Position Paper on Digital Communication in Dentistry

Officers and Regents of the American College of Dentists
Prepared by David W. Chambers

Abstract

Digital communication offers advantages and challenges to dental practice. As dentistry becomes comfortable with this technology, it is essential that commercial and other values not be accepted on a par with professional ones and that the traditional dentist-patient relationship not be compromised by inserting third parties that introduce nonprofessional standards. The Officers and Regents of the American College of Dentist have prepared this background and position paper as a guide to the ethical use of digital communication in dental practice.

There are eight principles:

1. The professional relationship between dentist and patient should not be compromised by the use of digital communication.
2. Digital communication should not permit third parties to influence the dentist-patient relationship.
3. Dentists should exercise prudence to ensure that messages are professional and cannot be used in unprofessional ways by others.
4. Personal data should be protected and professional communication should be separated from personal communication.
5. Dentists should be generally familiar with the potential of digital communication, applicable laws, and the types of information patients have access to on the Web.
6. Practitioners should maintain an appropriate distinction between communication that constitutes the practice of dentistry and other practice-related communication.
7. Responses to criticism on digital media should be managed in a professional manner.
8. Dentists should be prepared to make more accommodations to patients than patients do to dentists in resolving misunderstandings about treatment.

Electronic media have created entirely new ways for people to communicate. New media have altered what we discuss. They also have the capacity to build new relationships and change existing ones, and they leave a footprint. Finally, they are evolving at a rate that is currently faster than most users can keep up with, faster than society can absorb and respond to, and in ways that are not easily predicted.

Digital communication media are exploding. While household budgets for clothing and other items are shrinking, the digital budget is increasing rapidly. In terms of convenience and content, tablets outperform movie theaters. Handheld devices have more computing power than computers that filled rooms a few decades ago. There are apps for selecting apps. Few can name all the social media programs that exist, and the list will change next month. The big-box stores that threatened to dominate American commerce a decade ago are being shouldered aside by online shopping. Students can "fact-check" their professors while the lecture is in progress.

Some dentists are digital communication mavens, both personally and professionally. Others are reluctant. Still others contract for media services. The majority are perhaps fragmentary users. Regardless of dentists' attitudes and talents with digital media, their practices are affected by patients who are skilled in placing a digital interface between themselves and professionals.

Commercial firms have also inserted themselves into the dentist-patient relationship. They have not asked nor do they need permission to do so.

Integrity of Dental Values Uncompromised by Digital Media

In October 2011, the Board of Regents of the American College of Dentists created a task force to explore the impact of digital communication on dentistry, with a view toward preparing a position paper on the subject. The resulting position paper was approved by the board in October 2012.

The intent of this position paper is to inform dentists of some of the effects of digital communication on dental practices. Dentistry is based on a set of professional values that guide practitioners toward improving oral health consistent with the dignity of the patient. These values are expressed in the objectives and codes of the American College of Dentists and the codes of other professional organizations. Digital communication is also embedded in its own value structure. These values are more diffuse and not necessarily consistent with professional values. The overarching theme of this position paper is that dentists should live their professional values uncompromised, regardless of their involvement in digital communication. Further, it is incumbent on dentists to be familiar with digital

communication and its potential impact on dentistry, regardless of the extent to which they use these media.

A Classification of Digital Communication

The term "digital communication" is intentionally general: it is used to indicate a broad class of technology and uses, including cellphones, Google searches, turnkey electronic dental records, customized Web sites, e-mail, YouTube, sites that gather and disseminate information about dentists, Facebook and its many cousins, health-related apps, tablets for patients to enter health histories, and many others. To the extent that traditional forms of communication such as the Yellow Pages, newsletters, and phone calls share the functional characteristics of digital communication their use is incorporated into this position paper.

The physical characteristics and business names of digital communication devices is diverse and rapidly changing. The best way to understand this field is in terms of functional features. Despite their range of manifestations, digital communication shares these characteristics:

- Rapid, almost instantaneous dissemination of content
- Extremely low cost for multiple distribution
- Longevity of content, will not go away
- Potential for anonymity and aliases
- Inexpensive and rapid creation, editing, and updating
- Privileging of short messages
- Privileging of visual content
- Partial regulation
- Increased difficulties maintaining security
- Conflicted understanding of privacy
- Large participation but fragmented across platforms
- Senders and receivers need not share time and place
- Easy and almost costless duplication and forwarding
- Potential for misrepresentation and unintended use by others
- Potential for sharing content out of context

The intended use of digital communication is an accepted means of classification. There are three broad categories: (a) broadcast, (b) relationship, and (c) transaction.

