

Value categories in clinical dental ethics

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Ethics at Chairside is a new *Journal* feature. In this column, we will feature ethical issues faced everyday by practitioners, as well as broader issues affecting professionalism and ethics in dentistry. In this introductory article, the authors identify key value considerations and offer a ranking scheme to assist decision making. Contributions to this column are welcome.

As they care for patients, dentists make decisions that are inherently value-laden and involve choices between conflicting values.¹⁻⁶ Dentistry is a profession and dentists are clinicians, rather than craftsmen, precisely because their decisions are moral choices.⁷⁻¹¹ The focus of this essay is on ethical decision making in clinical dentistry; our aim is twofold. First, the most important value considerations involved in dental decisions, illustrated with short cases, are identified. Second, a ranking scheme for clinical decision making is proposed for occasions when these values are in conflict.

Part one: seven categories of value

Life and health

A 32-year-old man suffers severe facial trauma in a motorcycle accident. General anesthesia would be required for optimal surgical repair of his facial bone fractures, but history discloses he has malignant hyperthermia, a rare reaction to general anesthesia in which the body temperature rises rapidly to temperatures as high as

106 F. Although emergency treatment measures are effective in treating malignant hyperthermia, death may occur. The oral and maxillofacial surgeon discusses the situation with the anesthesiologist, and they decide the risks of general anesthesia for this particular patient are unacceptably high.

The primary concern of both general practitioner and surgical specialist is the life and general health of the patient. Dentists evaluate every patient and weigh every treatment with this value in mind. In this case, the potential risk of death forces the dentist to attempt alternative treatment methods using local anesthetic, even though such methods may be less than optimal from a purely technical point of view.

Appropriate and painfree oral functioning

A 45-year-old woman with severe gingival disease and several painful abscesses is evaluated. The dentist begins treatment, stressing the need for her to floss regularly as part of an ongoing disease prevention regimen.

Another value in dental practice is providing patients with the opportunity for appropriate and painfree oral functioning. This value is a complex one. Although there are general standards of appropriate oral function, the specific nature of such function for each individual patient depends on variables including the patient's age, general health, underlying anatomy, and compliance with dental hygiene. On a daily basis, appropriate and painfree oral functioning is one of the most prominent value considerations in dental diagnosis, prognosis, and therapy.

Preferred practice values

A 50-year-old man has undergone several procedures on an incisor in an attempt to save the tooth. The whole enterprise has been time-consuming, mildly uncomfortable, and costly, but when he asks his dentist why he doesn't just pull the tooth, his dentist replies that, as a rule, dentists believe natural teeth should be preserved whenever possible.

A third set of value considerations in dental care decisions are what we will call preferred practice values. In the course of their efforts to advance dental science and improve dental practice, members of the dental profession identify certain approaches to diagnosis, prognosis, and therapy as preferred approaches. The profession's collective judgment in such mat-

ters is dictated by a concern for a high standard of care. Dental school is a powerful socialization experience in which such preferred patient values, in particular, are inculcated in dental students. Such values, however, may not be shared by dental patients. Among such preferred practice values, as this example illustrates, is the preference for preserving natural teeth whenever possible.

Dentists take these values seriously because of their respect for the collective judgment of their peers; but each practitioner will have his or her own individual preferred approaches to practice, based on clinical experience. Both sorts of preferred practice values, those of the profession as a whole and of individual dentists, are subject to change as dental science discovers new techniques and as practitioners apply these techniques.

Patient autonomy

On his next visit to the dentist, the man discussed in the forgoing example says he has had enough of trying to save the tooth. He says he appreciates the dentist's efforts to save it but requests that the dentist pull it. The dentist agrees to pull it as in his clinical judgment it is an unhealthy tooth, reasonable efforts to save it have failed, and he believes the patient's wishes should be respected.

A fourth important value in dental care decisions is the value of patient preferences or patient autonomy. When patients are competent and capable of deciding between alternative treatments, dentists honor the patient's choice, providing it is reasonable and clinically sound. Autonomy is the value associated with choosing and acting on the basis of one's own goals and purposes, especially in regard to one's own body.¹² We most often express this consideration in the language of "informed consent," where the purpose of the information is to enable patients to make choices consistent with their own values. In the case we describe, the patient has his own values (the saving of time and money) that he uses in deciding that he will not consent to further efforts to save the tooth, but will consent to its extraction. When the patient is not capable of autonomous choice (for example, a child), the dentist consults with the child's parents or guardian in an effort to do that which is in the child's best interests. If the patient was formerly autonomous but is now incompetent (for example, suffering from dementia), one approach is to respect

his or her previously held values and goals.¹³

Esthetic values

An 18-year-old man requires a new crown; his dentist agrees to work on the crown but recommends an expensive porcelain crown instead of a less expensive crown because it will provide a more esthetically pleasing result.

