Reflection, Introspection, and Communication: A Psychologist's View of Dental Ethics

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Abstract

A psychologist with experience teaching ethics in dentistry observes that ethical practice involves three skills: reflection (to understand the ethical issue), introspection (to discover the forces for action), and communication (to carry ethics into action). Several short cases are presented showing how ethical communication can be difficult. Direct communication (what psychologist call confrontation) is recommended and some tips are offered.

Another year has passed, an other year at a dental school. As the years go by, trends have begun to emerge in my psychologist's mind, trends in dental ethics. I don't see things the same way that dentists do, and that is both good and bad, useful and distracting at the same time. This essay formally presents some of my psychologist's observations about dentists, dentistry, and ethics in a way that might be thought-provoking and helpful. Since psychologists focus on intrapersonal and interpersonal events, it is likely that our views have something important to contribute to the ethical practice of dentistry.

Ethical practice consists of three essential activities, one from the realm of philosophy and the other two from psychology. They are: reflection, introspection, and communication. While dental schools and ethicists do a very good job with reflection, I think we give the other two short shrift. This essay reviews several difficult issues that face dentists routinely and advocates increased direct communication, even when it is difficult to do.

Ethics Skill #1: Reflection

When bio-ethicists work on a case, they reflect. When we teach students about ethics in dental schools, we teach them how to reflect. We teach cognitive tools that are essentially philosophical. For example, students learn decision models such as Kant's deontological approach or a utilitarian approach or Ozar's central values or any of three or four others. The *Ethics Handbook for Dentists*, just published by the College (American College of Dentists, 2000) provides methods for ethical decision-making. These models require students to sift through complex dental cases to discern facts such as:

- What is the standard of care?
- Whose interests are at stake?
- Which "decision principles" or laws seem to apply?
- Which of the central values of dental practice apply, and in what order?
- What obligations exist?
- What options are available and how should we rank them?

Ethics, as defined by the College's *Handbook*, is a branch of "philosophy and theology" and "the systematic study of what is right and good with respect to character and conduct." It involves questioning, reflection, and judgment about what ought or ought not be one. When we reflect, we sift through options and "unpack" the logic behind those options. Key questions include: What do things mean? How do we value them? Who gets what?

We define our terms and check each party's perception to make certain that we agree on the basic definition of things. We use a certain linear logic to get to a solution that makes sense and is likely to be accepted by several parties, including those in positions of authority. This is a process, essentially, of practical philosophical inquiry.

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The process of reflection is the essential first step, for it informs us about how to proceed.

It is the tool we use to figure out the right thing to do. But it is only the first step. Often, however, in dental school and in ethics gatherings, it is also the last. We are left with the mistaken impression that, when we have sorted through the philosophical issues and come to a reasoned conclusion, we have solved the problem. Dentists in practice are well aware that this is just the beginning of the process.

Good ethics requires good communications.

Ethics Skill #2: Introspection

Once we have decided on the right course of action, we have to get ourselves (or someone) to actually carry out the action. Occasionally this may be simple or easy.

But if an extended course of reflection has been necessary, it is much more likely that our solution is "easier said than done." Introspection is essential to determine the internal forces, the forces within us that influence the action we take, and even whether we take action at all.

This second skill is substantially in the domain of the psychologist. The question is: How do we get ourselves to do what we think we should? This is a problem each of us faces in everyday existence. How do you get yourself to stop smoking? How do you get yourself to stop eating junk after your physician reads you the cholesterol riot act? Your lead dental assistant has been coming in late after lunch for the past several months. You know what to do. Now you have to figure out how to get yourself to do it. You can make all the right judgments in the world, but without action, they are, well, you know what.

At some point it becomes time to look inside of one's self and figure out why you haven't taken action and what it will take to get yourself to do it. At the dental school, students come to faculty members to ask them to stop another student from cheating. Faculty members approach administration to ask them to discipline a student or another faculty member. In many such cases, one person really needs to step forward and say something directly to another person about behavior they perceive to be objectionable. But they prefer to try to get others to take care of it for them. They hope that "Mom" or "Dad" will take care of it for them. Ethical inaction takes place for reasons that are understandable, if not commendable. First, remember that most ethical problems have some or all of the following characteristics:

- They involve embarrassing matters, including mistakes or bad outcomes;
- They imply future loss (money, reputation, license, and privileges);
- They require sanctions;
- They represent a negative judgment of another person.