Broadcast. The broadcast function of digital communication is a one-to-many dissemination of a fixed message. The typical Web page or blog is just a fancy, inexpensive Yellow Pages ad, billboard, catalogue, or other general message. Some dentists are producers of broadcast digital communication; all are consumers. Wikipedia, online dental journals, information about dental products, and room availability for conventions are examples of sites to which dentists refer for packaged general messages. Organizations of all types, from a local restaurant to the American Dental Association, create an image of themselves and reveal selected information to targeted audiences. By extension, these images also affect the public's perceptions of the dental profession generally.

Commonly, broadcast digital media are intended to distribute uncustomized information. Information is selected by the producer, not the consumer; it is not individualized, but instead tailored to a hypothetical "modal customer"; it is intended to put the best face forward; usually it has high visual content because attention span will be short. Sometimes called "Web 1.0," broadcast-function digital communication is one-directional. The trend is for such sites to invite transfer to other two-way communication media (the second function), such as a phone number or Twitter feeds or to sections that handle business transactions (the third function). Broadcast function sites often discourage interactive communication and may specifically state that no reply will be responded to. Success of Web 1.0 systems is measured in "hits" or "eyes."

Relationship. Web 2.0 is the common designation for a second function of digital communication designed to build relationships through exchanges of messages. Those who are struck by the banality of Facebook postings have missed the point. The message is subordinate to the relationship. Twitter limits the number of characters in a message to 140, forcing canned abbreviations. The small screens on handheld devices discourage depth of communication or management of complex issues.

Social media can be used to very quickly spread tiny bits of information through a network, but the work of network building must have taken place previously. Relationship-building digital media define status. Celebrities lose much of their legal protection from defamation because they are "public" figures and the number of their contacts is media content. Social media represent a challenge to established power because it is not based on established position or depth and accuracy of information, nor is it vertically structured. Every user of social media is at the center of his or her Web, and importance is a function of the number and richness of the cascading relationships. Cellphones and text messaging can be grouped under this heading. Web 2.0 measures success in terms of followers, members, subscribers, and the like.

Transaction. Digital media are rapidly beginning to manage transactions, and this is the third function. Dentists and their office staff can purchase supplies, register for meetings, pay professional dues, participate in surveys, and contract with Web designers using electronic media. Patients can locate

dentists, make appointments, pay bills, and fill prescriptions on the computer. Within the office, functions such as obtaining informed consent, patient education, and graphically assisted treatment presentations are becoming electronic. The situation has come further in medicine, where patient questions to providers are taken on the computer, chronic conditions are managed by teams of mid-level providers reaching out to patients before symptoms appear, and consultations among professionals and even diagnoses are mediated electronically and in the complete absence of a physical patient. The impact of the transaction function of digital media is measured in traditional business terms of time saved, accuracy, number of transactions, and profit.

The reason for offering this brief categorization of the three functions of digital communication is to demonstrate its reach, to show that dentists may occupy various roles in the network, to draw attention away from the gadgets and the apps and focus it instead on the effects that can be expected from various patterns of use of digital media. It is the effects of electronic communication that count. Dentists will participate in digital communication in many ways, and success will be defined differently across practices. It is the fit between the practice and the media that matters, not just getting the currently most fashionable equipment.

Principles for Professional Use of Digital Communication

Eight principles are presented to guide the use of digital communication as an effective extension of dental practice. Where the relationship between new media and dentistry is synergistic, we have noted ways dentists can enhance oral health care by taking advantage of new ways to communicate. Where there are conflicts, these are pointed out, including possible adverse effects and appropriate precautions. The term "should" and cognate phrases are used in their ethical sense, calling dentists to higher ideals. Although there are legal and regulatory considerations in the use of digital media, such as Health Insurance Portability and Accountability Act (HIPAA), the positions presented here are aspirational rather than requirements.

1. The professional relationship between dentist and patient should not be compromised by the use of digital communication.

The relationship between dentists and patient is special and essential to appropriate care. Although the term dentist-patient relationship will be used for convenience, this should be understood in the broadest sense of including the entire dental office team, the dental profession generally, and individuals who are not patients of record but are in need of oral health care. This relationship is based on trust. It is impossible for patients to know all the necessary details of their current oral condition, its likely course, alternative interventions, or even the competency of particular dentists to provide the best care. Similarly, dentists have to trust patients to provide accurate health status information, follow through on their part of care, and pay for services. Further, dentists have a wide range of individual strengths and skills, and patients represent individual combinations of medical, dental, and personal needs and values.

Dentistry is a relationship that is intensely customized and based on trust. It cannot be turned into a commodity without compromising it. A commodity is something of value that has been standardized and stripped of its unique features to the point where each unit is interchangeable and the only way to add value is to compete on price.