A fifth set of values in dental care decisions are esthetic values. These are important values from the patient's point of view, and dentists often propose treatments and make recommendations in terms of esthetic considerations, as our case illustrates.

Cost

An 18-year-old man requires a crown on a maxillary second molar. After the dentist has explained the different types of crowns available and their differing costs, the patient explains that, given the tooth's location, esthetic considerations are not important to him in the choice of therapy. The dentist then recommends a less expensive crown.

A sixth set of values concern cost. Again we might tend to think of this value category as primarily the concern of the patient rather than of the dentist. The dentist presents the treatment alternatives to the patient, each with its cost and benefit, and the patient makes the choice on the basis of the cost-benefit ratio he or she judges best. However, the ethical implications of cost are different from those of autonomy. Cost considerations factor into decisions in which autonomy is not a central issue, as in this case where the young man has already decided to have a crown. In addition, from the dentist's point of view, there are treatments that dentists refrain from recommending because they are not worth the cost, and there are treatments that dentists recommend cautiously because they know patients will be unable to pay for them. So cost can enter into the dentist's decision-making process as much as that of the patient, and the value of cost is not identical to that of patient autonomy.

External considerations

The patient is a 56-year-old man with alcoholism, altered mental status, and severe periodontal disease. The dentist's

concern is that compliance with dental hygiene is likely to be poor, so she elects to extract all his teeth and make dentures. However, before she proceeds, she has the office secretary contact the county social worker to discuss the patient's social and financial situation.

Finally, a variety of external considerations have a significant role in dental care decisions. The patient's life-style or social milieu may be such that a treatment regimen requiring meticulous self-care is unlikely to succeed. Members of a patient's family may have a voice in care decisions if a patient has diminished capacity for autonomous decision making; or a legal proxy may be necessary. External considerations also include principles of social justice, the allocation of scarce resources, teaching and research values, public safety and welfare, and dentists' other social responsibilities.¹⁴⁻²⁰ This group of values is a large and diffuse one; and it is difficult for dentists to factor in these concerns as they care for patients. Nevertheless, these values are important, and are becoming increasingly important in the current health care environment.

Part two: ranking the seven categories of value

There are often important reasons for distinguishing and ranking items located within one or more of these categories of value. So a hierarchic scheme will allow dentists to determine which factors can and should have a determinative role in ethical decision making. We have focused on these seven categories because we believe that, in the process of clinical decision making, these seven sets of value considerations dominate ethical reflection and therefore deserve the most careful attention. We now propose that they can be ranked in the following order of importance.

1. Life and health

No dentist would propose a treatment that involved significant risk to a patient's life or severely compromised a patient's general health except in the most unusual circumstances. As a general principle, then, we can say that the value of life and health takes priority over and ranks above the six other categories of value. Moreover, the only circumstances in which a dentist might ethically recommend a treatment risking life or health are those in which the oral condition to be treated poses sig-

nificant risks to life or health and the dental treatment might diminish those risks in the foreseeable future.

As our example illustrates, the practice of dentistry requires that general anesthesia be used only when it does not pose a significant risk to the patient's life and general health. Appropriate and painfree oral functioning and preferred practice values (oral and maxillofacial surgeons would probably prefer operating on a patient with oral trauma under general anesthesia), or the better esthetic results that could be obtained, do not override this value. The value of life and health is the highest ranking ethical value involved in dental care decisions.

2. Appropriate and painfree oral functioning

Although this value is not as important as that of life and health, it is a fundamental value in dentistry. Relatively minor trade-offs of function may be accepted for the sake of autonomy, cost, or esthetics. But accepting a trade-off which would leave a patient with significantly impaired or painful oral function, even for the sake of autonomy or preferred practice values, would be unethical practice. Thus, we rank appropriate and painfree oral function as the second most important value in clinical dental ethics.

3. Patient autonomy

The values we have called preferred practice values are identified both collectively and individually by dentists as those approaches most effective in achieving the values of life and health and appropriate and painfree oral function. However, as we have illustrated, their relation to these goals is not absolute, so the patient may choose to have a tooth extracted rather than saved. Do preferred practice values outrank the value of patient autonomy?

