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Enhancing Professionalism Using Ethics Education as Part of a Dental Licensure Board's Disciplinary Action

Part 1. An Evidence-Based Process

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Abstract

This paper describes a process and procedures for interacting with individuals who have violated the rules of professional conduct and includes descriptions of each of the assessment measures used to conduct a baseline assessment of four ethical capacities that are necessary conditions for reflective, ethical practice. The process and assessment methods are theoretically grounded in Rest's Four Component Model of Morality—a model that asserts that moral failing can result in a deficiency in any one of four abilities or capacities that are necessary for ethical behavior. Following descriptions of five well-validated assessment strategies, a synopsis of an educational intervention is presented.

Professional boards and professional schools often face questions about what to do when students or professionals violate the rules of professional conduct. In the judgment of professional boards and professional school faculty, such breaches raise questions about students' or practitioners' commitment to professional ideals and a willingness to live by the laws and codes of conduct governing professional practice. Of particular concern in recent years are instances in which students appear to be colluding with their peers to violate the rules governing student conduct (Editorial, 2006; Rudavsky, 2007; Sherman & Margolin, 2006; Sherman & Margolin, 2007).

In the late 1980s, I was approached by the Minnesota Board of Dentistry about offering an ethics course for individuals who had been disciplined by the board. The request came about because some of the board members had been involved in the design and validation of the performance-based assessment measures developed for the dental ethics curriculum I was directing at the University of Minnesota. Board members were also aware of courses being offered for dental students and wondered whether such instruction might be a helpful way to restore a sense of professionalism for individuals who had violated the state's dental practice act. Over a period of some months, we collaboratively designed a process and set of procedures for conducting such courses. The first course was implemented in 1991. Over the years, the process has been refined as we have gained experience and insight about ways to conduct such experiences. The goal is to help participants identify and address personal shortcomings that led to disciplinary action, while simultaneously satisfying the board's need to feel that they have fulfilled their responsibility to the public.

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A search of the literature for other efforts by professional organizations to deal with members' disciplinary problems reveals no systematic (or organized) efforts in dentistry, and scant results in other professions. However, about the time the Minnesota Board of Dentistry initiated its evidence-based ethics instruction, Joseph d'Oronzio (2002) began offering the ProBE Program, an intensive weekend educational intervention for healthcare practitioners under discipline by a licensing board, hospital administration, or other oversight agency. The ProBE program has received referrals from multiple state medical boards over the past two decades, and is currently managed by the Center for Personalized Education for Physicians (www.cpepdoc.org). ProBE differs from the program described here in several ways: it is of short duration, it is not based on identified deficiencies in ethical capacities, and it does not require demonstration of progress on validated measures of ethical abilities as a condition of licensure reinstatement. Testimonials do support ProBE's effectiveness in addressing the defensiveness and denial that often accompanies a challenge to one's professional behavior.

The purpose of this paper is first to describe the theoretical underpinnings for the design of the educational program. It then describes the overall process for conducting a course in professional ethics for dental professionals referred by a dental licensing board–a process that includes relationships with the board, relationships with the person referred by the board, the intake interview, the pre-instruction assessment phase, the educational program, the final assessment, the report to the board, and the reinstatement of the dental professional to practice. A second paper to be published in the fall 2009 issue of the *Journal of the American College of Dentists*, "Enhancing Professionalism Using Ethics Education as Part of a Dental Licensure Board's Disciplinary Action: Part 2. Evidence the Process Works," will present outcomes describing the effectiveness of presenting this program to 41 professionals referred by a state dental licensing board between 1991 and 2005.

Perspectives and Theoretical Framework

In the late 1970s, developmental psychologist James Rest began a review of the literature from multiple theoretical perspectives that he hoped would more fully explain moral behavior than that permitted by the existing focus on moral reasoning and judgment development. Rest (1983) proposed four reasons for moral failure: moral blindness, defective reasoning, lack of commitment to moral ideals, and deficiencies of character and competence. Rest's Four Component Model (FCM) of Morality (see sidebar) operationally defines competencies or capacities that need to be developed if one is to engage conscientiously, purposefully, and consistently in a pattern of behavior that one's peers would judge to be moral or ethical. It is possible, of course, to follow directives and be judged as moral or ethical without ever having thought through why one engages in a particular action–just as a child or adolescent may unreflectively (or even accidentally) simply "obey the rules or the directives of parents." Yet for consistency in moral action, especially in the context of challenging professional practice, Rest thought individuals needed to have developed four activating components of moral behavior. These include the capacities of sensitivity, moral reasoning and judgment, moral motivation

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The Four Component Model of Morality

Starting with the question "How does moral behavior come about?" James Rest (1983) suggested that the literature supports at least four component processes, all of which must be activated for moral behavior to occur. The four components are a useful way to conceptualize the capacities required for effective moral functioning.