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A traditional idea in dentistry, and one that the American College of Dentists believes should remain central to its identity, is the five Cs of comprehensive, continuous, competent, compassionate, and coordinated care. Appropriate care addresses all of the patient's oral health needs, not just ones that the patient picks out because of uninformed interest or the dentist identifies because of personal preference or potential for other returns. It is also continuous, both over the number of appointments needed to achieve stability and via recall. Competency for the level and type of practice is assumed by the patient and should be guaranteed by the profession. The phrase compassionate care is redundant, but it reminds us that "care" is not synonymous with "treatment." Finally, the capacity of one office should never place a limit on the potential for the health of any patient. Where appropriate, care should be enhanced by referral to a specialist while the general practitioner retains overall management responsibility, cooperation with insurance and other financial resources, and attention to total health by coordination with all health professionals.

This general ideal can serve as a standard against which to evaluate the use of digital communication.

New patients can be recruited by electronic means. It is certain that individuals use their computers and hand-held devices to make contacts and form first-impressions of potential practices. In this sense, the ethical issue is what image the practice provides for the general public in its broadcast of one-to-many messages. Information about practice type, including limitation of services based on advanced training or limited practice type, office location, hours, languages spoken, and even practice philosophy (family-oriented, comprehensive, community-based) are all appropriate. Insurance acceptance, credit availability, and other features having to do with payment are more nuanced. It is assumed today that standard financial arrangements will be available in all businesses, so dentistry may be well served to avoid any reference that might be construed as suggesting that oral health care is a commodity. Perhaps the most informative statement along these lines would be that insurance plans are not accepted.

Because search behavior of electronic media is dominated by superficial and quick searches for "hits," a position near the top of a search algorithm and a quality visual image are critical. One gets to the top of a page by paying for it, by having been successful in previous searches, and by using key phrases that match the terms potential users will use in beginning their searches. A patient who is interested in "sleep dentistry" is not seeking a definition of sleep dentistry (they have already searched the Web in general if they have any appreciable level of curiosity). They want to see the term on the office Web page, surrounded by other symbols they associate with quality care. In general, Web 1.0 users are not interested in reading a Web page but they can, in a fraction of a second, form an impression of the office from the overall appearance of the page.

The ethical issue associated with broadcast digital media is the difficulty of establishing personal relationships with patients. Because it is difficult to honestly express factors associated with the quality of care indicated by Web 1.0 format, there is a temptation to emphasize other characteristics. The proportion of Americans visiting the dentist has not increased noticeably in the past decade (it may have actually decreased slightly), but the number of patients changing dentists has grown. It is likely that broadcast digital communication has promoted "churning": patients moving

from one dentist to another. This represents a threat to the value of continuity of care.

It should also be borne in mind that the use of broadcast digital communication is one-way and there is a certain generality about where the message is coming from. That means there is no opportunity in the communication itself for correcting misconceptions. What is more troublesome about the communication channel itself is that the message can be and usually is interpreted as coming from "dentistry." The attractive expected outcome is what "dentistry" has to offer, and the one that most attracts the would-be patient's attention is just the best of what dentistry has to offer. All digital communication between dentists and the public speaks for the profession as a whole. The potential for broadcast digital messages regarding dentistry to reach the multitudes underscores both the legitimacy and the importance of the profession as a whole, taking an interest in what individual dentists are saying to the public about oral health.

A second characteristic of broadcast digital communication, one that is not as large a concern for relationship building and transactions, is anonymity and image manipulation. Traditionally, individuals sought out professionals based on their reputations among acquaintances. This was followed by a face-to-face meeting and the beginning of care that, if all progressed satisfactorily, grew into a relationship. Positive relationships feed positive reputations. The dentist-patient relationship was personal, customized, and based on the outcomes of care. Digital communication has the potential for short-circuiting this cycle and distorting the dentist-patient relationship. When dentists seek patients based on a promised image of care, the relationship collapses into one involving providers and customers. Dentists compete on criteria that can be standardized, such as appearance and price. Customers shop. What has happened in these cases is that expectations based on anonymous and mass-produced (or marketing-manufactured) images has been substituted for personal dental care. All five Cs are put at risk: comprehensive, continuous, competent, compassionate, and coordinated care are left off to the extent that they cannot be quickly depicted on a computer screen. It is a limp answer to say that digital communication allows us to better give the customer what he or she wants. This is a substitution of commercial for professional values. If such customers wanted veneers on periodontally involved teeth, no professional should accede.

