The Ethical Complexities of Dual Relationships in Dentistry

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Abstract

Dual relationships hold the potential for conflict because each relationship involves expectations for behavior and these expectations may be inconsistent. Examples are provided in the dental situation involving romantic, social, financial, and familial second relationships. Care must be exercised by dentists not to abuse the power of their position.

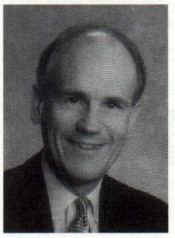
Dual relationships are created when a professional enters a second, nonprofessional relationship with a current patient or initiates a professional relationship when an existing social or business relationship is already in place (American Psychological Association, 1992; Pope, 1991; Sonne, 1994). For dentists, dual relationships occur when family members, close friends, or employees are patients, or when a dentist develops an intimate relationship with a current patient. Barter and business arrangements with patients can also produce dual relationships (Keith-Spiegel & Koocher, 1985).

Dual relationships can be harmful when they interfere with the professional's obligation to place the patient's care and well being before the professional's own interests (Gabbard & Nadelson, 1995; Keith-Speigel & Koocher, 1985). Specifically in regard to treatment, dual relationships can result in changes in expectations that may undermine the patient-professional alliance. They can distort the objectivity necessary for clinical assessment of a patient's behavior and adversely affect the patient's decision-making ability regarding treatment, as well as make confidentiality difficult to maintain (Chiodo & Tolle, 1995; Gabbard & Nadelson, 1995; Keith-Spiegel & Koocher, 1985).

While dual relationships are specifically restricted in the ethical codes of professionals offering psychotherapeutic services, dentistry's ethical code contains no such prohibitions (American Dental Association, 1999). Does dentistry need to be concerned with the ethical issues produced by dual relationships? Many dentists take such relationships, especially those in which family members are patients, for granted. Indeed, many dentists would never have completed their training and licensure if family members had not been willing to be their patients. But since dentistry produces interpersonal relationships characterized by trust, and since dual relationships place the professional in a position to misuse this professionally ascribed trust, the question of the ethics of dual relationships in dentistry requires careful consideration.

Non-Dental Health Professionals and Dual Relationships

The most common restriction concerning dual relationships among the ethical codes of different professions is the uniform prohibition against sexual involvement with current patients (Gorlin, 1994). Because of the



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The authors would like to acknowledge the contributions made by Dr. David Ozar and Dr. James Rule in their critical reading and editing of this paper. We would also like to thank the three initial reviewers of this paper for their insightful suggestions.

special nature of the psychotherapeutic alliance, engaging in a sexual relationship with a patient is viewed as harmful to the patient, represents a breach of professional trust, and is considered a serious ethical violation for psychiatrists, psychologists, and social workers (Gorlin, 1994; Plaut, 1997; Pope, 1988; Stasburger, Jorgenson, & Randles, 1995). The seriousness of this violation for psychotherapists is indicated by the recent movement in several states to criminalize the act of engaging in sexual activity with a psychotherapy patient (Stasburger, Jorgenson, & Randles, 1995).

Physicians' and chiropractors' ethical codes also contain prohibitions against sexual relationships with current patients. The American Medical Association's Code of Conduct warns that sexual relationships with former patients may also be unethical if the emotional condition the patient experiences after termination of the professional relationship is not sufficiently different from the condition that existed while the patient was being treated by the physician (American Medical Association, 1991; Gorlin, 1994).

Likewise, nonsexual dual relationships may also have the potential to cause harm. Psychologists, counselors, and social workers are prohibited by their codes of ethics from entering any secondary relationships that might exploit the patient's trust, and physicians are advised by the American College of Physicians against treating family members (Gorlin, 1994). Psychology's code of ethics warns that bartering with patients may evoke difficulties with dual relationships (American Psychological Association, 1992).

While other professions monitor dual relationships carefully, the profession of dentistry has paid little attention to dual relationships. The dental code of ethics makes no mention of multiple relationships (American Dental Association, 1999). In the dental ethics literature, several writers have discussed the difficulties associated with specific types of dual relationships, such as having sexual relationships with patients (Jorgenson & Hirsch, 1994; Rozovsky, 1989) or treating family members (Chiodo & Tolle, 1995). However, these articles focus on specific situations and do not examine the broader ethical issues evoked by dual relationships. What have other professions identified as the ethical issues raised by dual relationships, and how do these types of issues apply to dentistry?

When dental decisions are influenced or changed in a way that places the dentist's personal interests first, this can result in treatment that does not serve the patient's needs.

Problems Caused By Dual Relationships

Dentists are ethically bound to place their patient's care and well being before their own interests in most matters. This subrogation of self-interest permits patients to trust their dentist, knowing that the dentist will act in their best interests. A similar relationship exists between the trustee of an estate and its beneficiaries and is referred to as a "fiduciary relationship" (Plaut, 1997; Jorgenson & Hirsch, 1994). According to several writers, the critical problem caused by a dual relationship is that it may change the fiduciary relationship (Keith-Spiegel & Koocher, 1985; Gabbard & Nadelson, 1995). Having a second relationship with a patient is a problem because it violates a basic rule: The patient's needs are no longer the only consideration for the dentist. When dental decisions are influenced or changed in a way that places the dentist's personal interests first, this can result in treatment that does not serve the patient's needs. There are several ways the dental relationship can be adversely affected by collateral relationships.