Moral sensitivity focuses on the interpretation of a situation, the various actions that are available, and how each action might affect the self and others. Observing a situation as it unfolds involves these reflective processes: imaginatively constructing possible scenarios (often from limited cues and partial information); identifying realistic cause-consequence chains of events; and having empathy and role-taking skills. Both cognitive processes (perception, appraisal, and interpretation) and affective arousal (anger, apathy, anxiety, empathy, and revulsion) contribute to the interpretation of problematic situations.

Moral judgment follows a person's becoming aware that various lines of action are possible: one must ask which line of action is more morally justified. This is the process emphasized in the work of Piaget and of Kohlberg (1984). Even at an early stage of moral development, people have intuitions about what is fair and moral, and make moral judgments about even the most complex of human activities. The psychologist's job is to understand how these intuitions arise and what governs their application to real-world events. The educator's job is to understand how best to promote reasoning development, especially for individuals who have not developed this ability prior to professional education.

Moral motivation and commitment involve prioritizing moral values over other personal values. People have many values (e.g., careers, affectional relationships, aesthetic preferences, institutional loyalties, hedonistic pleasures, excitement). Whether the individual gives priority to moral concerns seems to be a function of how deeply moral notions penetrate self-understanding, i.e., whether moral considerations are judged constitutive of the self (Blasi, 1984). For moral behavior to occur, people must first decide on a morally correct action when faced with a dilemma, and then conclude that the self is responsible for that action. One is motivated to perform an action just because the self is at stake and on the line—just because the self is responsible. Moral motivation is a function of an internal drive for self-consistency. Blasi (1991) argues: "The self is progressively moralized when the objective values that one apprehends become integrated within the motivational and affective systems of personality and when these moral values guide the construction of self-concept and one's identity as a person."

Moral character and competence is having the strength of your convictions, having courage, persisting, overcoming distractions and obstacles, having implementing skills, and having ego strength. A person may be sensitive to moral issues, have good judgment, and prioritize moral values; but if he or she is lacking in moral character and competence, he or she may wilt under pressure or fatigue, may not follow through, or may be distracted or discouraged, and moral behavior will fail. This component presupposes that one has set goals, has self-discipline and controls impulse, and has the strength and skill to act in accord with one's goals.

It is noteworthy that the model is not conceived as a linear problem-solving model. For example, moral motivation may affect moral sensitivity, and moral character may constrain moral motivation. In fact, Rest (1983) makes clear the interactive nature of the components. Furthermore, and in contrast to other models of moral function that focus on the traditional three domains—cognitions, affect, and behavior—the Four Component Model of Morality assumes that cognition and affect co-occur in all areas of moral functioning. Thus, moral action is not simply the result of separate affective and cognitive processes operating as part of an interaction. Instead, each of the four components is a mix of affective and cognitive processes that contribute to the component's primary function.

Adapted from Bebeau, Rest, and Narvaez (1999); Bebeau (2006).

or identity, and moral implementation. When fully developed, these capacities give rise to conscious, consistent, and effective, rather than accidental, ethical decision making.

Rest envisioned each of these capacities as developing across the life-span. Thus, at any point in a person's life, one's inadequately developed competency in ethical sensitivity, moral judgment, one's undeveloped sense of professional identity, some flagging will or failing in interpersonal interaction and problem solving could result in an ethical problem. For example, a disgruntled patient or employee might report his or her unhappiness with a dental professional to the Board of Dentistry. Such an act sets in motion an investigation and, eventually, a judgment. If someone has been harmed or wronged, questions emerge about a professional's competence and possibly his or her intentions. Actions judged as unprofessional are not necessarily the result of bad intentions. In order to make such a judgment, an assessment of the previously mentioned four capacities is required. Only then can a learning plan be developed that can help the individual engage in self-reflection, goal setting, and ultimately, the enhancement of ethical competence.

Today, some 30 years after its development, Rest's FCM is broadly accepted as a useful theoretical framework for the development of ethics education across the educational spectrum. Findings from educational interventions described in this two-part series of articles support the explanatory power of measures based on Rest's FCM for understanding moral failings and the power of a remedial course for improving ethical decision-making abilities and for restoring a sense of professionalism.

Process and Modes of Inquiry

Following is a description of the process for conducting an individualized course in professional ethics for dental profes-

sionals, including the various modes of inquiry for arriving at judgments about the need for instruction and verifying instructional effectiveness.

Agreement with the Board of Dentistry

If the Minnesota Board of Dentistry judges that the behavior for which disciplinary action is being taken reflects unethical or unprofessional conduct, the board's stipulation and order states that the individual must, within a required time frame, complete an individualized course in ethics and (based upon a long-standing arrangement) names me as the instructor for the course. Whereas the stipulation and order states that the individual must complete the course with me as a condition for licensure reinstatement, the board also honors my judgment as to whether such a course is necessary or likely to be beneficial. Based on a general agreement with the board, ethics instruction is not prescribed to address problems with mental illness, substance abuse, impulse control, and sexual boundary issues. These cases are first referred either to the state's Health Professionals Service Program (HPSP) or for psychological assessment and counseling, though in some cases ethics instruction has been required following successful interventions with HPSP or other forms of professional counseling.

