Codes and Colleagues: Is There Support for Universal Patient Acceptance?

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Abstract: This article is a refinement of verbal reactions to O’Toole’s and Corsino’s remarks at a national conference on Access to Oral Health Care held at the headquarters of the American Dental Association in August 2005. The article consists of two parts, each part an answer to specific questions. The first is a reaction to Corsino’s explanation of Paththoff’s concept of Universal Patient Acceptance. Acceptance is supported and endorsed, and a case is made for the importance of a clear and accurate explanation of Universal Patient Acceptance, as it has a much greater likelihood of being embraced by dentists than “access” seems to have. A review of relevant codes of ethics in dentistry reveals mixed and uneven support for Universal Patient Acceptance. The second part of this article compares the way that the profession of psychology views access and acceptance with the way that dentistry seems to view them and concludes that, if dentistry is to remain a caring profession rather than a commercial enterprise, acceptance must be embraced.

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Key words: access to dental care, dental ethics, Universal Patient Acceptance

Question: How are “acceptance” and related topics reflected in codes of ethics? If not made explicit, is there a consequence for such silence? What are the key features of the ethics of access?

First of all, Corsino’s article in this journal and Paththoff’s views on patient acceptance are innovative and important, even brilliant. Nonetheless, it is possible that the subtle differences between “acceptance-to-help-someone-figure-out-what-to-do-about-their-possible-need-for-dental-care” and “obligation-to-provide-treatment-to-anyone-who-darkens-your-door” may be lost on most people at first, as it was for me. Acceptance is also likely to be understood by some as an obligation to ensure that everyone in the United States receives adequate dental care, no matter the price. As Corsino and Paththoff make clear, it is neither of these. It seems like a relatively simple duty to listen to people in need and help them figure out the next, best, appropriate step. That next step might include active dental treatment in your office and it might not. Additionally, it seems callous and un-doctor-like to respond to a person in need of dental advice or care with the answer, “Our office is not accepting new patients at this time.” That is simply not the appropriate answer of a doctor in my view.

Given the heated nature of discussions in dentistry about access and all that it represents, it may indeed be difficult to get the attention of busy, self-interested practitioners. Most dentists are very nice people, and like most nice people, they get a thrill out of helping someone in need. Yet, at the first whiff of an access discussion, many dentists tense up and reflexively become defensive in an effort to ward off images of a line of homeless people at their office door in the morning. The most difficult challenge facing Universal Patient Acceptance (UPA) may be the task of accurately communicating its meaning to anxious private practitioners in the small window of time available for such a discussion.

What Do Codes Say?

Ethics codes could certainly provide a powerful venue for this communication, but only if practitioners regularly read their codes, a dubious assertion in any profession. Nonetheless, inclusion of acceptance-specific language in ethics codes provides a basis for a wider acceptance discussion, and that might open the door to acceptance of acceptance.

My review of the 2005 ADA codes reveals the following:

1. The introduction section cites a “commitment to society,” but that commitment is to “high ethical standards of conduct,” not to service or acceptance or access per se.

2. The preamble cites “qualities of compassion, kindness, integrity, fairness, and charity” that “help to define the true professional.” Certainly these virtues would mandate acceptance as it is defined by Corsino and Paththoff. But this obli-
There is, however, a big problem when you read directly from the codes who are unfamiliar with the present discussion. The way that an individual practitioner interprets these lofty virtues is left to the discretion of each practitioner when it comes to access.

3. In a discussion of “beneficence,” the codes declare that “the dentist’s primary obligation is service to the patient and the public-at-large.” This certainly opens the door to Universal Patient Acceptance (UPA), but fails to explicitly mention it.

4. Under “community service,” dentists are informed that they “have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public.” Once again, such a statement is fully aligned with UPA but does not specifically mention or require it.

5. When the codes describe “justice” and what this principle means to the dentist, it states that dentists should deal with people justly and deliver care without prejudice. It also states that “the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.” (italics mine). This is another invitation for patient acceptance. Obviously, Universal Patient Acceptance fits the bill, but it is not mentioned by name or in the form described by Corsino and Patthoff. In fact, this paragraph seems explicitly aimed at universal access, unless I have suddenly lost the ability to read straightforward English sentences. Perhaps the issue depends on what the meaning of the word “improved” is. (Where are Bill Clinton and Donald Rumsfeld when we really need them?) Does “improved” mean “made just a little better but not necessarily treatment or help for all”? Or does it mean “improvement of access so that all receive care (or attention)”?

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If improved access is a goal, then universal (rather than random or selective) acceptance is most certainly a logical and necessary step toward that goal. Even so, acceptance is not mentioned in this section of the codes either.