Second, most dentists have little or no experience with direct confrontation. They do not do this regularly. They often have an office manager who takes care of the tough discussions.

They may have a front desk person who negotiates problems with patients. And they may live in a hierarchical office structure where they sit at the top, and their judgment is rarely questioned in a direct way.

Here are some intrapersonal questions that dentists might ask themselves when facing a difficult ethical problem:

1. How do I *feel* about this problem or question? Angry, nervous or afraid, bored, saddened, confused?
2. How would I feel if I did nothing?
3. What would my favorite person do in this situation?
4. What would my favorite person think if I did nothing?
5. What have I got to lose if I act or fail to act?
6. What will I think of all this five years from now?
7. What are my strengths and weaknesses relative to this situation?
8. Do I have any mixed motives or conflicts?
9. Is this a good time for me? (Am I stressed or feeling hostile?)
10. What do I need to do to get myself to act?

Ethics Skill #3: Communication

It is clear, but rarely mentioned or taught: Good ethics requires good communications. At the same time, good communications skills are extremely valuable, but rare.

Dentists sometimes lack sophisticated interpersonal skills. (This is, of course, a generalization. Many dentists, the most successful ones in particular, are exquisitely good at professional communication.) But dentists rarely choose their profession because of its social aspects. They choose dentistry for other positive reasons, such as a desire to help or heal people, a desire to join the family practice, an interest in an autonomous career life-style, or a wish to have a lucrative career. If they wanted to spend their professional time talking and listening, they would have chosen to be a psychologist or teacher or attorney.

Dentists receive precious little training in communications skills, and communication in dental practice might just be the most difficult of all the professions. Patients often don't want to sit in the dental chair and are afraid; they sit with their mouth full of gear for long periods, unable to speak; and many dentists move from patient to patient briskly and efficiently. Most dental schools now include explicit communication training in their curricula. But given the complexity of the task and the difficulty of the skills involved, there isn't room in crowded curricula for adequate training; ample communication and behavior science training

might add months to an already crowded dental school schedule.

Once students graduate from dental school, they must figure out how to master these skills on their own. Some do a marvelous job of this, and some possess good skills even before they matriculate. These lucky souls typically thrive. If they possess the baseline practical skills and decent judgment, they end up with lovely private practices, full of happy people, staff and patients, alike. Other dentists look around for models or night classes, but don't find them.

The Communications Problem

To reiterate, ethics training in most dental schools (such as the one where I teach) and in local professional organizations typically focuses on how to *think* about moral problems. We teach students and dentists how to spot ethical problems; and we teach them how to dissect and analyze these problems. We teach decision models, so that they will be able to work their way through difficult ethical situations in the future and think their way to an effective solution. But the solutions often require that they speak directly to someone about a matter that is very, very difficult. We don't do a good enough job of teaching dentists what to say and how to say it. There are too many possibilities and variations in real dental practice and real life and we can't rehearse for them all. Worse yet, more often than not, the ethics discussion actually stops when we reach a conclusion about the best decision. What most dentists need are the communications skills that will get them from the right decision to an effective resolution.

From time to time I am called upon to remediate dentists who have gotten in trouble with the law or with their state dental board. It has been my impression that many of these dentists' problems have resulted from an inability to communicate effectively. Sometimes they were unable to assert themselves when patients made unreasonable demands; sometimes they were unable to respond appropriately when staff members behaved poorly. Sometimes they were unable to handle demands placed upon them by their own family members. When I have been able to psychologically test them, they have frequently shown to be introverted, sometimes highly so. They are often interpersonally isolated. Some dentists write multiple prescription narcotic painkillers for patients who give implausible reasons for their requests. Sometimes male dentists treat female patients alone without other staff in their office on the weekend or in the evening. Sometimes dentists don't know how to verbally reprimand staff members or provide clear behavioral guidelines. Some dentists aren't able to assert themselves with their bookkeeper or accountant. Eventually, it is the dentist who takes the fall, even if the setting involves missteps by others.

Of course, not all dentists who lose their licenses are passive or poor communicators; but in my experience, many are. Had these dentists known how to handle admittedly difficult communications problems, they might have avoided a terrible personal setback.

Common Cases

There are several kinds of difficult "cases" in dentistry that require sophisticated application of complex interpersonal skills in order to solve ethical problems. Here are a few examples.