Even though the board's stipulation and order may indicate that course completion is a condition for licensure reinstatement, I, as the individual who agrees to provide such instruction, depending upon the results of the diagnostic assessment, may negotiate with the board that the requirement for ethics education can be satisfied by a diagnostic assessment that indicates the individual has no deficiencies in ethical competencies. In addition, in order not to go beyond my professional expertise–I am not a clinical psychologist–I reserve the right to refuse to provide instruction in certain instances. No cases are accepted for remedial instruction that involve substance abuse, mental illness, sexual boundary issues, or situations where the board has already decided to permanently revoke a license unless those issues are first, or simultaneously, being addressed by other professionals.

Initial Contact with the Referral

After signing the board's stipulation and order, the referred professional is expected to make all arrangements and pay for the educational programs required by the board. During the initial contact, the professional is asked to send me a copy of the board's stipulation and order for my review. At this point, I also find it important to inform the professional that, in my judgment, an encounter with the Board of Dentistry is not an indication that ethics instruction is warranted. We all make mistakes, and mistakes are not necessarily an indication of a flawed character. I indicate that if I agree, after reviewing the stipulation and order, to work with the individual, we will conduct an assessment to determine whether an ethics course would be of benefit. If the assessment reveals that the capacities are sufficiently well developed, I will inform the board that a course is not necessary and the individual will be responsible only for the cost of the assessment. At this point, I also inform the professional that the relationship is a confidential one, and although I am responsible to report the findings of the assessment to the board, the individual will have an opportunity to discuss the assessment with me before it is forwarded. Further, in the event a course would be indicated, only material that the individual has reviewed and personally approved would be forwarded to the board. My purpose is to establish a relationship that enables the professional to freely discuss experiences and even frustrations with the process he or she has experienced. If the individual feels comfortable with these conditions, an intake interview is scheduled.

The Intake Interview

The intake interview is a critical part of the process. Two hours are scheduled for this appointment, as I have three purposes: the first is to establish trust. After elaborating on my initial conversation about the confidentiality of our conversations, I use active listening to engage the individual in a telling of his or her story. I interrupt only to clarify details, to offer supportive comments, or to further elicit and verify feelings. It is not uncommon for the disciplined individual to be angry and emotionally hurt. My prior review of the stipulation and order enables me to flesh out the story. Second, I elaborate on my view that a judgment on the part of the board–that the person needs an ethics course–is not an indication that one is unethical or unprofessional or even in need of an ethics course. People make mistakes for all sorts of reasons, and the fact that one made an error in judgment, or failed to take an action someone thought they should have taken, or even engaged in a pattern of actions the board found indefensible, is not an indication of evil or unprofessional intent. There are reasons for moral failings that have nothing to do with evil intent. We all make mistakes. The point of an assessment is to determine whether there is a shortcoming in one of four capacities that give rise to ethical decision making. One's competence on each capacity is compared against one's colleagues. If no shortcomings are identified, there is no need for ethics

instruction. A third purpose is to introduce the theoretical reasons for moral failings and introduce the various assessments. I briefly describe the measures and the fact that they will be compared with the same assessments of the four ethical capacities previously compiled from dental seniors and from other dentists.

If concerns are raised about validity and reliability, I offer references to the literature. Usually, at this point in the process, the professional masks concerns about the assessment that may later surface. If the professional agrees to the terms for assessment, an assessment session is scheduled.

Assessment Session

The initial assessment takes a minimum of four hours. I typically advise the professional to plan to take the better part of the day. A quiet room is prepared and the individual is free to seek me out for questions or clarifications and to take breaks as needed. Five well-validated measures of ethical development (described in the next section) are used to estimate competence for these four abilities: (a) ethical sensitivity, (b) moral reasoning and judgment, (c) oral motivation and commitment, and (d) ethical implementation skills (i.e., problem solving and interpersonal effectiveness). Responses to the Dental Ethical Sensitivity Test (DEST) are tape-recorded, transcribed, and analyzed. The Defining Issues Test (DIT) and the Dental Ethical Reasoning and Judgment Test (DERJT) are sent to the Center for the Study of Ethical Development for scoring. The Professional Role Orientation Inventory (PROI) and Role Concept Essay (RCE) are evaluated and an interpretive report is prepared. The report (a sample of which is available on request) describes each of the measures for the referral and provides a basis for understanding the interpretive report.

Feedback Session

A two-hour session is scheduled with the professional to provide feedback on the diagnostic assessment. The session begins with a brief review of the theoretical reasons for moral failings and a reminder of each of the measures the individual completed. I usually begin by asking which of the measures the individual felt was most challenging, which seemed easiest, and so on. I begin with the person's strengths as indicated by the assessments and work toward an unfolding of any shortcomings. If it appears, based on the assessment, that there are areas of competence for which instruction is warranted, the professional is involved in the development of a learning plan, assignments, and a timeline for course completion. The forthcoming article describes reactions to the process.