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Patient Selection. This paragraph asserts that dentists (“in serving the public”) “may exercise reasonable discretion in selecting patients.” So, it seems that, in dentistry, in an effort to serve the public, doctors select their patients. This seems to imply then that patients do not get to select their doctors. To a psychologist this viewpoint seems almost bizarre. How could it be that a doctor (in serving the public) selects patients? On what basis is this selection made? In the world of doctors outside of dentistry, patients select their doctors based upon a wide variety of factors such as location, reputation, attractiveness, warmth, and (apparent) wisdom, as well as the ever-present issue of participation in the patient’s plan of coverage. Patients choose their doctors and doctors decide to treat them based primarily upon their ability to effectively carry out that treatment. Dentistry apparently turns this relationship on its head, holding onto a right to choose patients based on whatever factors dentists favor (excluding, of course, “race, creed, color, sex, or national origin”). Practice management consultants routinely advocate the importance of effective patient selection, sometimes revealing this secret to young dentists: “The key to a successful practice is careful patient selection.” Any doubt about what factors patients are successfully selected on? Here’s some advice if you find yourself with a toothache: you’d better be attractive!

The concept of careful patient selection does not seem to imply any duty to patients and their needs whatsoever. In fact, it actually seems to advocate abdication of any such duty.

In sum, a review of organized American dentistry’s latest Principles of Ethics and Code of Professional Conduct reveals a conflicted interest in access and patient acceptance. Several sections of the codes urge dentists to take care of patients and improve their access to care, but one problematic paragraph seems to cancel it all out in favor of the odious concept of “patient selection,” a right that is absent from the ethics codes of other professions as far as I can tell. For example, while the American Medical Association’s Code of Medical Ethics includes specific guidelines for exclusion of patients under certain circumstances (“The treatment request is beyond the physician’s current competence” or “The treatment request is known to be scientifically invalid” or “A specific treatment sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs”), the general tone of the codes is tilted entirely toward patient service rather than patient selection. Reading directly from the medical association’s code:

The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work
Physicians, as professionals and members of society, should work to ensure access to adequate health care. Accordingly, physicians have an obligation to share in providing charity care, but not to the degree that it would seriously compromise the care provided to existing patients. (Section 10.05)

The most current edition of the *Ethics Manual* of the American College of Physicians states the following:

By history, tradition, and professional oath, physicians have a moral obligation to provide care for ill persons. Although this obligation is collective, each individual physician is obliged to do his or her fair share to ensure that all ill persons receive appropriate treatment.

**What Are the Consequences of Code Inclusion or Silence?**

The consequence is mostly symbolic, but potentially administrative or legal, should someone use the code to support their position in a legal action. Most dentists (like other professionals) do not read their own codes of ethics frequently after dental school. But the process of inserting a reference to patient acceptance might cause a stir and a subsequent debate and discussion, which are likely to be healthy, if they are not divisive. Such a move, of course, assumes that the powers-that-be (those who have authority to add things to the ADA codes) are on board. That’s apparently a significant assumption. In my view it should be attempted nonetheless.

**Patient Acceptance as an “Ethic”**

There is plenty in Corsino and Patthoff’s article to warrant an assertion that patient acceptance represents the beginnings of a viable subsystem of ethics. The best next thing to add would be a detailed description of what “acceptance” includes. What options are available to the interested and willing dentist or auxiliary, and what minimal behavior is expected? How would Universal Patient Acceptance unfold in real life? Could it be practical?

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**How Psychology Views Acceptance**

**Question:** How do multidisciplinary experts contribute directly to the ethics education of dentists?

Since I happen to be one of those “multidisciplinary experts” who “contribute directly to the ethics education of dentists,” the following ideas are organized around my dual role as dental school ethicist and school psychologist.

First, a story. I was teaching a seminar on domestic violence in a counseling psychology program recently, when the issue of dentists came up. Dentists in California are mandated to make a report when they spot injuries that have been caused by assaultive or abusive behavior. One student made a remark that caught my attention and is worth sharing here, partly because dentists and dental educators, like most professionals, spend the majority of their time with others from inside the dental world. In that world, dentists are highly regarded. They do wonderful things for people. They alleviate pain, they fix broken teeth, and they give people beautiful smiles. My psychology student saw it differently. “A dentist wouldn’t report domestic violence,” she reported. “They are more into money, and reporting might get in the way of their income.” She made this statement in a very matter-of-fact way, and no one in the class bothered to question it.

The overarching issue related to Universal Patient Acceptance, in my way of thinking, is this: Do dentists want to be doctors (serving the public) or merchants (small business entrepreneurs)? There is certainly plenty of opportunity to be either—and maybe both.

Doctors and merchants live in very different ethical worlds, and they have differing sets of responsibilities. The serious student of the clash of these worlds is referred to David Nash’s important article in a 1994 volume of this journal. In the realm of the doctor, patient care is at the center. It’s the whole point of the enterprise. Doctors take care of patients, and they are (at least at this point in American history) well rewarded for their efforts. Merchants, on the other hand, make a profit. It’s their reason for doing
what they do, and it orients them on a day-to-day basis. Buyers and sellers enter into a competitive relationship when they interact in the commercial marketplace. Officers of a public corporation actually have an ethical obligation to make decisions that enhance value to shareholders, usually in the form of increased profits. In contrast, doctors and patients interact cooperatively, on behalf of patient care. Buyers must be careful to look after their own interests (caveat emptor) as they are well aware that the seller will not do that for them. Patients, on the other hand, cannot adequately compete with doctors, because the playing field is not even. Patients cannot accurately or reliably diagnose themselves. When they are told that they need a root canal, they cannot adequately evaluate that statement without the help and trust of a dentist. Finally, there is often more at stake in the doctor-patient arena, sometimes even life or death.

