Esthetics and Ethical Care
A Look at the Central Values of Dental Practice

The public’s interest in esthetic dental procedures has increased markedly in recent years. Many dentists have been happy to respond to this interest by offering their patients esthetic services not directly connected to procedures that involve preventing or repairing oral health needs. As this pattern of public interest and dentists’ response has increased in intensity, a number of dentists have expressed concern that these trends pose important professional ethical issues. This column will explore one aspect of the ethics of esthetic dentistry, namely the ethics of the decision-making relationship between dentist and patient when the central focus is on the patient’s esthetic enhancement rather than the patient’s oral health.

Esthetic considerations are central to the ethical practice of dentistry. Whenever a dentist is providing oral health services to a patient, one standard of appropriate care is that the dentist’s work conforms to the dental profession’s standards of teeth that are properly shaped and colored within a complete dentition and balanced with gingival and facial features. Every dentist learns about these standards and the dental profession’s commitment to them as part of his or her training. This also is why esthetics was identified as the “Central Values” of dental practice in Ozar and Sokol’s Dental Ethics at Chairside (2002).* In other words, esthetics is one of the chief kinds of benefits that dentists are professionally committed to providing to their patients by means of their distinctive professional expertise. It is rightly considered an ethically significant feature of everything they do.

But if esthetic considerations are central to the ethical practice of dentistry, then how could an increasing interest in esthetics be an ethical problem for the profession? One part of the answer to that question also can be stated in terms of Ozar and Sokol’s Central Values. They point out that, while esthetics is one of the Central Values of dental practice as these are understood in American society today, at least three other Central Values of dental practice rank ahead of it: the patient’s life and general health, the patient’s oral health, and the patient’s autonomy.

Some of the ethical concerns that have been raised about dentists’ increased interest in esthetic dentistry are based in the fear that dentists might be providing esthetic services that actually place patients’ oral health, or even their general health, at risk. If that were the case, obviously such practices would be unethical (specifically by violating one or both of the highest ranking Central Values of dental practice in favor of a lower ranking value). But the ethics of such practices are easy to articulate, and it is the subtler ethical issues concerning the dentist-patient relationship and the Central Value of patient autonomy that we wish to examine here.

For the purposes of this essay, therefore, let us assume that we are talking about dentists who have carefully evaluated the esthetic procedures they employ to be sure they do not place patients’ oral or general health at significant risk, at least insofar as contemporary research is able to determine. Let us also assume that the dentists we are talking about practice only those esthetic procedures that they have studied carefully and are fully competent in employing for their patients. Even with these obviously necessary ethical safeguards in place, there are still some subtle ethical questions that arise when we look carefully at the third ranking Central Value of dental practice, the value of the patient’s autonomy.

Consider the differences between these two scenarios. (In both scenarios, assume that the patient is a 41-year-old successful real estate broker who has been a regular patient of Dr. Burns, a general dentist, for more than five years.)
The patient practices excellent oral hygiene. Dr. Burns has just completed routine prophylaxis and a routine checkup of the patient’s healthy dentition. In both scenarios, from the point of view of dentistry’s own professional standards, the patient’s teeth are well within the normal range in terms of shape, color, and placement.

Scenario No. 1 (Cheryl Jones): “My friend, Betsy, who also is in real estate, has the prettiest teeth, and she told me that her dentist did the whitening for her in his office. Is this something you can do?”

Scenario No. 2 (Mary Anderson): “I am a bit embarrassed to say it, doctor, but I am always thinking that people are staring at my teeth, because they are so discolored. I have seen advertisements on television about making teeth whiter. Is this something you can do?”

Both patients are asking the dentist to discuss a service that the dentist, on our assumptions, can provide competently and safely. Would the conversation between dentist and patient be ethically satisfactory, therefore, if Dr. Burns simply said, “I have taken some excellent workshops on whitening techniques that would be appropriate for you,” and began describing the relevant esthetic procedures and appointing the patient or is that too simple?