At the end of the two-hour session, the professional is given a copy of the diagnostic report and is asked to spend some days reviewing it. The professional is encouraged to challenge interpretations or judgments that seem unfair or not supported by the assessment data. A follow-up discussion is scheduled, as needed, and a corrected report is prepared for submission to the Board of Dentistry. In my judgment, encouraging challenge to interpretations is a critical step, as the individual must feel that the assessments are sufficiently valid and reliable, and that his or her performance on a particular measure is a reasonable estimate of competence on that particular capacity.

Because the measures are performance-based and present realistic, though complex, situations (i.e., have face validity), it is usually not too difficult to convince the professional that there are better choices than the ones he or she selected. On occasion, an individual has questioned the validity of one or more of the measures, or felt that on that particular day, he or she was not performing at his or her best. In the first instance, I provide references so the individual can review for himself or herself the data on the measure's properties. In the second instance, I encourage the person to retake a measure. Allowing the person to do so, in addition to demonstrating one's openness to rethinking an estimate of an assessed ability, presents an opportunity to discuss such concepts as "standard error of measurement" or "test-retest reliability." Providing references to the extensive literature on a measure honors the fact that board referrals are themselves accomplished scholars who are capable of reviewing scientific literature. With respect to the DEST, it is also possible to have the individual assess his or her own performance using the extensive scoring manual that has been devised.

Diagnostic Assessment and Learning Plan

A summary of the diagnostic assessment and a plan for study are submitted to the Board of Dentistry for their approval. At this point, the Complaint Review Committee that initially interacted with the professional has an opportunity to review the assessment and require modifications to the educational plan. It is not uncommon for the board to express concern that particular issues should be stressed in the educational plan.

Implementing Instruction

The specially designed course is implemented as approved (or modified) by the board. Again, the professional is assured confidentiality of conversations during the instructional process and, once

more, assured that no written assignments prepared for the course will be submitted to the board without the professional's approval. A typical course consists of 25 to 30 contact hours of instruction spread over several months. A course may be given to a single individual, or if there are several referrals in need of instruction, a course may involve as many as five participants. In the event of a joint course, all potential participants must agree to participate in all the instruction, rather than only the part the individual needs. There is heavy emphasis on performance and personalized feedback. For each session, participants engage in reading assignments and case analysis and write-ups, for which they receive personalized feedback. When conducted in a group setting, participants are required to disclose to others the reasons for which disciplinary action was taken. In addition to the benefits of learning from others, costs for the course can be shared. The course is costly, not only financially, but in terms of study time, and travel time—some must travel long distances to attend the sessions.

Final Assessment

At course completion, a final assessment (similar to the pretest) is scheduled to assess progress. If ethical sensitivity and moral judgment were addressed in the course, alternative forms of the DEST and DIT are used. In addition to repeating the Role Concept Essay, the PROI, and the DERJT (if indicated), each participant also completes a self-assessment of learning that includes a description of the changes he or she has made in practice as a result of the course. Prior to scheduling the final assessment, participants are required to turn in the final draft of essays required of the course. For most referrals, an essay, "What does it mean to be a professional?" which participants work on during the course, is required. Similarly, at the end of the course, each participant must develop an ethics case reflecting the set of circumstances for which he or she was disciplined. For many, this is a challenging task that can take several weeks. After the case is refined and approved, the participant develops a well-reasoned argument in support of an ethically justified position.

Final Report

A final report, including analysis of pretest to post-test progress and sample work products, is prepared and submitted to the Board of Dentistry for final approval. This report is not shared with the participant before it is sent to the Board of Dentistry, but participants are aware that no work products are included that they have not approved. The board typically engages the Complaint Review Committee members who initially interacted with the referred professional in a review of the final report. Of particular interest for this committee is the participant's final assignment—the dilemma developed that describes the circumstances for which the individual was disciplined and his or her ethical analysis of the case. Similarly, the self-assessment of learning and plans for change are of interest.

Feedback and Licensure Reinstatement

If the board is satisfied with the participant's progress, a copy of the final report is sent to the participant and, if warranted, a follow-up meeting is scheduled. Licensure reinstatement is a separate action taken by the board, when the licensee has completed all requirements specified by the board. Most licensees simultaneously complete other educational and testing requirements and submit to one or more in-office inspections before their license is reinstated.

If it appears, based on the assessment, that there are areas of competence for which instruction is warranted, the professional is involved in the development of a learning plan, assignments, and a timeline for course completion.