Case 1: Bad Outcome. In this situation, the result of dental treatment doesn't work out as well as one would like. Perhaps the caries was extensive and close to the pulp chamber. Exposure of the root was unanticipated, but it happened. Now the patient must be told that a root canal is necessary and that she will be paying five times what she was originally told. Perhaps the margins of a crown are not as close or precise as the dentist would prefer, and now he or she has to decide whether to do it over, even though it is probably "good enough." You don't have to be a "bad" dentist to make mistakes, either. As Hasegawa and Mathews noted in a recent article in this journal, if your work is 99.95% error-free, and you see ten patients per day and work four days per week for fifty weeks each year, you will make fewer than one mistake each month, but ten mistakes per year. Over a ten year period, that's one hundred errors.

Case 2: The Work of Other Dentists. All dentists get to see the work of many other dentists. (This is much different from the psychologist's situation. We have virtually no idea about what other psychologists really do when they work with patients. It is all done behind closed doors, and the discourse is confidential.) Dentists don't always know what happened that resulted in the outcome that they are staring at, but most have a theory or point of view. What do you do when a crown looks terrible? Or when a bridge seems to have been ill-advised? Or when a crown doesn't seem to have lasted as long as you'd have liked (or as long as the patient wished it had)?

Case 3: Whistleblowing—You Know of Terrible Behavior of a Colleague. Occasionally, every professional comes across a situation where it appears that a colleague has done, or is doing, something reprehensible. Although it is not always clear, sometimes it really seems as if action should be taken. A child has been neglected. An immigrant shows up with restorations on every single occlusal surface.

A confused patient seeks counsel because a new dentist has presented them with a $30,000 treatment plan, and you can't find much pathology in the mouth. Maybe you have begun to see a disturb-

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ing pattern of poor work by a dentist from whom you have been receiving referrals for years.

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Case 4: Adolescent Confidentiality. In this case, your patient is a pregnant adolescent. Perhaps she doesn't want to be x-rayed. At any rate, she insists that you do not inform her parents of her condition, as she plans an abortion soon.

Case 5: The Unreasonable and Demanding Patient. Your patient wants treatment that you think is a bad idea. For example, your patient has many untreated carious lesions and a few loose teeth due to periodontal disease. When you present your treatment plan, which is expensive, she tells you to simply remove all of her teeth and give her dentures. She nearly begs you to see things her way. She tells you that she is not likely to reverse long-standing oral habits.

Case 6: Your Employer is Systematically Taking Advantage of Patients. You are an employee dentist. Perhaps you are a young or new dentist, recently minted. You are not ready to start or buy your own practice and you have some tuition bills to pay. Or maybe you have recently moved to a new state to accommodate your spouse, so you take a position in a large dental practice or clinic. Initial screening and treatment planning is done by senior dentists who then pass cases along to treating dentists, like yourself. Soon, you begin to see a disturbing pattern. Although the principals seem legitimate and sincere, their treatment decisions seem too profit-driven to be ethically defensible.

Case 7: Dual Relationship. For one reason on another, you have developed multiple relationships with several of your patients. For example, you treat your accountant, or your contractor, or the principal of your child's school. Perhaps you even date one of your patients. That person makes a decision that you don't like very well. In fact, they do something downright objectionable. Or, you decide that you don't desire to continue the social relationship with them anymore. How do you handle this ?

Case 8: An Employee of Yours (or a Patient) is Harassing Another Employee. There are several possible scenarios in this area. Let's say that one of your best employees tells you that one of your other high performers is sexually harassing her. In another scenario, a patient is telling sexually loaded jokes, and one of your dental assistants seems embarrassed by them. Or one of your employees seems to regularly try to convince others to join her religious faith. Or one of your employees is trying to recruit others in a real estate scheme.

Each of these cases includes a challenge for ethical reflection. The thoughtful and ethical dentist must first wade through the dental and moral issues to come to a conclusion about the right action. Although these cases are difficult ones, decision making models are available to help with the process. See Ozar and Sokol's text, *Dental Ethics at Chairside* (1994) or Rule and Veatch's *Ethical Questions in Dentistry* (1999) or some of the other references provided at the end of this essay. In some cases, a prioritized set of responses is ideal. Create a Plan A and a Plan B, just in case. But, after one has decided about the right action, the plan must be put into place—that is, you must somehow get yourself to do it—and for each of these cases, clear and direct communication is called for under difficult circumstances. Not everyone is going to get what he or she wants. Someone is going to hear some bad news. That's life in the real world of practical ethical behavior.