One possibility is that the dentist should take more time and have a more careful discussion with Mary Anderson. Her request for esthetic enhancement presumes that her dentition is esthetically defective when her dentition is esthetically normal by professional standards. Of course, the patient’s esthetic values for dentition are not necessarily the same as the profession’s. But a person who makes a judgment for esthetic services on the basis of an assumed defect may be choosing without complete information and also may be choosing on the basis of an incomplete sense of his or her own worth as a person and as a chooser. Every patient who is capable of decision-making must be carefully informed of the professional evaluation of his or her dentition to make a careful choice of treatment. Many patients need additional enabling in order to function as effective choosers because of their fear of dental procedures, their inappropriate deference to authority figures, and other reasons. Thus, the processes of enabling the patient to make a fully autonomous decision about treatment involves diagnosing not only the condition of the oral cavity, but the extent of the patient’s ability to understand his or her situation and to exercise good judgment and make a careful choice. Ethical practice requires the dentist to be habitually attentive to these matters and respond to each patient, as much as is feasible, with the education and enabling support that the patient needs.

Mary Anderson needs to be informed that her teeth are not discolored from the point of view of what is normal in
human teeth. This does not mean she should stop inquiring about whitening if she desires it, but she should recognize that her current condition is not properly considered a defect. It is also unlikely—given that her dentition is normal in appearance—that people are staring at her because of her teeth. So Dr. Burns should probably recommend that Mary think carefully about the matter and perhaps seek the advice of family or friends before making a decision. Dentists are trained to provide some of the basic kinds of listening and counseling that might be warranted by Mary’s preoccupation with others’ perceptions of the color of her teeth. At a minimum, suggesting that she make her decision with more advice and, in any case, that she give it more reflection, would be an appropriate way to try to lead her to a more balanced and careful decision for esthetic enhancement.

What about Cheryl Jones? Her words are matter-of-fact and offer no hint of an impoverished view of her dentition or of herself. Would it be ethically adequate for Dr. Burns to simply proceed by describing the appropriate esthetic procedures and appointing the patient? In a way, the answer in this scenario is even more subtle than the other. Few human beings who are concerned about their appearance are truly simply matter-of-fact about it. The sorts of concerns that are obvious in the Mary Anderson scenario—about particular aspects of personal appearance, about how others view them, and a person’s judgment of their own worth and capacity as a chooser—are often only slightly below the surface in matters of personal appearance, even if skill in social communication enables a person to talk about them in a matter-of-fact manner.

Perhaps Dr. Burns should routinely say more than “I have taken some excellent workshops on whitening techniques that would be appropriate for you,” and proceed to describe relevant procedures. Every dentist who is approached for esthetic services by a patient should perhaps say instead, “I have taken some excellent workshops focused on whitening techniques that would be appropriate for you. But this is an important, elective decision, and often one in which a person can be influenced by what is fashionable at the time. I suggest we talk about your goals in considering whitening....”

This is one of the ethical complexities of dental treatment that focuses primarily on esthetics rather than on oral health. Dentists are dealing with matters in which the patient’s subjective esthetic judgments are central to the decisions that the patient and dentist will make together. But in this instance, the dentist has no professional expertise in such subjective esthetic matters, much less in the subtle issues of self-image, self-worth, psychological deficits in the capacity for independent, autonomous judgment, and choice in esthetic matters. Properly enabling the patient’s autonomous decision and keeping the Central Value of the patient’s autonomy as a higher-ranking priority above esthetic considerations are simply more difficult when oral health is not the central focus of the dentist’s services.

A second aspect of the dentist-patient decision-making process that deserves comment is the fact that some of the esthetic procedures currently available have not been around long enough to assure patients of their long-term esthetic effects. Even if we assume that there has been sufficient research to assure dentists and their patients that these products and procedures will not harm oral or general health in the long run, for many of them we have had only a decade or so of experience (if that) concerning their esthetic effects. This raises the question of how much this uncertainty about long-term esthetic effects ought to be part of an ethically adequate communication between dentist and patient.