The Measures

For each of the four capacities, one or more measurement strategies is used to estimate the individual's competence on the particular capacity. Obviously, other strategies could be devised, but the following have been well-validated for use in a dental ethics curriculum. The four capacities being assessed are distinct from one another. In other words, competence on one does not predict competence on the others. In addition to construct validity, each measure has good face validity, good test-retest reliability, and sensitivity to the effects of instruction. For the reader concerned with the full spectrum of questions related to construct validity and measurement reliability, references are included to the literature to the manuals for the tests and to the available scoring services. The following descriptions are not intended as an interpretive guide for the dental professional who is being evaluated or for the Board of Dentistry that is attempting to understand and interpret a performance report. Interpretive guides have been prepared and are available upon request from the author.

Ethical Sensitivity

The Dental Ethical Sensitivity Test (DEST) (Bebeau, Rest, & Yamoor, 1985) measures a person's ability to interpret the ethical dimensions of problems that occur in the practice of dentistry. It exists in two forms, one of which is used as a pretest, the other as a posttest. Each form presents four tape-recorded radio dramas. The respondent listens to each drama, and then verbally responds to the hypothetical patient as he or she thinks would be best in such a situation. Responses to the hypothetical patient and to a number of probe questions are tape-recorded, transcribed, and later scored by me using an extensive scoring manual. The manual directs the evaluator to use information from any part of the transcript (typically two to three single-spaced typed pages per case) to judge the extent to which the participant interpreted what was happening and recognized his or her ethical responsibilities. In judging ethical sensitivity, the evaluator is not attending to how effectively the participant responded to the patient or dilemma character, but rather the extent to which the participant interpreted the clues to the moral problem and recognized a responsibility to act. For example, a participant might recognize that an empathic response is required, but then choose words to convey his or her intentions that would be highly ineffectual. The participant would be judged high on ethical sensitivity, but low on ethical implementation (the fourth capacity described next).

Since the cases present different ethical problems that are likely to confront a professional, the total score for each case is computed and compared to a random sample of fourth year dental students. An analysis of case scores and item scores across cases permits a diagnostic assessment of specific strengths and shortcomings in identifying ethical issues, while a computation of the total score (sum of scores across cases) enables a comparison with two reference groups: fourth year dental students who have had an ethics curriculum and all previous referrals from the Board of Dentistry. For a comprehensive discussion of the measurement of ethical sensitivity, including a summary of the validity and reliability of the DEST, see Bebeau (2006).

Ethical Implementation

Because the DEST presents situations that simulate real life performance and asks the respondent to respond in dialog to the hypothetical patient or a dental colleague, it is possible to make a number of judgments about the professional's ability to implement effective action plans. A review of the recording and the transcript enables the evaluator to make professional judgments about problem solving and interpersonal communication competencies. The evaluator prepares a narrative summary for each case describing strengths and weaknesses in the way the respondent handled the issues presented. Because I have a large database of responses, including some devised by ACD Fellows who participate in the dental ethics curriculum, it is not difficult to convince the respondent that more effective responses to the cases are possible. Also, a summary across cases often identifies patterns of responding that suggest a need for remediation. This assessment requires expert judgment.

The reader will likely recognize that referrals to the Board of Dentistry often result from ineffective interpersonal communication and problem solving. Sometimes respondents are aware of their own shortcomings in interpersonal interaction, such as their lack of assertiveness or their ineffectiveness in addressing particular kinds of patient issues. With this awareness in mind, a reexamination of the circumstances that led up to the complaint may be helpful in identifying shortcomings in ethical implementation.

Moral Reasoning and Judgment

There are two measures used to assess moral reasoning and judgment. The first is a standardized test, the Defining Issues Test (DIT), with a long validation history. The second, the Dental Ethical Reasoning and Judgment Test (DERJT), is a more recently developed test designed specifically to assess reasoning and judgment

in the context of dental practice. Recent research (Thoma et al, 2008) from nine cohorts of dental graduates illustrates a relationship between the two measures. Graduates who demonstrate competence on the DIT, which is a measure of life-span moral judgment development, have enhanced ability to distinguish better and worse action choices on the profession-specific measure of reasoning and judgment, the DERJT (described below).

The DIT (Rest, 1979; Rest et al, 1999) measures the relative importance of reasoning strategies (moral schemas) used by an individual when confronted with complex moral problems and also whether the individual uses his or her preferred moral schema when making moral judgments. The primary version of the test (DIT-1) presents six moral dilemmas that cannot be fairly resolved by applying existing norms, rules, or laws. Respondents rate and rank arguments (12 for each problem) they considered important in coming to their selected decision as to what they would do. The arguments reflect three moral schemas used by adults to justify their actions: a Personal Interests Moral Schema; a Maintaining Norms Moral Schema; and a Postconventional Moral Schema. Scores reflect the proportion of times a person selects arguments that appeal to each. The most widely used score, the P Index (for postconventional moral thinking), reflects the proportion of times a respondent selects arguments that appeal to a coherent theoretical approach for resolving problems. The test does not discriminate which theoretical approach an individual uses to ground his or her moral judgments (e.g., casuistry, utilitarian, virtue theory, or other approaches), but rather whether the individual selects arguments that are grounded in a coherent moral theory. (See Beauchamp & Childress, 1994.)

