Important Notice

This is one of a series of ethical dilemmas published in the Texas Dental Journal between 1993 and 2005. The lead author of these dilemmas, Dr. Thomas K. Hasegawa, died tragically in 2005. The dilemmas remain an important legacy for dentistry.

Format

Each ethical dilemma was originally introduced in one issue of the Texas Dental Journal with the question, “What would you do?” The more expansive analysis of the dilemma was presented in a subsequent issue. The second page of this file depicts the cover of the issue containing the analysis of the dilemma, not the issue containing the briefer introduction to the dilemma. The ethical dilemmas were compiled for digital use by the American College of Dentists in 2008.

Purpose

This ethical dilemma and the other dilemmas in the series are only meant to further your knowledge and understanding of dental ethics by presenting, discussing, and analyzing hypothetical ethical dilemmas that may occur in dental settings. The dilemmas are not intended to: a) provide legal advice; b) provide advice or assistance in the diagnosis or treatment of dental diseases or conditions; or c) provide advice or assistance in the management of dental patients, practices, or personnel.

Terms of Use

To use the digital ethical dilemmas in the series, all or part, you must first agree to the Terms of Use specified at https://www.dentalethics.org/termsofuse.shtml. By using this dilemma, or any in the series, you are affirming your acceptance of said Terms of Use and your concurrence with the Purpose presented immediately above.

Permission

The ethical dilemmas are used with the permission of the Texas Dental Journal.

Support

For more information about this series of digital ethical dilemmas, contact:

American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614
301-977-3223
fax 301-977-3330
office@acd.org

Version 1
2008
Ethical Dilemma

What Would You Do?
Ethical Dilemma #22

It is the end of a particularly frustrating day for Dr. Foster. Three emergency patients added stress to an already full schedule. That, however, was not the only source of frustration. Two of the patients were new exams, healthy patients in their 30's, with almost identical dental needs. Both patients had faulty four-surface amalgam restorations on three molars. Both had centric cusps of the molars compromised by the large restorations and there was cusp wear due to group function occlusion, although there was no evidence of bruxism.

The concern was the difference between the final treatment plans for both patients. Ms. Stevens has a fee-for-service dental plan, and her treatment plan included build-ups and crowns. The treatment plan for Ms. Nance, who is in a capitation program, included four-surface, pin-retained amalgams. Dr. Foster did not include crowns as recommended treatment for Ms. Nance.

Ms. Nance is one of a growing number of capitation patients in Dr. Foster's three-year-old general practice. The $6 per-month, per-member premiums for the 4,000 employees allowed for more coverage two years ago when Dr. Foster first joined the plan. The usage the first year was about 10% but that rate is now approaching 40%. The plan provides for two yearly dental examinations and prophylaxis. With the increase in usage, however, the practice must absorb more of the cost of the care.

Dr. Foster is facing an ethical dilemma. Check the course(s) of action that you would recommend to Dr. Foster and mail or FAX this page, or a note suggesting your recommendation, as instructed below:

1. _____ go with the original plans for both patients;
2. _____ provide crowns for both patients and absorb the loss;
3. _____ go with Ms. Nance's crowns but limit further capitation patients; or
4. _____ other alternative (please describe) ______________________________________

SEND YOUR RESPONSE BY July 6, 1995 ATTENTION: Dr. Thomas K. Hasegawa, Jr.
Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677 or FAX to (214) 828-8952.
Ethics of Managed Dental Care

Response to Ethical Dilemma #22

It is the end of a particularly frustrating day for Dr. Foster. Three emergency patients added stress to an already full schedule. That, however, was not the only source of frustration.

Two of the patients were new exams, healthy patients in the 30s with almost identical dental needs. Both patients had faulty four-surface amalgam restorations on three molars. Both had centric occlusions of the molars compromised by the large restorations, and there was wear due to group function occlusion, although there was no evidence of bruxism.

The concern was the difference between the final treatment plans for both patients. Ms. Stevens has a fee-for-service dental plan, and her treatment plan included buildups and crowns. The treatment plan for Ms. Nance, who is in a capitation program, included four-surface, pin-retained amalgams. Dr. Foster did not include crowns as recommended treatment for Ms. Nance.