I think that dentists really need to think about this paradigm and make serious value decisions about which world they want for their practice, identity, and reputation. At the University of the Pacific, we stress that question with our dental students, some of whom show up at the dental school with a merchant’s point of view already in place. Many learned it from their parents. Others pick it up in reaction to the understandable fear they feel in their stomach when they think about paying back student loans or buying a practice.

Other kinds of doctors, Ph.D.’s in particular, can have input to the moral education of dentists, as I do. In my opinion, psychologists bring a different sensibility to questions of who treats whom, who gets treatment, and what should happen to those who cannot seem to afford care. As far as I know, psychology does not have as much of an “access” problem (although it is sometimes difficult to attract psychologists to remote rural locations). This may be because dental care is viewed as more of a mandatory treatment than, say, psychotherapy, marriage counseling, or substance abuse treatment. Most Americans are probably aware that everybody should visit a dentist regularly, even if they don’t do it themselves. Few, however, would say the same thing about their psychologist, if they even have one. Many Americans actually treat a visit to the psychologist as if it were a shameful defeat, and one dental student recently informed me that one of her goals in dental school was to survive the entire undergraduate experience without having to visit my office. So the comparisons between dentistry and psychology might be an apples and oranges exercise, but it may also shed some light.

In my world, every American ought to have ten free sessions of individual psychotherapy a year, along with as many ongoing group sessions as they desire. The world would be a better place, marriages would last longer, and there would be fewer alcohol-related tragedies. But this is, of course, pie in the sky.

Psychologists generally think differently about access issues than dentists typically do. For better and for worse, psychologists don’t really think much like business people.

In contrast to the patient selection content found in codes of dental ethics, the current *Ethical Principles of Psychologists and Code of Conduct* document published by the American Psychological Association (APA) says the following:

> Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.

Psychology spells it out. All persons are entitled to access. I cannot imagine such a statement in a dental ethics code. Psychologists and dentists think differently about these things (and dentists end up making a lot more money). I can still remember feeling shocked when I first encountered, more than a decade ago, the way that dentistry tends to view this issue. It was jarring and disorienting, but I did not say anything about it at the time, as I didn’t feel that I understood enough as an outsider to offer cogent insight.

When psychologists are hired by dental schools to help develop new dentists, we bring with us a certain viewpoint about service and access. We tend to think that doctors have serious obligations to anyone who needs help. In fact, a second section of the APA codes states that “Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.”

These differences manifest themselves in the following ways in my dental school. As the person responsible for virtually all of the formal ethics instruction, I have overtly attempted to inculcate dental students with the psychologist’s view of service to patients. It seems to me that, for the reasons described above, and because dentists have a monopoly on the provision of dental care, dentists, in the aggregate, have responsibility for the provision of dental services to the entire general public. While such a statement may be overly expansive, it
is safe to say that dentists have a responsibility to the public certainly greater than that of treatment (only) of current patients of record or even of patients who seem attractive. This point of view does not always go over well with dental students. Some students, the idealistic ones, are open to discussions about access, service, and the treatment of “unattractive” patients (e.g., patients without money, patients lacking a “good” dental plan, patients with disabilities, patients with complex medical situations, the elderly, and patients with HIV). Others, however, are not so open. Some simply keep quiet and tolerate the class until it finally ends. If I call on such a student, though, I occasionally get an earful of realpolitik—that is, the way it is out there in the real-life practice of dentistry. It is naïve, they tell me, to think that dentists have a responsibility to take care of the oral health needs of everyone in their community. Their dad, they say, is a very good person and he takes excellent care of the people in his practice—those who are responsible enough to show up for their appointments and pay their bills on time. The responsibility goes both ways, they tell me, and patients have responsibilities, too. Besides, you have to be careful. If you give work away for free, there will be a line of indigent people in front of your door by Monday morning, when word gets out that you are a soft touch. The discussion can get a little nasty, and it rarely stays on a rational track for very long.

Dental students exercise patient selection, and the dental school culture and environment exert a powerful influence. I spoke with a student recently about how to manage his difficult school situation, and he told me that due to an anomaly he currently had an excess of patients. This was a good thing, he matter-of-factly reported, because he could then keep the attractive patients and “discard” the others. This decision making process amounts to a serious survival skill in the difficult arena of dental school. I probably would have made the same decisions myself under those circumstances.

While psychologists and ethicists can do their best to bring outside views and influence into the dental school mix, it would be a violation of social psychology’s “fundamental attribution error” to assume that they can have a strong enough influence to make a significant difference in the face of powerful, contrasting environmental forces. But, we can try, and our voices do count.

REFERENCES