Research indicates that mature thinkers appeal to moral ideals much more frequently than do immature thinkers. Because professionals are often required to apply ethical principles or ideals to new problems that emerge in their profession, this skill is necessary for effective moral functioning. Research indicates a strong relationship between postconventional thinking (P Index) and a wide-range of prosocial actions (including clinical performance for healthcare professionals). For an updated summary, see Bebeau and Monson (2008). In addition to the P Index, the test also determines the proportion of times an individual selects arguments based on two other problem-solving strategies: The PI Index (for Personal Interests) describes the proportion of times a respondent selects arguments that appeal to personal interests and loyalty to friends and family—when doing so compromises the interests of persons outside one's immediate circle of friends; and the MN Index (for Maintaining Norms) describes the proportion of times a respondent selects arguments that appeal to maintaining law and order—irrespective of whether applying the law in the case results in an injustice. In addition to the three main indices, the program calculates two information processing indices: a U score (for Utilizer), which describes the degree of consistency between reasoning and judgment; and an N2 Score, which takes into account how well the respondent discriminates among the various arguments. This is often a better indicator of change than the P Index. If the N2 score is higher than the P score, it indicates that the respondent is better at discriminating among arguments than at recognizing postconventional arguments.

The DIT is an extensively validated and widely used measure of moral reasoning development. Norms are available for many groups that have taken the test. See Rest, Narvaez, Bebeau,

The ability to clearly articulate the full range of professional expectations distinguishes the moral exemplar from the entering student.

& Thoma (1999), a book detailing the validation of the Personal Interest Schema, Maintaining Norms Schema, and Postconventional Schema for adult development. For a comprehensive interpretation of test results and for the most recent update on validity and reliability of the test, see Thoma (2006). For information on the availability of the DIT-1 or the DIT-2, see http://centerforthestudyofethicaldevelopment.net/index.html.

The Dental Ethical Reasoning and Judgment Test (DERJT) (Bebeau & Thoma, 1999; Thoma et al, 2008) consists of five dental ethical problems followed by action choices and justification choices. The action choices and justifications for each problem were generated by a group of Minnesota dental faculty and residents. When taking the test, a respondent rates each action or justification, then selects the two best and two worst action choices and the three best and two worst justifications. To assure that the test is a test of "dental ethical expertise," dental ethics teachers from around the country took the test and commented on the appropriateness (or inappropriateness) of each action choice or justification. Judgments of these experts were used to construct a ranking of the action choices and justifications. There was good agreement among experts as to better and worse choices, and good agreement between the experts and a group of Minnesota dental faculty. (Incidentally, there was good consistency between the judgments of dental ethics teachers who had degrees as dentists or dental hygienists, and those who did not.)

Scores are determined by calculating the proportion of times a respondent selects action choices and justifications consistent with "expert judgment." Three scores are reported: (a) percent of good action choices that agree with expert judgment; (b) percent of good justification choices that agree with expert judgment; and (c) overall score which combines recognition of both good and bad actions and justifications. The validity and reliability of the measure are reported by Bebeau and Thoma (1999) and Thoma and colleagues (2008). Mean differences for groups expected to differ in dental ethics expertise (college freshmen, dental freshmen, and dental seniors) are used to compare an individual with his or her peer group.

Moral Motivation and Identity Formation

Two measures are used to assess the professional's understanding of and commitment to professional expectations and roles.

The Role Concept Essay (RCE) is an essay that presents a series of open-ended questions designed to elicit a participant's perception of his or her role as a professional. Essays are read and scored for six concepts derived from the literature (Rule & Bebeau, 2005) that describe professional obligations: (a) to acquire the knowledge of the profession to the standards set by the profession; (b) to keep abreast of changing knowledge through continuing education: (c) to make a commitment to the basic ethic of the profession–that is, to place the oral health interests of the patient above the interests of the professional, and to place the oral health interests of society above the interests of the profession; (d) to abide by the profession's code of ethics, or to work to change it, if it is inconsistent with the underlying ethic of the profession; (e) to serve society (i.e., the public as a whole)–not just those who can pay for services; and (f) to participate in the monitoring and self-regulation of the profession. There are at least three dimensions to the last expectation: to monitor one's own practice to assure that processes and procedures meet ever-evolving professional standards, to report incompetent or impaired professionals; and to join one's professional associations, in order to participate in the setting of standards for the continuation of the profession. The latter is an ethical, rather than a legal responsibility.

Failure to describe one or more of the six concepts does not necessarily mean the dentist is unaware of the obligation. Rather, the obligation does not readily come to mind when prompted by a number of probe questions. The ability to clearly articulate the full range of professional expectations distinguishes the moral exemplar (Rule & Bebeau, 2005) from the entering student (Bebeau, 1994).