The answer depends on the model of practitioner-patient relationship that is considered normative for dental practice. We have argued elsewhere^{1,12} for a model that stresses the autonomy of patients in any matter that is optional from the point of view of the central values of health care (life and health) and of the practitioner's professional specialty (appropriate and painfree oral functioning). Nevertheless, the practitioner's right and duty is to suggest and adhere only to those treatments that would encourage life and health, and appropriate and painfree oral functioning. Suggestions to the contrary, even from the patient, must be rejected by

the ethical practitioner. For example, if a tooth is healthy and the patient requests that the dentist simply remove it, for any number of reasons, it would be ethical to refuse to remove the tooth even though such refusal violates patient autonomy.

With this caveat in mind, the value of patient autonomy ranks before preferred practice values in the hierarchy of values in clinical dental practice. It is the patient's right to decide among the alternative treatments consistent with life and health, and appropriate and painfree oral functioning, even if some of those treatments are not necessarily consistent with preferred practice values. Thus, in the case of the man with a severely diseased tooth, the dentist explains the possibilities, among which would be continued attempts to save the tooth by root canal and capping, as well as the alternative of extraction. The latter is consistent with the values of life and health and appropriate and painfree oral functioning, but inconsistent with the preferred practice value of saving natural teeth. In the end, the patient has the choice; he decides which course of action to follow, which may or may not be that which the dentist would prefer.

4. Preferred practice values

We have seen that life and health, appropriate and painfree oral functioning, and patient autonomy rank above preferred practice values in the context of dentists' ethical decision making at chairside. But this ranking does not mean that preferred practice values are not crucially important in dental care decisions. They rank before esthetic and cost considerations; and, except in specific circumstances, they rank ahead of other external factors. Preferred practice values will have a significant impact on many other aspects of dental practice, besides their role in ethical decision making. For example, they will have an important role in the clinician's selection of the tools and techniques to be used in carrying out a particular treatment, as well as in diagnostic workup and patient management.

5. Esthetic values

Dentists are concerned about the oral and facial appearance of their patients. Oral and facial appearance is important to self-image and to the opportunities that are made and lost for people by virtue of their physical appearance. Nevertheless, the link between preferred practice values

and the higher ranking values is sufficiently strong that dentists usually do not rank esthetic values before preferred practice values. Esthetic values determine priorities among treatments that are equally likely (or nearly so) to achieve the values of life and health, appropriate and painfree oral functioning, and preferred practice values.

But higher ranking values being equal, a dentist would rather produce an esthetically pleasing result than one that might cost less, so esthetic values rank above cost.

This is not to say dentists are ethically obligated to provide more esthetically pleasing work, regardless of cost to the patient. In our case of the young man who chose a less expensive crown, the dentist need not insist on the more expensive option to preserve esthetics. The value of patient autonomy requires that all options that satisfy the two highest ranking values be presented to the patient for consideration and choice. The value of esthetics means, as our case also illustrates, that a dentist would be acting ethically to recommend the most esthetically pleasing treatment above a less esthetically pleasing treatment that would result in financial savings to the patient.

We also recognize, however, that under certain circumstances it would be consistent with the value hierarchy proposed here if a dentist refused to undertake a more esthetic treatment if doing so would mean severe financial loss to the dentist. Such a refusal would be ethical if the dentist informed the patient of the various options so the patient may be able to exercise autonomy and seek financial assistance or alternative care. Sometimes this is necessary when, in dentists' judgment, such economies are necessary to maintain a practice (preferred practice values) in which the higher ranking values could then be preserved. Esthetic values may be ethically sacrificed in such a case, not because the value of money outranks these values, but only because the sacrifice enables the preservation of the overall dental practice and its higher ranking values.

6. Cost

Dentists may ethically recommend, and patients may choose, less expensive dental work. In our example, the patient received the less expensive crown. So it is important to ask in what ways money may ethically influence dental care decisions. Dentists value a great many other things that

can be summarized as cost, as ordinarily, money is the link between care decisions and the achievement of many other values. This is not to say money can buy everything; our point is that there are a great many other things that dentists value besides the categories examined here. So the values summarized in our notion of cost are myriad.

As noted in the previous section, insofar as saving or making money is a means to assuring the achievement of higher ranking categories of value, its pursuit may be quite consistent with the concept of ethical practice. But may cost be ethically considered for the sake of values other than those higher on this ranking? Our answer is, not if any of the higher ranking categories of value are sacrificed for it. Among alternatives that equally achieve the higher ranking values, however, there is nothing unethical in a dentist's recommending a less costly rather than a more costly treatment, simply on the basis of the monetary savings involved.