Kitchner (1988) points out that in dual relationships, the behaviors, expectations, obligations, and goals of a professional role and those of personal relationships can conflict. For example, in one form of dual relationship, the dentist has to behave as a dentist and also as a friend at the same time. Sometimes, the dual role behaviors are consistent—such as the expectation that the dentist-friend will be kind and caring. However, the expected behaviors and the goals of the personal and professional roles can also conflict. The goal of dentistry is a positive oral health outcome, not a close friendship. Therefore, one does not expect a friend to act in a confrontational manner in response to noncompliance with treatment regimes or to ask personal questions about sensitive medical areas. When conflicts between the two relationships occur, the dentist may have difficulty upholding the responsibility to place the obligations of being a good dentist before the expectations of the secondary role. For example, a dentist treating his or her child may want to scold the child as a parent would for not complying in the dental situation when other behavior management techniques would be a more appropriate professional intervention. According to Kitchner, the greater the difference between the professional role expectations and the expectations of the other relationship, the more likely it is that there will be ethical problems caused by the dual relationship.

Another possible mechanism by which dual relationships may be ethically problematic is that they may cause harmful conflicts of interest between dentist and patient (Pope, 1991). With most patients, a dentist does not have a personal interest in the

final outcome, only a professional interest. However, when there is a dual relationship, having a personal stake in the outcome of a procedure may influence the treatment that is delivered. For example, an orthodontist might not seek orthognathic surgery for his or her child out of a parental concern for the child's welfare, thereby denying the child access to needed and indicated care that the orthodontist would otherwise recommend to a non-family patient. Another example of this sort concerns the dentist's commercial interest, in which recommendations to patients may be influenced by profits from the sale of products such as nutritional supplements or electric toothbrushes. In this case, the dentist is acting as both dental health professional and salesperson. Conflicts of interest occur if dental decisions made by the dentist are based on the dentist's interests rather than the patient's best interests. Again, the basic rule–patient's needs first–is violated.

While obvious conflicts of interests in dual relationships might be successfully avoided with sufficient self insight and care, or by appropriate disclosure of commercial interests, dual relationships may also cause a subtle distortion in professional judgment that is not as easily overcome by the professional (Keith-Spiegel & Koocher, 1985; Pope, 1991; Sonne, 1994). But since roles in dual relationships cannot always be clearly separated, one cannot always disconnect one's feelings, motivations, and knowledge in one relationship from affecting the other relationship. For example, it may be difficult to judge a patient's behavior independently of your history of interaction with that person. Interpreting communication can be clouded by one's familiarity with the patient. Patient pain, impatience, and anger may be misread. A purely professional stance is often the only way to offer treatment options effectively, to ask sensitive questions during an interview, and to negotiate pain management strategies with a patient.

The possible distortion of judgment that can accompany dual relationships is further complicated by changes in the nature of the professional relationship that result from the overlapping relationship (Pope, 1991). Dual relationships alter professional "boundaries"; that is, the rules, limits, and expectations the dentist creates to define an appropriate professional relationship (Plaut, 1997). Taken together with rapport (Chambers & Abrams, 1992), these unspoken understandings between the dentist and patient assist dentist-patient relationships in functioning efficiently (Kitchner, 1988). Dual relationships change these limits and produce a hybrid relationship where professional expectations and understandings are no longer clear. This change in the expectations about the relationship could undermine the dentist's influence as an oral health care provider and adversely affect the dental relationship. For example, familiarity in the patient-professional role may cause the patient to take the dentist's proscriptions less seriously ("It's only Uncle Dave"), and this, in turn, may influence the dentist's attempts to alter oral health behavior and the patient's compliance with oral health care instructions (Chambers & Abrams, 1992). Patients who have personal relationships with the dentist in other respects may fail to respect appropriate professional boundaries and limits. For example, they may call at inappropriate times, make inappropriate treatment requests, and fail to respond to the professional's advice regarding treatment planning.

Outside business relationships with patients can also complicate routine professional financial dealings, since interactions with the dentist involving money are occurring in other settings, and these experiences may change a patient's expectations about payment in the dental situation. An example of these altered expectations is when a business partner expects a reduction in fees for dental services, which would be particularly problematic for a dentist in a group practice where compensation is shared equally among the partners. Likewise, it would be difficult to collect payment for dental services from close family members, particularly if they had financed your dental education.