The Professional Role Orientation Inventory (PROI) (Bebeau, Born, & Ozar, 1993) attempts to overcome some of the shortcomings of the essay and interview methods. It consists of four ten-item scales designed to assess commitment to professional values over personal values. For example, studies have shown that groups of Minnesota graduates show a significantly greater sense of responsibility to others than do entering students (Bebeau, 2006). Additionally, the graduates' mean score was not significantly different from that of a group of 48 dentists, who demonstrated special commitment to professionalism by volunteering to participate in a national seminar to train ethics seminar leaders. Participant responses to the items are useful in corroborating the statements made in the essay. Later, the items can be used to stimulate discussion of the professional's role. For a summary of validity and reliability studies for the PROI, see Bebeau (2006).

The Educational Intervention

The educational intervention attempts to provide very practical and engaging instruction, practice, and feedback for each area in which a shortcoming in ethical abilities was identified. A typical course involves from 20 to 30 contact hours—usually in two-hour face-to-face seminars—distributed over several months. Seminars are spaced to allow adequate time for reading, writing, self-assessment, and reflection. Opportunities for self-assessment of responses given to the cases presented in the initial assessment are also included. Writing assignments are submitted by e-mail or fax at least a day before the seminar, so there is time for the course instructor to use the written work as the basis for discussion. Each course begins with a focus on the role of the professional in contemporary society and ends with a capstone activity in which the professional creates an ethical dilemma that encapsulates the issues for which disciplinary action was taken and then creates a well-reasoned argument to support a decision. Following is a rather general description of the learning activities, readings, and course assignments developed for the four capacities.

Moral Motivation: Role Concept Development

The course begins with a lecture and discussion session that poses this question: What distinguishes a profession from an occupation? A list of occupations and professions is presented, and participants are encouraged to think about the features that distinguish between them. Usually, participants are able, with guided questions, to identify most of the features sociologists and ethicists (Hall, 1975; May, 1999; Welie, 2004a; 2004b; 2004c) articulate. See Bebeau and Kahn (2003: pp. 425-427) for a synthesis of the characteristics of a profession, and the discussions by Welie (2004a; 2004b; 2004c) to hone one's understanding of these distinguishing features. After eliciting features that distinguish among occupational groups, it is possible to engage participants in a discussion of the expectations that society and the profession have for those who are or wish to become members. At this point, it is helpful to affirm the responsibilities the referred dentist articulated in his or her role concept essay, and suggest these as a starting point for the reflective essay the individual will be asked to write, rewrite, and refine as the course proceeds, and as greater clarity about the professional's responsibilities and society's expectations is achieved. The essay is critiqued and rewritten until each professional responsibility is expressed with clarity and with illustrative examples, reflective of the way the professional implements or intends to implement, these responsibilities. The essay also forms the basis for changes the professional expects to make in his or her practice as a result, not just of the disciplinary action, but of a renewed commitment to professionalism. At the end of the first seminar, participants are sent home with an inspirational videotaped lecture (and study guide) by William F. May entitled: "The Intellectual and Moral Marks of a Profession." The completed study guide serves as a stimulus for discussion at the subsequent session and the concepts of professionalism serve as a basis for feedback that is provided on subsequent iterations of the essay.

The activities just described are designed to clarify the role of the profession, to engage in active reflection upon professional responsibilities, and to engage the individual in a general reflection on his or her past action. The aim is to have the person set aspirational goals that may, in turn, become an action

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plan. Because disciplinary action often results from a lack of self-regulation and monitoring, it is particularly important to begin with a discussion of the role of the profession in society and the expectations that accompany the implicit social contract (which isn't written down anywhere), but is the basis of society and patient expectations. A secondary purpose is to gain consensus on professional responsibilities. Without such consensus, it is difficult to make much progress in dilemma discussion.

Moral Judgment Development

Moral judgment development begins with a discussion of the moral schemas that guide decision making. Participants are helped to reflect on the moral schema that is most predominant for the individual (DIT scores reflect preferences for a personal interest, maintaining norms, or postconventional moral schema) and to identify moral arguments that appeal to each. Individuals whose shortcomings are in moral reasoning usually are unfamiliar with basic theoretical approaches to resolving moral problems and may not be able to articulate the ethical principles that are used as an organizing framework for the ADA Code of Ethics. Participants are asked to read Rule and Veatch (2005) Chapters 3 (Basic Ethical Theory) and 4 (Ethical Principles), and a course handout (Bebeau, Pimple, Muskavitch et al, 1995) that articulate criteria for developing a well-reasoned argument for a moral dilemma. These criteria then form the basis for judging the adequacy of moral arguments that participants will develop in response to a series of five dental cases presented for discussion and case write-ups. These complex cases have been extensively tested in the dental ethics curriculum. Facilitator notes and criterion checklists have been developed and extensively tested over a 20-year period. These cases, notes, and checklists often serve as models for practitioners as they prepare for the capstone assignment (described below).