Sadly, there are many nonproductive ways that humans tend to handle difficult interpersonal situations. Here are some examples.

1. Do nothing and act like every thing is okay. Since most of us are chickens when it comes to conflict, our first choice is to avoid the issue. Maybe it will go away, if we just ignore it or walk around it. Maybe we can just put it off for a while and nothing bad will happen. At least, then, we won't have to think about it or worry.
2. Use the "silent treatment." When someone is behaving poorly or they have offended us, we communicate displeasure by not communicating. This way, we don't have to take any risk, but we can still let them know we are unhappy with them.
3. Attack or accuse the person whom we think has done a wrong thing. We line up our evidence and let them have it. While this seems like the only thing to do sometimes, given how poorly other people can behave, for some people it is a standard response to challeng - ing situations.
4. Talk about the situation with countless peripheral people who are likely to sympathize with us and support our point of view. Tell them how upset we are.
5. Use indirect messages, sarcasm, or oblique references.
6. Try to enlist someone in a position of authority to step in and take care of the problem for us. This is the "Mom" or "Dad" solution.

All of these approaches are sub-optimal precisely because they lack directness and honesty. They do not involve a clear communication with the essential parties. On the positive side, so to speak, they do not require much courage; but they are conflict-avoidant to a fault.

Direct Communication

Recently, I was working with a dental practice to help the members strengthen

their team. In talking to them about direct communication, I used the word "confront" and was met with a negative reaction. "We really don't like that word," they said. "Maybe you could call it something else." The term "confrontation" has gotten a bad rap lately, and many in the dental profession are simply afraid of it. Perhaps some of the nasty elements of daytime TV or rap music are the culprit, implying that when people confront each other it is unseemly or even dangerous because someone will throw a chair or start shouting or shooting. In avoiding confrontation, many people seem to have concluded that politeness is more important than authenticity. But there are positive as well as negative aspects of conflict, and it is a mistake to thoughtlessly avoid it.

Confrontation can be done in ways that are respectful. It can reveal important information and differences in viewpoints. It can increase your understanding of yourself and others. It can deepen your relationship with important people because each time you work through a conflict—assuming you do it in a relatively healthy way—it strengthens your connection. On the other hand, if done poorly or recklessly, it can permanently scar a relationship and can disrupt the workplace, creating long-lasting uncomfortable emotions. It can steal time from other kinds of work functions, and it can keep people on edge. Sometimes it is indeed best to just avoid a conflict, especially when the matter is small. Also some people are extremely uncomfortable with conflict because they grew up in a yelling or violent family. Others are avoidant because their family of origin was so sweet and gentle. But consistent, even compulsive avoidance of conflict typically leads to entrenched and unresolved issues that ruin the atmosphere in an otherwise good office.

Appropriate confrontation is not only a good thing in dentistry and life; it is an essential thing. We must confront each other from time to time in order to establish and maintain an authentic and functional relationship. It would be a rare relationship, indeed, that never needed an occasionally difficult conversation or confrontation, even if the conversation is simply to clear things up. ("What did you mean when you said that last week? I thought maybe you were talking about me. Did I do something wrong?"). When conflict is mindlessly or even compulsively avoided, misunderstandings and resentments are almost sure to follow.

Introspection is essential to determine the internal forces, the forces within us that influence the action we take, and even whether we take action at all.

Some Tips for Direct Confrontation

1. Check with your liability carrier. Get some friendly advice from an attorney if there is any possibility that legal issues are involved. For example, they may have a lot to say about how you speak to patients about the suboptimal outcomes described in Case 1, and they may urge you to avoid certain phrases when you speak to patients. Your insurance company will be happy to give you advice if it means that they can avoid a costly action. In some cases they may render an opinion that is too conservative, but in others they may insist that you confront a situation directly.
2. Decide whose interests are at stake and how they affect your proposed action. This is critical in Case 2 (The Work of Other Dentists), for example, when you spot work that you think is unacceptable or below the standard of care. Several parties have an interest in the situation: the patient, the previous treating dentist, that dentist's malpractice carrier, and yourself. Are you likely to avoid direct communication because of the embarrassment it might cause you (in the case of an error you might have made)? Would open discussion of a difficult situation cause you to lose money—and does that have an impact on your decision-making ability? These are interests that you have at stake in such a case.
3. Ask the question: Will direct confrontation hurt someone unnecessarily? This aspect of the situation must be factored into the equation. Sometimes uncomfortable words must be said that will cause hurt feelings; and sometimes the matter can be resolved other ways. There is no sense in hurting someone unnecessarily. The whistleblower case (Case 3) is a perfect example. What should you do when you fear that an older dentist has lost his "touch?" What should you do about the possibility that what you might say could really hurt?
4. When you confront someone, be sure that you are talking to

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the right person. There is no sense in a confrontation if you are not dealing with the decisionmaker or the actor. The point of confrontation is to clear things up so that things change. Don't waste time and energy grousing about the matter to those in the periphery unless they can help you to get the job done, somehow.