7. Other external factors

Other external factors are more difficult than the preceding categories to incorporate into an account of ethical decision making. Their influence will vary considerably, depending on factors that may be difficult to perceive in the clinical situation or that are only significant in specialized circumstances. For example, in the case of an alcoholic patient with severe periodontal disease, the advice of the social worker and the demands of social justice are complex elements that the dentist must consider in making an ethical decision. But such external factors, although they should be considered by dentists, would rarely, if ever, be of such ethical significance as to outweigh the values of life and health, and appropriate and painfree oral functioning.

Nevertheless, the principles of distributive justice, of social policy, and of public

safety and welfare are of such importance that we cannot conclude that such external factors might not be weightier than the other values within our proposed hierarchy on certain occasions. In the current atmosphere of cost containment, the professional obligations of dentists regarding the equitable distribution of health care and health care resources should perhaps rank even higher in this hierarchy.^{13,21,22}

Conclusion

This ranking of values for dental ethical decision making at chairside is offered here out of a conviction that it is a reasonable ranking. But even if it is rejected, we hope that it will serve to prompt further reflection and discussion among clinicians. We will be pleased if this essay prompts others to define more carefully the process of clinical-ethical decision making in dentistry. Since ethical values have a central role in the day-to-day activity of dental practice, it is crucial that dentists be thoughtful and articulate about the relative importance of the values that guide their practice of dentistry.

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1. Ozar, D. Three models of professionalism and professional obligations in dentistry. *JADA* 110(2):173-177, 1985.

2. Burns, C. Dentistry: professional codes in American dentistry. In Reich, W., ed. *Encyclopedia of bioethics*, vol 1. New York, Free Press, 1978, pp 314-316.

3. Conway, B., and Rutledge, C. The ethics of our profession. *JADA* 62(3):333-342, 1961.

4. Nash, D.A. Ethics in dentistry: review and critique of *Principles of Ethics and Code of Professional Conduct*. *JADA* 109(4):597-603, 1984.

5. Nash, D. Ethics . . . and the quest for excellence in the profession. *J Dent Educ* 49(4):198-201, 1985.

6. McCullough, L.B. Ethics in dental medicine: a framework for moral responsibility in dental practice. *J Dent Educ* 49(4):219-224, 1985.

7. Jonsen, A.R.; Siegler, M.; and Winslade, W.J. *Clinical ethics: a practical approach to ethical decisions in clinical medicine*, ed 2. New York, MacMillan, 1986, pp 1-15.

8. Siegler, M. The doctor-patient accommodation: a central event in clinical medicine. *Arch Intern Med* 142(10):1899-1902, 1982.

9. Siegler, M. Searching for moral certainty in medicine: a proposal for a new model of the doctor-patient encounter. *Bull NY Acad Med* (57):56-69, 1981.

10. Cassell, E.J., and Siegler, M., eds. *Changing values in medicine*. Fredericks, MD, University Publications of America, 1985.

11. Pellegrino, E. Toward a reconstruction of medical morality: the primacy of the act of profession and the fact of illness. *J Med Philos* 4(1):32-56, 1979.

12. Ozar, D.T. Patient autonomy: three models of the professional-lay relationship in medicine. *J Theoret Med* 5(1):61-68, 1984.

13. Ozar, D.T. The central values of geriatric dentistry. In Chauncey, H., and Hefferen, J., eds. *Clinical geriatric dentistry*. Chicago, American Fund for Dental Education, to be published.

14. Palmer, B.B. The philosophy of dental health service: its relation to the changing social order. *J Am Coll Dent* 48(3):179-192, 1981.

15. Bebeau, M.J. Teaching ethics in dentistry. *J Dent Educ* 49(4):236-243, 1985.

16. Bebeau, M.J.; Rest, J.R.; and Yamoore, C.M. Measuring dental students' ethical sensitivity. *J Dent Educ* 49(4):225-235, 1985.

17. ADA Council on Dental Research. Guidelines for the use of human subjects in dental research. *JADA* 98(1):86-88, 1979.

18. Schiedermayer, D.L., and Siegler, M. Believing what you read: responsibilities of medical authors and editors. *Arch Intern Med* 146(10):2043-2044, 1986.

19. Smith, J.; Fretwell, L.D.; and Zucker, S.B. The dentist's role in combating child abuse. *VA Dent J* 55(3):18-21, 1978.

20. Waldman, H.B., and Schlissel, E. Honor codes and peer review—is peer review really possible? *J Dent Educ* 41(3):126-128, 1977.

21. Siegler, M. A physician's perspective on a right to health care. *JAMA* 244(14):1592-1596, 1980.

22. Ozar, D. Justice and a universal right to basic health care. *Soc Sci Med* 15F(4):136-141, 1981.