In addition to the dilemma discussions, for each seminar, practitioners read a chapter from the Rule and Veatch (2005) text and select one or more cases to write about. Journaling (handwritten or typed) engages the participant with the instructor in discussion of issues each chapter presents. Typically, the participant picks one or two cases per chapter for written commentary and (as time permits) follow-up discussion in class. Since the cases are real cases from dental practice, the participant is often reminded of challenging cases he or she has personally experienced. Journal entries describing such cases and how the participant resolved them give the instructor an opportunity to challenge participants' thinking and decision making. Many rich discussions have ensued.

As a capstone assignment, the participant is asked to develop a dilemma based on issues for which he or she was disciplined. The dilemma is critiqued and rewritten until it meets criteria for a well-written dilemma. When the dilemma meets this standard, the participant develops a justification that meets the criteria for a well-reasoned moral argument. This challenging assignment is not undertaken until the participant has concluded the activities above and those related to the Rule and Veatch text *Ethical Questions in Dentistry*. Normally, this assignment requires several discussions and rewrites, both to develop the case and to develop the well-reasoned response.

Ethical Sensitivity Development

Ethical sensitivity begins with an exercise in which participants are asked to reflect on their practice experience and make a list of characteristics of people that interfere with acceptance of treatment recommendations. Sometimes, thinking of the most difficult patients one has encountered in professional practice facilitates the development of this list. When done as a group activity, participants are asked to describe each characteristic and I group the characteristics in two columns following a framework (Bebeau, 1996) I devised after conducting this activity with many groups of practitioners. The framework then serves as a template for interpreting the ethical dimensions of cases. After working through the template with practice cases, the template is used as the practitioner engages in a self-assessment of the DEST cases that were completed as a pretest. In a later exercise, I ask practitioners to use the template as they conduct an intake interview with a new patient. Identifying ethical issues often entails working through why the dentist might have a duty to intervene in a particular situation. Examples of such a situation include: child, elder, or various forms of substance abuse; boundary issues of all sorts—including misuse of auxiliary personnel, cognitive deficiencies, personality disorders, and so forth. Identifying ethical issues and recognizing that the practitioner is responsible to take action, when such factors present, naturally leads to strategies for effective implementation.

Ethical Implementation Development

Ethical implementation requires skill in working out exactly what to say and do in order to effectively resolve an ethical problem. Not only is it important to have a clear conception of an ethically defensible process (e.g., for achieving consent for treatment), but it is also essential

that the practitioner is able to work out what to say and how to say it. As will be evident in the subsequent paper in this series, this is the area of ethics instruction practitioners have most valued, and an area that, in my experience with ethics education, is often neglected. Once a practitioner has actually practiced what to say and how to say it in a challenging situation–like talking to a previously treating dentist about work that seems not to meet professional standards, or speaking with a parent you suspect of abusing or neglecting a child, or respectfully declining to perform a patient's requested services–the probability of engaging in such conversations in the future is enhanced. Two references (Fisher & Ury, 1981; Wright, 1997) have been particularly helpful resources for practitioners struggling with effective communication. Helping practitioners recognize that interpersonally effective communicators often have little formulas they rely upon in challenging situations and then practicing the use of these does effect a greater sense of professional satisfaction and well-being. After the DEST transcript has been used to assess ethical sensitivity, it also can be used to examine communication strategies. Because each of the cases presents a challenging ethical issue, participants can rethink how to handle the problem and then create a dialog to achieve their good intentions.

Summary and Adaptability to Other Settings

In this paper, I describe a process, together with measures and educational intervention strategies, that the Minnesota Board of Dentistry and I devised to provide an opportunity for professionals–following an adjudication of complaints about their professional competence or conduct–to engage in a reflection on their ethical competencies, and to remediate any identified deficiencies. In the second part of this series of articles, I will summarize the evidence, from multiple data sources, that supports the effectiveness of the program.

My purpose in presenting the process and describing evidence of effectiveness is to provide others, both licensing boards and ethics educators, with a detailed description of what has worked for us in our context. As I have described our process and measures to other interested parties, several questions emerge about the administration of the measures: Who actually administers the measures? What kind of background should such a person have? Are there areas for which training is necessary, and if so, how could it be acquired? Is collaboration with an expert possible, and if so, how?

As I tried to indicate, all the measures are available for use by others. None require special expertise to administer, though anyone using a particular measure needs to become familiar with the measure and its directions for administration and interpretation of findings. Except for the DIT, and the RCE, the measures are specific to the profession of dentistry–though each has been adapted in at least one other profession. (See Bebeau & Monson [2008] for more details about the most recent adaptations of the measures to other settings.) All measures have been used by other dental ethics educators without special training, though such training would likely be helpful. Collaboration with persons with expertise is possible, and the American Society for Dental Ethics (ASDE) sponsored a workshop on the use of the outcome measures at the 2009 annual meeting of the American Dental Education Association. Both the ACD and ASDE could assist interested parties to arrange for future workshops. ■

Helping practitioners recognize that interpersonally effective communicators often have little formulas they rely upon in challenging situations and then practicing the use of these does effect a greater sense of professional satisfaction and well-being.

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