Ms. Nance is one of a growing number of capitation patients in Dr. Foster's three-year-old general practice. The $6 per month per member (pmmp) premiums for the 4,000 employees allowed for more coverage two years ago when Dr. Foster first joined the plan. Usage (by employees) in the first year was about 10 percent, but that rate is approaching 40 percent. The plan provides for two yearly dental examinations and prophylaxis. With the increase in usage however, the practice must absorb more of the cost of the care.

Dentists who responded to Dr. Foster's dilemma chose each option: 1) go with the original plans for both patients; 2) provide crowns for both patients and absorb the loss; or 3) go with Ms. Nance's crowns but cap further capitation patients. Other alternatives were identified and are included in the response.

Dr. Foster's dilemma inspired more correspondence than any previous case. Dentists identified an array of considerations and concerns that resonate throughout the health care literature. The letters marked the range and polarity of opinions about managed care. We have selected four ethical issues in managed care including: 1) capitation: public health and/or cost containment; 2) fidelity in the face of cost containment; 3) gaming the system; and 4) quality of care: the real issue. The brevity of this response can only offer an interview of these issues.

Capitation: Public Health and/or Cost Containment

Early capitation programs in dentistry held public health benefits as a primary goal. The dentist Max Schoen developed the dental component of a capitation program for the children of ILWU-PMA workers in Los Angeles. The goal of the program was the achievement of the "best possible oral health status of the enrollee at a reasonable cost" and care was provided from 1954-1966 (1).

Core features of this program included aggressive stimulation of regular use of care, few exclusions, limitations and copayments, capitation payments that were sufficient to cover average provider costs with care provided by broad-spectrum group practices with no intermediaries. Goals for the program included high use (86.5 percent overall), completion of initial care, and regular maintenance care. From this early experience, Schoen noted that, "the original 'public health' concepts of 'population dentistry' could be achieved by a financially viable group dental practice receiving reimbursement on a capitation basis (1)."

Schoen commented that the current capitation system has low utilization rates, high benefit levels for patients and few copayments (but often with significant limitations and exclusions). Capitation premiums target marginal rather than average costs, with care provided by a "dentist on every corner" arrangement rather than conveniently located larger facilities. He concluded, "With few exceptions, existing capitation plans, predominantly networks, must be considered public health failures, in that they do not adequately attend to the needs of the eligible populations"
they are supposed to serve," and, "The special shame of capitation is that a concept, where feasibility was demonstrated, has, with few exceptions, been perverted (1)."

Cost containment is a primary goal of current dental programs. The yearly capitation rate in Schoen's 1954 program was $60 per year per child (2), a figure that was "low but competitive with fee-for-service options (1)." By 1993 standards, that yearly amount is equivalent to $332, or about $28 ppm (2). A profile of four independent practice network plans examined capitation reimbursement, and it was estimated that a capitation reimbursement of $6.94 ppm (comparable to Dr. Foster's $6.00 ppm plan) would cover 35 percent of the average cost of providing care for patients. At overhead costs over 50%, this would neither meet the overhead nor begin to compensate the dentist (1, 2). Schoen observed "the incentives to undertreat and to cut corners are enormous (1)."
The philosopher David Ozar describes this as a "terrible ethical bind" that places pressure on a dentist to consider providing inadequate treatment for patients (3).

Dr. Foster's capitation plan has high benefits (100 percent of crowns with no copayments) with low premiums and a high utilization rate. Will his practice survive? Will patients

---

### What Would You Do?

**Ethical Dilemma #24**

Ashley Jacobs is a new patient in your general practice who has recently moved with her family from Seattle. Her father is in the oil and gas business and the family has moved six times in the last four years. She is 16 years old and her mother reports that she is in good health. Her vital signs are within normal limits and she has had the usual childhood diseases.

Your first impression is that she looks very thin at 5'4" and 105 pounds. She has received yearly dental examinations, and her mother notes that she has had few fillings although her teeth have been more sensitive to cold these last three years. Ashley stopped eating ice cream and drinking cold drinks about the same time, and her mother notes that her weight is about the same since then.

Ashley has a quiet, pleasant demeanor and answers questions with a yes or no. As you begin your examination she immediately asks, "please don't use water or air on my teeth." Her previous dentists, she explained, avoided using cold water or air. The oral examination reveals mild to moderate enamel loss due to acid erosion on the lingual surfaces of the maxillary centrals and laterals.