The change in the nature of the dentist-patient relationship is bi-directional. As is true of dentists, the influence of the second relationship may impair the patient's ability to act in the role of patient. Consequently, the patient may fail to disclose pertinent information or be influenced by the dentist's persuasive attempts to change oral health behavior. The patient's feelings of trust towards the dentist may be changed by the second relationship. The patient's ability to make his or her own best treatment decisions could be affected by the patient's perception of the dentist's behavior in the second role. For example, an employee-patient's feelings about the value of dental work done by a dentist-employer may be influenced by such matters as the employee's feelings about salary or knowledge of the dentist's finances and practice. Such perceptions could affect, and possibly interfere, with the dentist-patient alliance. When any harm is done to this partnership, the patient's best interests are not served.

Problems with confidentiality are another complication of dual relationships (Keith-Spiegel & Koocher, 1985). The professional receives confidential information both as a professional and as a friend, and the friend's obligations are different from the professional's. Because patients are disclosing information to both a dentist and a friend, patients may not be as willing to volunteer sensitive medical information (Chiodo & Tolle, 1995). Role conflicts also affect confidentiality, since information gained in one role cannot ethically be used in the second role. This can create conflict and difficult ethical dilemmas (Keith-Speigel & Koocher, 1985). For example, the dentist may be in an uncomfortable position if the medical

information that is learned in a professional setting cannot be shared with others (e.g., a dentist's best friend's wife discloses she has a sexually transmitted disease) even though the dentist might feel obligated to do so as a friend or family member. In these situations, the dentist's roles as a professional and as a friend or family member yield conflicts about dental obligations to maintain patient confidentiality.

A final, and perhaps the most important issue inherent in dual relationships, derives from the imbalance of power that exists in the dentist-patient relationship. Dual relationships are restricted in psychotherapy, above all, because it is recognized that a psychotherapist holds a position of influence and power over their patients and this power could be exploited by the therapist (American Psychological Association, 1992; Sonne, 1994). A similar, though ordinarily less potent differential in power, exists in the dental relationship because of the dentist's knowledge and skills that the patient needs but does not have. The dentist therefore needs to act to secure trust and establish a dental alliance precisely because the dentist is in a position of power relative to the patient (Chambers & Abrams, 1992; Gabbard & Nadelson, 1995).

Thus, dental relationships bear a close resemblance to psychotherapeutic or medical relationships in some important respects. Dentists have confidential and sensitive information about patients, they create long-term relationships based on trust, and they have specialized skills that inspire a patient's regard and trust. They often deal with patients who are in pain or who are afraid, and these conditions may make patients emotionally vulnerable as well. In addition, the unidirectional nature of the dentist-patient relationship (with attention and care being focused on the patient and the dentist revealing little about themselves in the professional transaction) may inspire "transference-like" phenomena in patients (Gabbard & Nadelson, 1995; Plaut, 1997). Transference is a phenomenon where patients act as if the patient-provider relationship is similar to a significant past relationship. When transference occurs, the patient may generalize and project emotions from a past relationship onto the dental relationship. In doing so, they may ascribe qualities to the professional that are neither warranted nor desired by the dentist. For example, after successfully helping a fearful patient through a difficult and painful dental procedure, the patient may come to view the dentist as similar to other nurturing or powerful figures in the patient's life. This distorted emotional view of the relationship could place the dentist in an even more influential position of power with respect to the patient. Under these conditions, patients may not be able to make good decisions about entering into personal relationships or business dealings with their providers.

But even in the absence of transference, dentists still hold the upper hand in professional relationships. They set the tone of the relationship, they have knowledge of intimate personal information about their patients, and they control the details and the pace and intensity of treatment. Because patients do not hold equal power emotionally or socially, entering a dual relationship under these conditions creates the potential for the dentist to subtly exploit a patient (Pope, 1991). Since the fiduciary nature of the dental relationship requires that interpersonal influence given the dentist be used for the patient's benefit, this would seem to obligate dentists to avoid conflicts caused by dual relationships.

Why Should Dual Relationships in Dentistry be Examined?

Dual relationships have the potential to create conflict when professional and personal roles conflict, when one's professional insight is impaired by the dual relationship, and when the professional character of the dentist-patient relationship is changed by the second relationship. These conditions are likely to be present when a dentist is treating close friends, employees, and family members. The present analysis suggests that professional relationships with persons in these groups should be avoided. While other types of dual relationships (such as treating acquaintances) are less likely to create ethical difficulties, these relationships need to be monitored to assure that the professional's judgment and the patient's judgment are not being adversely affected by the second relationship. Likewise, outside business relationships with patients may create conflicts of interests and the potential for abuse of the trust striven for in the professional dental relationship. It is necessary to carefully assess such relationships to assure that the fiduciary relationship is maintained.

Good dental treatment does not occur in a vacuum. The success of oral health education, patient compliance and long term oral health outcomes depend on good dentist-patient communication (Chambers & Abrams, 1992). Such communication occurs best in the context of a trusting dentist-patient relationship. It is not consistent with the ethical practice of dentistry to have a secondary relationship with a patient that may disturb this trusting relationship. Examining the potential for such harm is an obligation that comes with the privilege of practicing dentistry.

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