A large positive potential exists for digital communication to build relationships between existing patients and the practice. This is the function that was managed traditionally by the office newsletter. Patients begin to identify with the practice when they see their comments or images on the office Web site. They will check to see whether their Facebook postings have been responded to. The practice is building a community by hosting a site. The important values promoted by an effective office Web site include all but one of the five Cs: comprehensive, continuous, compassionate, and coordinated care. These four are fertile fields for effective use of social media. Competence of the dentist and staff is the one value that cannot be enhanced through the use of electronic communication. Claims of competence, even indirect ones such as announcing that the dentist has been selected for some form of distinction, are inappropriate and unnecessary in electronic communication designed to build relationships between the office and the patient. Use of the initials FACD in electronic communication with patients is contrary to the Code of Conduct of the College precisely because it can be misinterpreted as a claim of competence.

Electronic transactions are just beginning to become a part of dental practice. To the extent that they ease any perceived barriers to care they offer great potential. The largest issue with respect to digital support for transactions in the dental office is that most such applications are purchased from outside vendors. Care should be taken to ensure that the services match both the needs of the office and the characteristics of the range of patients served. Additional care is required to make certain that patient privacy, confidentiality, and security are honored. It is also appropriate to inquire of vendors with respect to the full-value proposition or business model. It can happen that the fee paid to vendors is only a small part of the benefit they derive from an arrangement. Access to information about patients can often be of great value to vendors, as can connection with the dentist's business relationships, reputation, and even control over access to patients.

2. Digital communication should not permit third parties to influence the dentist-patient relationship.

Some dentists are quite adept at developing and using digital communication as an extension of their practices. Most copy general trends in the profession and must rely on commercial vendors and consultants. This situation is much like the relationships that exist between dentists and equipment manufacturers, brokers, insurance companies, and advisers, including practice management consultants. The role of third parties in dentistry is to assist the dentist in providing more and better dental care

than would be possible otherwise.

As dentists seek assistance in designing and implementing digital communication systems in their practices they should be aware of the potential for introducing the virus of commercialism that sometimes accompanies these applications. There is no value in equipment sales or software development that corresponds to the oral health promotion value or dentistry or the professional value of promoting the patient's long-term interests. Advice, services, and equipment are sold to dentistry as commercial transactions, and the standards governing these sales do not extend to cover the same range of values that prevail in dentistry. It is the dentist's responsibility to ensure that decisions about digital communication place commercial interests in a position subordinate to oral health.

Dentists are open to introducing third-party influences in all three types of digital communication: broadcast, relationship, and transactions.

Web designs, communication practices, building of electronic communities, and computerized interfaces with customers that are most effective in commercial applications are not automatically the best ones for a dental practice. The operative question is not what other users are doing or what financial rewards others have gained but whether patients have better oral health as a result of the practice adopting certain kinds of digital communication.

The common commercial index of success, number of "hits," is of doubtful value. The true professional value is oral health outcomes. Discounts and giveaways orient patients to cost rather than health. Chaining and hosting—rewarding patients for using their computers to promote your practice—are mistaken notions of what dentistry offers. Advertising prices and offering guarantees may be acceptable to other clients for whom Web designers' work or some things which a practice might be tempted to copy, but they risk being false or misleading in dentistry because of its custom nature. Unqualified price offerings can drift toward "bait and switch" practices. The common thread in these examples is that nonprofessional, commercial values may creep in when digital communication is designed by outside vendors or borrowed from sources that do not understand the professional nature of dentistry. It is the dentist's responsibility to ensure that inappropriate third-party influences are kept in place.

In extreme cases, third parties insert themselves into dentistry by becoming co-providers of care. Groupon is an example where a for-profit company has attempted to broker increased numbers of patients to the dentist in exchange for lower cost to the patient. The prospect that a third party could make a profit from such a model presumes that there is an excess margin in dental fees. There are also third parties who are willing to provide ancillary dental services, such as lab testing, financial services, and patient education to be accessed from the Web pages of practices. This normally includes a financial return to the dentist for allowing others to become partners in patient care.

It is embarrassing to Google-search a dentist's name and find half a dozen sites introducing that dentist. It is sometimes the case that dental trade association groups that dentists join will sell personal and practice information to vendors as a source of non-dues income. The American College of Dentists does not engage in such practices. These sites offer unrelated services, such as listings for other dentists in the area, advertisements in the margins, and even an opportunity to rate the quality of the dentists one has not yet seen. Typically, such sites offer patient education information about such topics as disciplined licenses (which they mine from public records available to all through state Web sites) as a value-added feature. Other vendors are more direct, offering to give an opinion without being asked. For example, organizations now notify dentists that they have been recognized and offer to publicize this fact for a fee. In all of these cases, a third party with some sort of commercial interest is seeking to insert itself between the dentist and the potential patient. This is perfectly acceptable in a commercial culture. Dentists should regularly monitor their electronic public image. To the extent that all dentists offer excellent care based on the five Cs, there is no commercial value that third parties can profit by selling. Third-party information is only valuable to the extent that it guides patients and others through a fragmented profession.