As you ask if she ever has any problem with "sour stomach" or vomiting, she becomes very nervous and upset. "How do you know that?" she asks, and says "maybe I have an occasional problem with vomiting." You explain that acid from vomiting causes erosion of the enamel and that chronic vomiting may be a serious health problem. Ashley breaks down and admits that she frequently self-induces vomiting. She and a few friends have the "same problem." She pleads, "please don't tell my mother, she'll just freak out! I'm better now and my mom doesn't need to know."

You are faced with an ethical dilemma. Check the following course(s) of action you would take here and mail or FAX this page, or a note suggesting your recommendation, as instructed below:

1. _____ follow Ashley's recommendation and avoid telling her mother;
2. _____ ask Ashley to tell her mother or you will;
3. _____ inform Ashley that you will inform her mother, as you are concerned for her health;
4. _____ inform Ashley that she may need professional help and that not telling her parents may contribute to further medical and dental problems; or
5. _____ other alternative (please describe) ____________________________________

**SEND YOUR RESPONSE BY OCTOBER 6, 1995 ATTENTION: Dr. Thomas K. Hasegawa, Jr. Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677 or FAX to (214) 828-8952.**
Ethical Dilemma

be undertreated because the plan is underfunded, or will Dr. Foster defer care for the capitation patient that he would normally recommend to fee-for-service patients? Or will he find more efficient ways of practicing, thus lowering his overhead (4)?

The incentives are clear. In capitation-based reimbursement programs, profits are received up front, favoring less treatment — just the opposite of service-based reimbursement (5). Dr. Foster appears to have made a decision that, as one industry representative stated, “can lead to serious negative practice possibilities (6).”

Dentists’ advice to Dr. Foster included: “look over the plan for ‘how to quit’ and follow the instructions”; “renegotiate the capitation plan or get out”; and “if the company he has contracted with is not providing him with an adequate return, then he should withdraw from the plan.” Another dentist found that “properly blended with fee-for-service, a capitation plan can be a nice addition to a practice.” He continues, “In fact, when indemnity insurance first came around, much of the same talk (about third-party interference) was going on, but who would like to eliminate that from their practice?”

Dr. Foster’s plan could place him in serious financial risk. Dentists are advised to recognize and avoid poorly managed or underfunded DHMO’s (7, 8, 9), and they are not required to sacrifice their practices to meet unreasonable contractual agreements. The ADA has prioritized managed-care education (10) in response to ethical concerns by member dentists. The ADA and state dental associations have personnel to advise dentists about managed-care affiliations.

Fidelity in the Face of Cost Containment

The philosopher Haavi Moreim observes: “Cost containment challenges medicine to its very core. Conflicts of interest and of obligation, always a part of medicine, arise on a scale not seen before (11).” Can health care providers uphold the promise of fidelity to patients by protecting the patients’ vulnerability and promoting their best interests while also serving as gatekeepers for resources, financial, professional and otherwise?

For example, financial incentives in medicine limit the use of diagnostic tests, referrals to other physicians, hospital care, or other ancillary services. Physicians may receive bonuses from a managed-care plan or have their fees withheld to make them more cost-conscious. Thus, patients’ needs may conflict with the financial interest of physicians in a managed-care plan (12).

Some dentists who responded to the case failed to see how this financial conflict would produce a moral conflict. One said, “The obvious correct answer is to provide the proper dentistry for both patients, regardless of the insurance. One should do this for the capitation patient or get off the plan.” Also, “I fail to see how there could be any possible choice of the correct course of action other than performing, or offering to perform, the best possible service for both patients. That the fact that the insurance coverage differs for the two patients should have absolutely no bearing on the issue at all.” Another said that the dentist should ethically “do the crowns and absorb the costs, and realize that as long as he is in this plan that is what he will continue to do, absorb the costs.”

In response to the ethical issues about managed care, the ADA Council on Ethics, Bylaws and Judicial Affairs published the following statement:

The dental profession is challenged today to maintain its high ethical standards in the face of changes in the dental marketplace and the growth of managed care. The ethical statements subscribed to by the profession place the patient’s welfare above any other consideration. Although the method of health care delivery may change, the overriding duty of the dentist will always be to provide quality care in a competent and timely manner.

