dental health of the public,” (Section 1-C); “seek consultation ... when welfare of patients safeguarded or advanced,” (Section 1-E); “obligation of making results and benefits of investigative efforts available to all when useful in safeguarding or promoting the health of the public,” (Section 4). Thus, there are several references to the duty to benefit the individual patient as well as the public. These references need to be balanced by appealing to the right of self-determination on the part of society and the patient, in order to avoid an attitude of paternalism by the profession and the practitioner. Incorporation of the principle of autonomy would necessarily express the concept of the patient's informed or valid consent, a concept not identified in the current Principles and Code. Failure to address self-determination continues to emphasize a common misconception that informed consent is a legal principle, not a moral one, and important to protect the professional in the courts but without relation to the ethical practice of dentistry. In contrast to dentistry's silence on the issue of self-government, medicine has spoken strongly. The Reference Guide to Policy and Official Statements of the American Medical Association states:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. Informed consent is a basic social policy ... Social policy does not accept the paternalistic view that the physician can remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, ... 61

The second professional obligation delineated in the previous section, “Dentists as Professionals," was continuing education. The Principles and Code speak directly and forthrightly to this in Section 2, stating “dentists ... have the obligation of keeping their knowledge and skill current.”

The last two duties were included in the organization component of profession. First was the idea of justice in the distribution of services. Section 1-C, Community Service, suggests that service to the public in providing quality care can assume a community dimension and that dentists have an “obligation to use their skills, knowledge and experiences for the improvement of the dental health of the public.” If dental services are distributed, according to need, not by merit or ability to pay, then the principle of justice is addressed.

The final obligation of self-government is addressed in Section 3 which states: “every profession owes society the responsibility to regulate itself,” and that “dentists have the dual obligation of making themselves a part of the professional society and observing its rules." The duty of self-regulation is also implied in Section 1-G where dentists are “obligated to report ... instances of gross and continual faulty treatment by other dentists.”

At this juncture, comment must be made regarding self-government, its validity and effectiveness. Today laxity reigns professional self-regulation. In 1979, the most recent year for which these data are available, there were 117,223 dentists actively practicing in the United States. The ADA's Council of Bylaws and Judicial Affairs indicates that three practitioners were expelled from the Association for violations of the Principles and Code in each of the years 1981 and 1982. These sanctions do not become specific to membership in the Association, and it is not known whether loss of license to practice dentistry occurred. The American Association of Dental Examiners has not designed to the past collected data regarding loss of licensure from its membership of state boards of examiners. However, effective January, 1982, it is serving as a clearinghouse for disciplinary action by state boards if they choose to supply such information. No cumulative national data are in violation of state dental practice acts is currently available. Clinicians have observed that self-regulation continues to be a problem in the profession.

The general failure of health care professions to reasonably enforce professional standards has led to increased regulation from society's agent, the government. The ruling on advertising by the Federal Trade Commission brought the health professions into a common category with commerce. In essence the FTC said the professions have pretended to be more moral than the marketplace and assumed the right of self-government, but in fact have not regulated themselves. Advertising will encourage competition among health professionals while perhaps elevating their ethics to the level of for-profit businesses. "For the sake of ethics, the so-called professional ethic had to be challenged." The public is challenging as unrealistic and unpractical the notion of professional self-regulation.

Can the concept of professional self-regulation using a document such as the Principles and Code be ethically justified? Veatch wonders if it can and criticizes the concept by suggesting that since the codal statements are generated by the profession, professional duty becomes no more than what the profession says it is. “This is a clear example of the inherent dangers of ethical relativism in professional ethics.” He also suggests that codes are not necessarily grounded in philosophical or ethical thought. Furthermore, he argues that “professional ethics that can be grounded on custom or self-imposed standards without ref-
herence to any higher authority so stretches the meaning of the term ethics that one wonders if it has not been misunderstood. Matters that really count, including those affecting society, cannot be left to the concensus of the group. Society has no basis for assuming on faith that the profession has interpreted the ethical foundations properly in determining the professionals' role. From this argument derives the necessity of societal interaction with the professions in determining a code of conduct. The code is really a covenant with society, the purpose of which is to guide the behavior of professionals in fulfilling their obligations. (This is in contrast to the statement in the postscript of dentistry's Code that the purpose is to "uphold and strengthen dentistry as a member of the learned profession.") It would seem incongruous for one party of a covenant relationship to determine unilaterally its stipulations. From Veatch's argument it follows that dentistry specifically, and the health professions generally, need to seek consultation from the public, and from ethicists, to assist in developing a document that can be acceptable to the two parties of the covenant. The Code, as it exists, cannot provide the basis for regulation, as it has been unilaterally developed.

The issue of self-regulation is subject to debate, even if a mutually approved code is developed. If historical evidence is suggestive, the health professions, including dentistry, have been too protective of the guild at the expense of the public and can expect to have less decision-making responsibility in evaluating and sanctioning the behavior of their members. A hopeful sign, however, is the development and acceptance of programs of peer review and quality assurance by the profession. Many dentists would agree with Young's comment, "it would be wished that these developments had occurred earlier, but the climate of professional attitudes only recently shifted from the traditional desire to maintain total independence from outside forces."

Finally, in critiquing the Principles and Code, application of the principle of individual justice must be considered. "Justice" in this regard is the virtue that motivates the keeping of the moral rules. In what aspects are following the moral rules advocated by dentistry's codal duties? "Don't deprive of freedom or opportunity" underlies the concept of non-discrimination in Section 1-A; confidentiality of patient records in 1-B; and "telling the truth without disparaging comments" in 1-G. "Keep your promises" is implied in making reasonable arrangements for emergency care. "Obey the law" is referenced in "delegating...only...duties which are legal." "Don't deceive" is basic to Sections 1-G and J. "Dentists shall not represent the care being rendered to their patients or the fees being charged for providing such care to them in a false or misleading manner," and "patients should be informed of their present and future oral health status." All codal duties relating to professional announcement are oriented toward not misleading the public and have their origin in the rule "don't deceive."

This critique of the Principles and Code can be summarized by stating that they are deficient in their failure to acknowledge societal indebtedness and subsequent failure to address the right of self-determination. Additionally, they are deficient in failing to provide for public participation and philosophic consultation in their development. While the Principles and Code do not appear to be effective in self-regulation, they do speak to the principle of beneficence. Justice, both in its distributive sense and individual connotation, is addressed, albeit not as definitely or as systematically as desirable.

**SUMMARY AND CONCLUSIONS**

This study has reviewed an ethic for the dental profession based on natural moral order, and expanded by references to the classical characteristics of a profession. The Principles of Ethics and Code of Professional Conduct of the American Dental Association have been reviewed and critiqued. The following conclusions are drawn:

- The dentist has a duty, as a participant in human society, to live a moral life, following the natural moral rules.
- The dental profession and the individual dentist have a duty to recognize the reciprocity of the relationship which exists with society and the duty of covenantal fidelity.
- The dentist has a duty to conduct his or her professional life in accordance with the ethical principles rooted in the moral rules. These are the principles of beneficence; autonomy; and justice, in both its individual and societal contexts.
- The dentist has a duty to keep his or her level of knowledge and skill current.
- The dentist has an obligation to participate in the professional community to help ensure a just distribution of society's resources and to share the burden of professional self-regulation to the extent such a privilege is granted by society.
- The current Principles and Code are helpful expressions of dentistry's professional obligations, but are deficient in not speaking to reciprocity of relationship, the principle of self-determination, and not providing for societal participation in the covenant agreement.
- The profession of dental medicine is not as rigorous in regulation of itself as necessary, causing assumption of increasing degrees of government by society.

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