3. Dentists should exercise prudence to ensure that messages are professional and cannot be used in unprofessional ways by others.

The communication between dentists and patients is inherently individual, personal, and complex. The discussion of how best to manage oral diseases, their complications, and the effects these have on patients' lives is best done in an environment of trust, give and take, and where there is an opportunity for immediate responses to patient's concerns and an opportunity to evaluate nonverbal and other circumstantial factors.

There are aspects of dental communication that do not require this level of interaction and may be well suited to digital communication. These include information about the practice location and characteristics such as office hours, bills sent to patients on a monthly payment program, and information shared as a community outreach, such as back-

ground information about an upcoming public water fluoridation campaign.

Although it is impossible to prevent all cases of others misusing messages and information that appear in digital format, reasonable precautions include password protection and other security practices, legal disclaimers accompanying postings, care in distributing messages, and prudence regarding content. The last suggestion—not saying anything one would be embarrassed to read on the Internet with one's name attached to it—probably affords the greatest degree of protection. Care should be taken to ensure that professional communication matches the media used. Three factors are especially important.

First, no claim should be made in a public forum that is not universally applicable to all patients or the public. If there is any question whether a statement on the office Web, in a text response to a patient, or through a commercial service will have to be qualified once there is a direct relationship between the dentist and the patient, it is questionable whether such a statement should be made. Claims such as "one-day tooth straightening" and "painless dentistry" either are misleading or involve puffery, a watering down of professional communication. An office that blogs about how friendly it is to everyone runs the risk of not being able to dismiss patients or cultivate a "select clientele" without broaching hypocrisy. Adding quibblers such as "generally" will make the lawyers happy but may still leave a bad taste about the profession as a whole in the mouths of patients. The ethical principle of veracity is defined by philosophers as not allowing others to maintain misbeliefs that are detrimental to them. This is a higher standard than telling the truth.

Second, care should be taken with claims and information where others can hijack the information for their own, nonprofessional purposes. Politicians, CEOs, actors, and sports stars are not the only ones who have been bitten by an unflattering remark captured on a cellphone. The concept of "going viral" means that digital content has escaped the control of the originator. That can be an attractive prospect in the case of flattering messages, but devastating if the message has negative overtones. The important thing to remember is that there are reasonable controls on the context of direct communication between dentists and patients that disappear when the content becomes digital. Digital content has a life of its own, and it is an indefinitely long life.

Third, consumers of messages on digital media are often unclear about the source of the message. The reputation of every dentist is affected by the actions of heavy users of media, regardless of their own attitude toward it. Many dentists or their office staff have been confronted with a computer printout of an unsubstantiated treatment or of price quotes from other offices. Some messages are naturally easier to express digitally. Usually attractive outcomes are better understood by the public than improvements in health. Simple and quick treatments are easier to explain than cases involving staging, tradeoffs, and complex decisions. Inexpensive, single prices are easier to grasp than fees contingent on the multiple factors of the case. Because digital communication favors short, standardized messages, it is intrinsically biased toward misrepresenting the most appropriate forms of oral health. That is the case before considering the attractiveness of digital media in the hands of those who intentionally misuse it for personal gain.

4. Personal data should be protected and professional communication should be separated from personal communication.

A traditional idea in dentistry, and one that the American College of Dentists believes should remain central to its identity, is the five Cs of comprehensive, continuous, competent, compassionate, and coordinated care.

Patients have unprecedented access to health information and misinformation on the Web.

United States law has established standards for healthcare professionals with regard to their communication about patients. Certain individuals and entities are entitled to access to this information, including patients themselves, insurance companies, and the courts under some circumstances. Others are specifically excluded from seeing the information. The HIPAA regulations are over 1,000 pages long. The "P" in HIPAA does not stand for privacy. The word is "portability," as in Health Insurance Portability and Accountability Act. The underlying issue addressed in this legislation is that patient information will be ballooning in value and flying around at fantastic rates once it has become digitized, thus formal standards are needed.

The three fundamental standards in HIPAA are privacy, confidentiality, and security. These are not three terms for the same general idea; they are three ways that the information about people is part of the dignity of the person.

Privacy refers to the right to refuse to reveal personal information. If a patient is coerced or tricked into revealing information about their sexual preferences, their income, or their health status to individuals who have no business knowing this, their privacy has been violated. This is true even if that information is not shared with anyone else. In an electronic world where there is so much personal information in cyberspace, we have become concerned that we should not have to reveal anything more about ourselves than we choose to, unless that information is needed for legitimate purposes. Usually, we must be informed about privacy policies, although the notifications are now so ubiquitous, lengthy, and expressed in such legal language that in fact we may not actually be informed. Think of a violation of privacy as looking for information that one should not have.