Dentists who enter into managed care agreements may be called upon to reconcile the demands placed on them to contain costs with the needs of their patients. Dentists must not allow these demands to interfere with the patient’s right to select a treatment option based on informed consent. Nor should dentists allow anything to interfere with the free exercise of their professional judgment or their duty to make appropriate referrals if indicated. Dentists are reminded that contract obligations do not excuse them from their ethical duty to put the patient’s welfare first (10).”

This is consistent with the TDA Code stating, “Dentists should merit the confidence of their patients by rendering appropriate service and attention, competently and timely, based upon the patient’s right of informed self-determination.” It also asserts that “Trust by the public that serving only their true dental needs with appropriate quality care is the heart of the patient-dentist relationship (13).”

Gaming the System

With the emergence of new managed care arrangements, physicians are steadily losing their accustomed control over the resources for the patients (13). The ideal that the health care provider’s duty is to the patient, not to society or to insurers (14), is increasingly challenged by systems that have productivity requirements and link providers salary incentives and bonuses to reduced use of tests and procedures for patients (15, 16). Providers may resort to gaming the system to secure resources for their patients, hospital or themselves (13).

There are several ways that a health care provider could game the system and lower the quality of patient care. For example, by not attending to patients in the plan, the dentist violates the principle of nonmaleficence, or avoiding harm. This may include rationing by inconvenience, by not preappointing or recalling capitation patients. There is also a violation of veracity, or honesty, as the patients...
Ethical Dilemma

may assume this is standard for all patients and not those in a specific managed-care plan. Then there are justice issues, particularly contractual justice with the patient and the payer. The patient has paid for dental care based on the assumption that the care will be available, meet reasonable standards, and will comply with the benefits promised by the plan. Gaming is morally and medically hazardous and short-sighted (13). If Dr. Foster finds himself tempted to game the system, he should approach the payer and openly challenge or terminate rather than undermine the contract.

Quality of Care: The Real Issue

Treating similar patients differently; misleading, if not deceiving, patients; gaming the system; all these developments make it evident that quality of care is the real issue behind managed care. While it is true that perverse incentives underlie the fee-for-service system, the financial incentives imposed in managed care are no less perverse — and may be much worse. Under the fee-for-service system, providers make more by doing more. Under managed care, they make more by doing less. Under fee for service, my health isn’t at risk, but my pocketbook is. Under managed care, my pocketbook isn’t at risk, but my health is.

As the health care system moves forward toward the next century, it must come to grips with two “needs”: the need to control health care spending and the need to maintain — if not improve — quality. If managed care is to remain a viable method of reimbursement, it must become compatible with the highest quality of care. Many dentists are understandably skeptical that managed care and quality care can coexist. If managed care is to remain with us, the burden must fall on those who run managed care systems to establish policies and capitation rates that ensure quality care.

Conclusion

Assuming that the patients have similar needs, Dr. Foster is ethically bound to provide the same care for both Ms. Stevens and Ms. Nance. Despite the type of insurance plan, the dentist’s primary professional obligation is to benefit the patient by providing competent and timely care. Ms. Nance’s capitation program may be an example of a plan that is unreasonable, placing the dentist at financial risk. If Dr. Foster is tempted to game the system or lower the quality of care for his patients in the capitated plan, he should pursue renegotiating or terminating the contract.

References

9. Mayes DS. “Show stoppers”: Serious flaws to be aware of in a DHMO. Dentistry and Managed Care News 1995; 2(3):6, 8.

EDITOR’S COMMENT: Responses to the ethical dilemmas are views of the contributors and consultants and not Baylor College of Dentistry, the National Center for Policy Analysis or the Texas Dental Association. Questions about managed care may be addressed to either Ms. Bonnie Simpson, Director of Dental Care Programs or Ms. Sally Hanners, Director of Governmental Affairs at the Texas Dental Association. Address your comments to Dr. Thomas K. Hasegawa, Jr., Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677, for fax to (214) 828-8952.

Errata

There was one error in Case #21, “Dental School Blues.” It reads: “A recent survey of U.S. dental schools found comprehensive care programs increasing from 25 to 40 schools between 1989 and 1993.” (4) Correction: “A survey of 56 dental schools found that 25 (61 percent) of the 41 respondents have comprehensive care programs.” (4)