A third area of ethical inquiry arises if the dentist is the one initiating the conversation about esthetics. Consider two more scenarios that take place at the end of a routine exam in which the patient has said nothing at all about esthetic matters. (Assume the same kind of patient as above, and assume the same safety-preserving assumptions about the dentist’s training and choice of esthetic procedures.)

Scenario No. 3 (Dr. Tremont): “Well, your teeth are healthy and strong. But I was wondering if you have noticed how the fashion is moving toward whiter teeth. You do not have any exceptional staining, just the natural changes in color that are perfectly normal for your age. But I know you are constantly in the public eye in your business and I was wondering if the new techniques that have been developed for whitening teeth safely are something you would care to discuss.”

Scenario No. 4 (Dr. Martin): “Well, your teeth are healthy and strong. But I have noticed that they have been gradually changing color and getting duller in tone as you have gotten older. I know you are constantly in the public eye in your business and I was wondering if you would care to discuss the new techniques that have been developed for whitening teeth safely.”

In Scenario No. 3, the dentist suggests a negative judgment about the patient’s appearance without explicitly saying so. In the business and sales world, this is known as planting the seed. In Scenario No. 4, the dentist offers such a judgment expressly. If dentists were simply members of the public, discussing appearances in casual conversation, their comments would be brash at worst, unless they were friends of these patients who knew their comments on their friends’ appearance would be either welcome or taken properly. But dentists are never members of the public to their patients. Like it or not, they are authority figures on matters of the oral cavity. Therefore, it is appropriate to ask if dentists have any professional expertise in subjective esthetic judgments, whether grounded in current fashion or offered without context. The obvious answer is that they do not.

In these two scenarios, then, not only are all of the ethical issues mentioned above in evidence, but we must add to them the significant ethical issue of misuse of authority. In these two scenarios, the dentist not only fails to enhance and enable patients’ autonomy, but may actually inhibit the patients’ ability to make a careful, autonomous decision in the matter. Comments of this sort, of course, are thoroughly commonplace in our lives, but they are commonplace as instances of marketing in our society’s commercial enterprises. The fact that we are familiar with them does not justify their use in professional practice.
of the ethics of the dental profession, there are serious ethical problems with dentists making such comments. Each and every dentist, by the nature of his degree and admission into the dental profession, is also an authority figure. The position of dentists as professionals thus significantly increases the influence of their suggestions. Furthermore, in making such comments, the dentist is setting aside the professional relationship between patient and professional in favor of the competitive relationship of the commercial marketplace. Not only is the dentist risking the essential trust relationship that is at the core of being a professional with regard to this particular patient, but he or she also is risking loss of this trust relationship with other patients who know this patient. Because every dentist is always also a representative of the whole profession, the dentist is placing the trust of the entire profession at risk. In addition, the hidden features of this now-commercial relationship will often remain hidden, because patients who lose their professional trust in their dentist will look for another dentist, while those who are happy with a commercial relationship with their dentist will remain. There is more that needs to be said about the professional ethics of the trend toward dental services that are not principally aimed at oral health. But the concerns discussed here, which relate specifically to the ethics of the relationship between individual dentist and individual patient, are serious enough to deserve careful consideration.◆

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David Ozar, PhD, is professor and co-director of graduate studies in health care ethics in the Philosophy Department of Loyola University Chicago. He was the founder and first president of the American Society for Dental Ethics (ASDE) in 1987. He served as president again in 1998, as its unofficial executive director from 1989 until 1993, and formally as its executive director from 1999 until 2005. He has published more than 100 articles about ethics and social issues in professional journals and scholarly books, and is the co-author, with David Sokol, DDS, of Dental Ethics at Chairside.


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