Confidentiality is sharing information you have, whether obtained by appropriate means or otherwise, with people who have no business knowing it. Most of the "privacy" issues involving electronic information are really concerns about confidentiality. Selling mailing lists, leaking classified information, and gossiping about famous patients are violations of confidentiality.

Security, the third function, means taking reasonable precautions to ensure privacy and confidentiality. Unauthorized individuals should not be placed in positions where they may overhear private details. Charts should be stored in locked cabinets. Staff should be trained. And suspected breaches must be reported according to the regulations of federal and state laws.

Broadcast digital communication is not likely to be an issue with regard to personal information—it is the dentist who is making revelations. Transaction digital communication is especially at risk as it contains health history, financial, and other sensitive matters. Relationship digital communication may become an issue as cellphone communications and texts can now be subpoenaed and may be inadvertently sent to the wrong people. Hosted Web sites may post information that later is recognized as inappropriate. The dentist should make a determination in building relationships where the proper boundary is between professional and nonprofessional communication.

It would also be out of bounds to brag about well-known patients on the practice Web site. If permission had been given for such posting it would not be illegal, just very bad taste. Facebook and

other social media sites should be closely and continuously monitored and inappropriate postings removed immediately in cases where that is possible. In fact, it would be good practice to have a clear policy regarding publication of personal information printed on the site. Transaction electronic sites, such as payment systems, automated health histories, and insurance apps need to be carefully designed and monitored for conformity with HIPAA regulations. It is prudent to give training and guidelines to all staff members, and to log in from time to time as a potential user of one's own digital communication to see what it looks like from the outside.

A slippery area is the dentist's personal media use. Occasionally, the formal office protocol is immaculate, but the line between personal and professional communication of the dentist becomes blurred. Dentists should not become faceless, unreachable non-entities. Neither should they be everyone's "hangout buddy." Virtually all professions except dentistry have formal language in their codes of professional conduct regarding avoidance of dual relationships. Dentists should protect against the ambiguities of indistinct professional boundaries by maintaining separate e-mail addresses, Facebook and other social media accounts, and cellphones. One is for the dentist as a person and one is for the dentist as a professional. Communication to patients or staff that comes over the wrong channel is apt to be misinterpreted. A legal action should never open a dentist to requests for access to personal communications just because they have been blended with professional ones.

Although the dentist is ultimately responsible for all practice communication, it may prove useful to delegate continuous monitoring of the office social media site to a staff member for the sake of consistency and immediate attention. First, the staff member has more time. Second, there needs to be a buffer in decision making between the request and the dentist as the ultimate responsible authority. And third, patients may overuse direct access to the dentist and they might interpret everything the dentist says as professional communication. Diagnosing on the cellphone is very risky business.

5. Dentists should be generally familiar with the potential of digital communication, applicable laws, and the types of information patients have access to on the Web.

Digital communication affects all practices, even those where the dentist is personally determined not to participate. Because of the nearly universal use of digital communication and the inevitability of having to make decisions about its benefits and its abuses, dentists should know enough in a general way to make ethical decisions and to seek competent advice when that would be helpful. At a minimum, dentists should be able to distinguish between those opportunities that help or harm patient care based on informed opinion rather than vague awareness of "trends."

There are no general laws or ethical principles that apply exclusively or in a special way to professional use of digital communication—with the exception of HIPAA and perhaps some others. Special cases may come to light, and dentists should seek the advice of qualified council if that is suspected to be the case. The obligation that cannot be avoided is to think through the effects of using digital communication and then to apply the same standards of law and ethics that would be applied to the same effects were they the results of any other action not involving digital media. The five Cs of comprehensive, continuous, competent, compassionate, and coordinated care can serve as a guide.

Dentists should also be familiar with applicable law and regulation regarding practices involving digital communication and ethics and professional standards that guide their use. Among the issues that are essential are relationships with third parties (as in responsibility for patients), relations with other practitioners (as in fee splitting), privacy, confidentiality, and security (as in HIPAA), and copyright, libel, and conflict of interest matters. Various codes of professional conduct and ethical guidelines are also relevant. For example, mention of branded products or treatment modalities on one's Web site may constitute an endorsement and create an undisclosed conflict of interest. Colleagues may come to regard claims or even the general appearance of broadcast sites as claims of superiority. And, of course, every practice or statement that is ethicalyl questionable when presented in any other medium is equally suspect in digital format.