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5. Pick a good time and place. As the saying goes, "Timing is everything." Choose a setting that is non-threatening and reasonably comfortable, and don't spring difficult messages on people in elevators or at the end of the day, just as they are leaving the office. Don't do it in front of others either. Find a quiet, private place and take your time. A brief, on the spot discussion with the pregnant adolescent (while she sits in your dental operatory) may not be the best time or place to get anything accomplished. You could actually do more harm than good.
6. Listen. Most people are not willing to listen until they feel that they have been heard or that they will be heard when their turn comes. Communication is always a two-way street. A good conversation is like a good game of "catch." It only works if you toss things back and forth. If one person brings a stack of Frisbees and just starts hurling them, one after another, the person on the receiving end will soon become tired or frustrated or worse. The talking must go back and forth, no matter what the original purpose of the interaction, hear the other person's side of the story. It might even change your own view.
7. Learn and use "active listening." Teach yourself to repeat back to the speaker, in some form or another, what you think is an accurate representation of what you understand them to be saying and meaning. Do it until they agree that you have got it right. Conversations with angry or "difficult" patients are terrific opportunities to practice listening. As a rule, patients who feel that they have been heard are much easier to deal with. There are many stories in the healing lore about patients who forgive serious errors in doctors' judgments simply because they believe their doctor cares about them and is eager to understand their point of view.
8. There are many other useful skills and techniques available to make direct communication work, including how to use "I" statements, contingency statements, and requests. References are listed at the end of this article, and practice consultants all have their favorites.

It is difficult to consistently do the right thing in any professional practice, and the first steps, decision-making and introspection, include philosophical and psychological skills. But the hardest part of the equation is often the last one: communicating your solution to the right person at the right moment in an effective way.

References

American College of Dentists (2000). *Ethics handbook for dentists: An introduction to ethics, professionalism, and ethical decision making.* Gaithersburg, MD: The College.

Burton, J. (1996). *Conflict resolution: Its language and processes.* Lanham, MD: Scarecrow Press.

Chambers, D. W. & Abrams, R. (1986). *Dental communication.* Sonoma, CA; The Ohana Group.

Deutsch, M. & Coleman, P. (Eds.) (2000). *The handbook of conflict resolution: Theory and practice.* San Francisco, CA: Jossey-Bass.

Fisher, R. (1997). *Interactive conflict resolution* (Syracuse Studies on Peace and Conflict Resolution). Syracuse, NY: Syracuse University Press.

Hasegawa, T. K., Jr. & Mathews, M. (2000). Human error or substandard care: where do we draw the line? *Journal of the American College of Dentists, 67 (Autumn),* 39-42.

Kulich, K. (2000). *Interpersonal skills in the dentist-patient relationship: The art of dentistry.* Unpublished doctoral dissertation. Department of Psychology, Goteborg University, Sweden: Vasastadens Bokbinderi.

Ozar, D. & Sokol, D. (1999). *Dental ethics at chairside: Professional principles and practical applications.* Washington, D.C.: Georgetown University Press.

Rest, J. & Narvaez, D. (1994). *Moral development in the professions: Psychology and applied ethics.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Rule, J. & Veatch, R. (1993). *Ethical questions in dentistry.* Chicago, IL: Quintessence Publishing Company.

Stone, D., Patton, B., & Heen, S. (1999). *Difficult conversations: How to discuss what matters most.* NY: Penguin-Putnam, Inc.

Ury, W. (1999) *Getting to peace : Transforming conflict at home, at work, and in the world.* New York, NY: Viking Press.

Weinstein, B. (1993). *Dental ethics.* Philadelphia, PA: Lea & Febiger.

Zimbardo, P. (1977). *Shyness: What it is and what to do about it.* Menlo Park, CA: Addison-Wesley.