A 2009 study of all dental practices in San Francisco revealed that 11% of dentists practice in offices that market themselves by a fictitious name that does not include the identity of the dentists. It might be imagined that these practices have distanced themselves to some extent from direct personal relationships with patients. Disconcerting is the fact that less than half of these practices with fictitious business names have registered the name with the state dental board, a requirement for licensure. The same study found that 24% of practices list a Web site. Likely the number is

greater today. There was no difference in the average age of dentists who have Web sites and those that do not.

Patients have unprecedented access to health information and misinformation on the Web. No one can "unring" that bell. It then behooves dentists to be at least familiar with both commonly used patient sources of information and with the more widely circulating claims. A dentist should count it as fortunate when patients present questions about such claims and ask for a professional opinion. The alternative of patients simply matching their uninformed opinions with dentist Web sites that contain the key words they are looking for is borderline collective malpractice. But dentists should be informed well enough about what patients are finding to have an honest discussion that extends beyond their own scientifically-based knowledge. It is an irony that in an age of massive information available to the public, professionals now have the additional responsibility of being familiar with the misinformation that patients are apt to encounter and of having the skills to guide patients to sound oral health choices.

6. Practitioners should maintain an appropriate distinction between communication that constitutes the practice of dentistry and other practice-related communication.

Some dental treatment is accomplished without the use of a handpiece. For example, a patient may phone with postoperative pain and be instructed by the office staff to take analgesics and continue self-monitoring. It might be argued, if the case fails, that the staff member was practicing dentistry without a license. Similarly, patients may rely on information posted on the office Web site in a way that causes complications. Although disclaimers can be added to digital communication, it is unclear at this point the extent to which this constitutes legal protection. There have been reports from the medical community that physicians responding to text messages from patients have increased legal exposure.

The fact that dental licensure in the United States is managed at the state level raises additional concerns because electronic media know no geographic boundaries. Charts, prescription information, photographs, and radiographs can be transmitted electronically, often with no clear identification of the location from which they originated. If patient advice, professional consultation, diagnosis, or direction of care given by staff is interpreted as constituting dental treatment that crosses jurisdictional boundaries, the dentists may be practicing without a license.

7. Responses to criticism on digital media should be managed in a professional manner.

It is unlikely that the growing availability of electronic media has or will increase the proportion of actual negative experiences in dental practice. The ratio of patients upset with their care and the ratio of patients who are difficult to manage are likely constants. What is rapidly changing is the capacity for these disagreements to be played out in front of a large audience and the prospect that third parties will become involved. In two studies of dentists' preferred response for managing issues of a technical nature or those involving staff, patients, financial matters, and office routine, the overwhelming "go-to" strategy was face-to-face communication. This is judged by dentists to be both the most commonly used approach to solving problems as well as the most effective one. Appropriate adjustments are made and reputation is maintained most effectively through personal conversations. Such conversations are increasingly taking place in public. It will become more difficult for dentists to exercise control over oral health communication.

Increasing caution is required with regard to communication in the office regarding patients and one's professional colleagues. It has always been unprofessional to make disparaging comments about patients, especially those that involve value judgments. With more office records being in electronic format, even including texting and cellular phones, the prospect is growing that damaging remarks will be uncovered during the discovery phase of a legal action. Sophisticated electronic search algorithms exist for finding information, and data has an increasing life span and is becoming almost impossible to dispose of. A more professional level of discussing patients and of discussions with patients is now required. Training of the office to ensure that this standard is the dentist's responsibility.

There have been clear examples of dentists' reputations being unfairly impugned by patients spreading reports of what they interpret as poor treatment. Various electronic media have been used for this purpose, including postings on dentists' Web sites, postings on patients' own sites, and postings on public sites, as well as traditional word of mouth. Some of this damage has been justified and some has not. More people are reached by digital postings, messages tend to be more strongly worded because the writer must justify the position, blasts reach people who are not in a position to know all of the relevant facts. These circumstances narrow the possible actions a dentist can take in response.

The new reality of wider public scrutiny of practice invites any of several responses.

Improved patient relationships in the office are the preferred strategy. This

takes the form of full communication, more extensive involvement in informed consent, development of multiple channels of communication with staff, and clear signaling that the dentist is willing to listen and discuss concerns on a personal basis. In this sense, the best antidote to potential abuse of digital communication is effective use of non-electronic communication in the office.

Once patients have signaled, publically, that their sense of trust has been violated, the dentist has the options of ignoring the matter, denying the facts, offering excuses, promising reparations, apologizing, and taking or threatening legal action. Efforts should be made to obtain a copy of the electronic complaint. Failing to respond, denial, and making excuses (including blaming the patient) generally have the effect of creating further distance and potential escalation in front of an audience. Even when the original issue is ambiguous, a disgruntled patient is on very solid grounds in complaining to anyone who will listen when the dentist refuses to engage in a conversation. That will become the dominant voiced concern. Courts and malpractice carriers are sensitive to due process matters. Promising reparations is a decision about the costs of maintaining a patient or one's reputation. Some malpractice carriers still advise against professionals apologizing, although the literature shows that this does not increase and may actually decrease settlement costs in the event of legal action. It does have a strong effect on decreasing the likelihood of legal action. Apology includes a believable expression of regret over the outcome and openness to accept just responsibility. The apology should be extended in private and should be understood as an invitation to seek a mutually satisfactory resolution.

The literature on service recovery (effective management of customer complaints) shows that satisfied customers tell three friends and dissatisfied customers tell seven to ten. Digital media magnify these numbers but probably do not change the ratio. The goal of service recovery is to convert an unsatisfied customer into a satisfied one. An open effort to do this is often effective, and surprisingly, recovered customers are actually more loyal than originally neutral ones. It is something like remineralized enamel.

A third alternative is to engage in positive reputation building through customers. Recently companies have very openly taken to "coaching" customers about responding to satisfaction surveys and openly soliciting testimonials and positive comments. It is not uncommon for service companies to instruct personnel to inform customers that they "expect a perfect 10 on the third-party survey you will be receiving." This has extended to language, often buried in consents and agreements that the customer can be used for promotional purposes at the discretion of the company. There are firms that will sell bulk Facebook "likes." At the homemade level, small businesses encourage employees to make positive comments on relationship-hosted sites and to recruit their family and friends to do the same. This local ballot box stuffing is sometimes so crude that it must be obvious. The ethics of professionals soliciting favorable public opinion is suspect.

The most reactive, and certainly the most damaging, response is for professionals to attempt suppression of negative opinions expressed in public. There are two forms this response takes. First is legal action under the head of prosecution for libel. Libel is the publication of defamatory remarks that tend to injure another's reputation. To prevail in a libel case the plaintiff must be able to show that the claim was made by a

The most reactive, and certainly the most damaging, response is for professionals to attempt suppression of negative opinions expressed in public.

person who knew or should have known that the damaging statements were false. A patient's opinion that he or she was not treated as they expected to be treated generally does not meet this criterion. A second strategy that some professionals have attempted to prevent negative postings to electronic systems is to require that patients sign a promise that they will not criticize the provider. Courts have almost universally rejected libel cases brought by dentists against their patients and have held that contracts precluding expression of opinions following treatment to be against "public policy" and unenforcable.

Sites such as Yelp, Angie's List, Healthgrades, Ratemds, Vitals, and Doctoroogle are commercial platforms that serve the public by hosting the opinions of users of professional services. They are lay ratings of professional services—uninvited electronic scorecards. Presumably there is an equal potential for an uninformed patient or a family friend to give a practice an unrealistically high rating or for an equally uninformed or biased individual to give an unwarranted low rating. The fact that third parties can make a profit by hosting such ratings demonstrates that professional reputations have value. Dentists should monitor these ratings and seek to diagnose opportunities to improve their reputations.

8. Dentists should be prepared to make more accommodations to patients than patients do to dentists in resolving misunderstandings about treatment.

There is a perception of a double standard for professionals and the public in terms of what can be said in public about their relationships and how far each should go to resolve differences. That perception is accurate, and professionals have to extend themselves more than patients do.

This is the case for two reasons: one ethical and the other economic. There is an implied contract between the professions and the public which includes, among other matters, an expectation that the profession will have exclusive markets and a degree of self-policing in exchange to its agreeing to serve the public's interests. This is different from the relationship between the public and commercial operations such as car dealerships or pest control. Professionals are granted a very large measure of trust from the beginning of any relationship that strictly commercial relationships must earn.

To the extent that dentistry is both a profession and a business, there is a risk that professional trust will be compromised when dentists signal an emphasis on commercial values. There is certainly ample potential for confusion. It would be inherently unethical for dentists to expect the full benefits of professional trust at the same time they counted on full access to the rewards of commercial enterprise. Digital communication, with its bringing previously private relationships between patients and dentists into public view and beginning to make a place for third parties in those relationships has drawn attention to the ethical dimension of this double standard.

The economic reason why dentists must extend themselves further to reconcile differences of perception between themselves and patients is because dentists are in a favored position in the relationship. Finding the "fair" balance between parties of unequal power is known as the Nash Bargaining Solution. John Nash won the Nobel Prize in Economics in 1994 for, among other things, pointing out that society pulls toward a balancing of conflicts of interest based on how much each party has to lose by not reaching accommodation. Generally dentists enjoy economic status, reputation, and positive standing in the communities where they live and work that exceed those of their patients. Ethically fair resolutions of disagreements are based on adjustments that are proportional to what each party stands to lose by not coming to agreement. ■

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